AMERICAN HANDBOOK OF PSYCHIATRY

Volume One

SILVANO ARIETI · *Editor*

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PREFACE

Silvano Arieti

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PERHAPS NO OTHER FIELD of human endeavor is so encompassing and difficult to define as that of psychiatry.

Like his fellow scientists, the psychiatrist must be aware of the developments in at least a score of related fields and must subject his studies to the rigor of scientific procedure. Unlike his fellow scientists, however, he extends his investigations to the subjective world of the individual and must include, in all of its aspects, the drama of man. Thus, the psychiatrist searches areas which were, until recently, reserved to the intuition of the poet and the artist and to the speculation of the philosopher. With this increased responsibility psychiatry's horizons are larger and richer, but psychiatry's consistency is threatened. The expanding horizons and the threat to consistency, however, reflect the drama of man; they are in their turn appropriately reflected in this book.

This work represents a serious effort on the part of 111 authors to present the developments, concepts, trends, techniques, problems, and prospects of psychiatry today, in a form useful for both the expert and the beginner, in which every leading school of thought and every major approach is included. Some of these approaches converge and integrate; others diverge; but until the above-mentioned threat to consistency is eliminated by the effect of an as yet unforeseen synthesis, we must follow this multiple, diversified approach. Any other path would lead not to unity or synthesis but to that pseudo-unity and pseudo-synthesis which is reductionism in its various forms.

The orientation of the editor and the editorial board was toward completeness, representation of all points of view, and reliability, rather than uniformity or consistency. Each author was requested to cover his special field; he was free to express his personal point of view, but he was asked also to present alterna-

tive conceptions and to reduce his private terminology to a minimum, or to define it immediately.

The authors who were invited to participate in this project are in most instances recognized authorities in their respective fields. In several instances, the task of selecting the author was difficult because many people had made important contributions in the same field. Some authors could not participate because of heavy involvement in other work.

A guiding principle in the organization of the *Handbook* was that of presenting a check and balance between different approaches whenever it was feasible. For example, Chapter 3 (Ostow), illustrating the basic role of instinct in human behavior, is balanced by Chapter 4 (Bone), which emphasizes the nonbiological aspects of behavior. Chapter 28, by Cleckley, which discusses psychopathic states, is predominantly nosologic; counterbalancing this is Johnson's Chapter 42 on juvenile delinquency, which is psychodynamically oriented. Communication is treated by both Ruesch and Rose Spiegel in chapters which supplement and counterbalance each other. Goldstein in "Functional Disturbances in Brain Damage," Weinstein and Kahn in "Symbolic Reorganizations in Brain Injuries," and Brosin in "Psychiatric Conditions Following Head Injury" present three major approaches to similar topics. All major psychotherapeutic and psychoanalytic schools and physical methods of therapy are included. Chapter 89, concerning the contributions from the field of religion, was assigned to four authors. Appel, Higgins, and Ostow represent the three major religious denominations in the United States—Protestant, Catholic, and Jewish—and Von Domarus speaks from a non-Western point of view.

The *Handbook* is divided into fifteen parts, and the headings and divisions are self-explanatory. A few comments, however, are perhaps necessary. Not only does the book cover all the subjects reported in a usual textbook of psychiatry, but several topics are presented here for the first time. In spite of this broad scope, some limitations had to be imposed. For instance, chapters 1 and 2 deal with the history of psychiatry in America rather than of psychiatry in general, since the space limitations would not permit an adequate account of the broader subject. Part Five covers many important, but not all of, the possible aspects of psychosomatic medicine. Such topics as psychosomatic aspects of ear, eye, and skin disorders as well as of allergic, dental, and arthritic conditions have been omitted. Part Thirteen, reporting on contributions from related fields, could have been expanded many times. Here arbitrary selection was necessary.

In spite of these limitations, the book is offered as representative of American psychiatry today. The name American used in this context refers specifically to the receptivity to all possible approaches which is characteristic of psychiatry in the United States. Although most of the great psychiatric contributions originated in Europe, in no country other than the United States is there such willingness to listen to, try out, and evaluate all theories, methodologies, and techniques and to absorb and find a place for all or many of them.

This work could not have been accomplished without the generous cooperation of many people. Some contributors made suggestions which could not be accepted because they would have altered the purposes and aims of the book. Two or three of our contributors disagreed with editorial policies but participated nevertheless. It is obvious, of course, from the organization of the *Handbook* that the views expressed in the various chapters are the responsibility of the respective authors and do not necessarily represent those of the editor, the editorial board, or the publisher.

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Sadly, the period that this work was in preparation has seen the death of four of our original contributors. On January 19, 1958, Dr. Abraham Fabian, an important writer in the field of child psychiatry, died at a young age. Dr. Fabian had not yet completed his manuscript for the *Handbook*. On February 25, 1958, Dr. Eilhard Von Domarus died after a distinguished career. Dr. Von Domarus was known particularly for his interdisciplinary approach in the fields of anthropology, philosophy, psychiatry, and religion. His major contributions, which were in the field of schizophrenic thinking, stimulated others to pursue this important subject. Dr. James Papez, one of our greatest neuroanatomists, died suddenly on April 13, 1958. Dr. Papez's contributions are too many to be enumerated here, but the one which received the most consideration is his neurophysiologic theory of emotion. And on December 20, 1958, death took Dr. Clara Thompson, a distinguished clinician-teacher whose writings have done so much to integrate the cultural approach into the framework of psychoanalysis. Dr. Thompson was Director of the William Alanson White Institute, and those of us who had the good fortune to know and work closely with her have lost a source of inspiration and stimulation. The contributions of Dr. Von Domarus, Dr. Papez, and Dr. Thompson appear posthumously in these volumes.

Some of our 111 authors also served as members of the editorial board; they have been generous with their time in the original planning as well as in the revisions of some of the papers. Miss Martha Crossen, who was in charge of the editorial staff assigned to the *Handbook*, was an invaluable help with her many suggestions concerning the presentation of the various subjects, style, and similar matters. Not only the extent of this enterprise but also the spirit of cooperation by which it was animated are indicated by the number of people I have mentioned and the many more I could add. As editor, I express to all of them my deep gratitude.

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PART ONE

General

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CHAPTER 1

AMERICAN PSYCHIATRY FROM ITS BEGINNINGS TO WORLD WAR II

Nolan D. C. Lewis

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PSYCHIATRY HAS DEVELOPED in combination and association with the other branches of medicine to the extent that its borders, as a specialty, in certain areas are not sharply outlined, and, moreover, most of its particular concepts and aims are exceedingly difficult to trace accurately in terms of their chronological appearance.

Medicine is seen with a matrix of economic, political, social, and cultural elements. It is but one aspect of the state of general civilization of a period, and its particular philosophy and practice are determined to a considerable extent by the current cultural conditions of its locality and time.

To attempt to trace the complex growth of psychiatric thought is an interesting experience. The most satisfactory way to understand a complicated phenomenon is to follow its pathway of genesis, but, to cover the span of time indicated by the title of this chapter, one must resort to a condensed style of communication. The topic includes more than a hundred years, during the early parts of which are revealed only a few records of basic importance in our particular field; however, there are some outstanding persons and events which appear as bright promises of progress to come in later years.

Since the aim in this chapter is to indicate some of the most important trends of thought which constitute the background of present-day psychiatry in this country, no attempt has been made to present a complete history of psychiatry in America, and thus many workers and their accomplishments have been omitted. In psychiatry as well as in other branches of medicine, one can find pioneers, men whose energy and curiosity were so great as to lead them to devote their lives to the promotion

and extension of knowledge beyond the existing outposts of what was accepted and practiced. Benjamin Rush (1745–1813), "America's first psychiatrist," was one of these men.

At the termination of the American Revolution in 1783, Dr. Benjamin Rush joined the staff of physicians at the Pennsylvania Hospital in Philadelphia, which event is often referred to as being the actual beginning of American psychiatry. Although at this time Rush was only thirty-eight years old, he was already a very famous physician. He had been a precocious student, having graduated from the New Jersey College (now Princeton) at the age of fifteen. He received his doctor's degree from the University of Edinburgh at the age of twenty-two. While at Edinburgh he studied under William Cullen (1710–1790) who was one of the most famous professors of medicine of his time, with an interest in the nervous system and in behavior phenomena. Cullen was a follower of Locke, but he originated a new doctrine of physiological significance. In his system irritability of the nervous system was of special importance, and the causes of mental disorders were within the individual, that is, endogenous. Insanity was a pathological condition of the mind and not some force entering from without, and therefore its expressions should be interpreted in the light of normal psychological functions. His *First Lines of the Practice of Physik* (London, 1777) described paranoid forms of mental disorder which he called "vesaniae." Rush was introduced to Cullen by a letter from Benjamin Franklin, a fortunate occurrence since Cullen exerted a strong influence on Rush's subsequent career which was thus oriented in the theory and therapy then prevalent in Scotland and England.

Dr. Rush, equipped with a keen mind and the best training available at the time, attacked the problems of mental disorder, a subject which was infiltrated with superstition and ignorance as well as characterized by neglect and actual brutality. He was apparently the first American physician to approach the investigation and treatment of mental disorders from a scientific viewpoint, the first American teacher to propose an original systematization of psychiatry, and the first to write a general treatise on psychiatry in America. This book, published in 1812 under the title *Medical Inquiries and Observations Upon Diseases of the Mind*, remained the only American book of its kind for seventy years.

Rush's principal remedies were purgatives, emetics, and bloodletting, of which he was a particularly strong advocate. The condition of the blood circulation in the brain was a prominent focus for his theories and therapy. He devised two curious instruments, the gyrator, based on the principle of centrifugal action to increase cerebral circulation, and the tranquilizer (1810) "to obviate these evils of the 'strait waistcoat' and at the same time to obtain all the benefit of coercion." These instruments, which were certainly rough on the patient, were decidedly "shock" measures—a form of shock therapy, and, like all shock therapies including the modern ones, were interpreted as effecting cures.

Benjamin Rush was one of the earliest, if not the first, to recommend labor and prison sentences instead of capital punishment for criminal offenses, and he consistently advocated a modification of the harsh and cruel elements in the system of criminal jurisprudence. In the minds of many medical historians, he did for America what Pinel and Esquirol did for France. His biographers are in accord that he, like many originators and creators, was a strongly opinionated man, difficult to get along with, frankly intolerant of anyone who did not agree with his theories and practices, and at times actively quarrelsome. He was a very learned man who not only served the poor of his community but was foremost in patriotism and a signer of the Declaration of Independence. His was an overwhelming personality, fully justifying the title by which he is known today, "The Father of American Psychiatry."

Dr. Adolf Meyer (1866–1950) in 1945 made the following pertinent comment:

> Had Benjamin Rush had a successor akin to his own spirit American psychiatry may have had the lead over the European and its actually colonial development. It took a hundred years before the step towards a culture for responsible life began to assert itself. . . . I do not know what the

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names and teachings of the immediate successors were. . . . Psychiatry may see the influence of the 1840's in J. P. Gray.[28]

Psychiatry has always been more hospital-centered in England and other countries than it has here in America, but there were some important early, as well as later, developments of this nature that are of historical significance. For example, the old San Hipolito, established in Mexico in 1566 by the philanthropist Bernardo Alvares, was the first hospital in the Americas for the study and care of mental disorders and, of course, one of the earliest for this purpose in the whole world. At first this institution was not devoted exclusively to the treatment of mentally disordered patients, but before long the increase in the number of these cases made it necessary to restrict the admissions to nervous and mental patients.

It was nearly two hundred years before the first institution to care for the mentally disordered in the American states was organized. In 1752 the Pennsylvania Hospital in Philadelphia received insane patients, and this was followed by a few other public and private institutions. In 1773 the first public hospital exclusively for mental patients was established at Williamsburg, Virginia, then the capital of the colony. For half a century mental patients were kept at the Pennsylvania Hospital, in cells in different parts of the building, but in 1796 a new wing was provided for these patients, and at the end of another fifty years a separate building was constructed for them. The Bloomingdale Asylum was another of the early institutions for the mentally disordered. It was opened in the New York City area in 1821 as a separately managed hospital, although it had its beginnings in the earlier founding of the New York Hospital. It continues today in White Plains, New York, as the Westchester Division of the New York Hospital.

Out of a meeting held in 1844 by a group called the "original thirteen" came the organization known as the Association of Medical Superintendents of American Institutions, which was the first national society of physicians in the country. From 1893 to 1921, it was known as the American Medico-psychological Association, and is now the American Psychiatric Association, with a large and ever-growing membership. In the year of its origin (1844) the *American Journal of Insanity*, later to become *The American Journal of Psychiatry*, the official organ of the Association, was established under the editorship of Amariah Brigham (1798–1849), one of the original thirteen superintendents. The *Journal* has continued to be a leader in the field by virtue of the management of a line of distinguished editors.

In their day the "original thirteen" made a lot of psychiatric history, both as a group and as individuals. It is well to note some of their particular contributions as pioneer workers.

Samuel B. Woodward (1787–1850) was the first president of the Association of Medical Superintendents of America and a strong force in its organization. He aided in establishing the Retreat for the Insane at Hartford, Connecticut. In 1832 Massachusetts was the first state in New England to build a state hospital. Woodward supervised the construction of this hospital and became its first superintendent. He believed in specialized medical care for alcoholics, and in 1838 his volume entitled *Essays on Asylums for Inebriates* was published. He was elected to the Connecticut state legislature in 1830.

Isaac Ray (1807–1881) was an avid student of scientific matters, both in America and in Europe, and a prolific writer. He was one of the most eminent and versatile of the group. In 1841 he became medical superintendent of the State Hospital for the Insane at Augusta, Maine, and later of the famous Butler Hospital in Providence, Rhode Island. He wrote a book on mental hygiene in 1863 and was interested particularly in the relationship between legislation and mental disease. As a matter of fact, the first book in the English language concerning forensic psychiatry was published by Ray in 1838, which made a profound impression and established him as a pioneer and leader in medicolegal matters. The title of this book was *Treatise on the Medical Jurisprudence of Insanity*. It was used as an authoritative text for court work for nearly fifty years.

Amariah Brigham (1798–1849), founder of the *American Journal of Insanity*, was a dis-

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tinguished author, teacher, and hospital administrator whose influence for the better understanding and care of the mentally sick was widespread. He wrote lucidly on such diverse subjects as cholera, religion, clinical neurology, and clinical psychiatry. At one time he taught anatomy at the College of Physicians and Surgeons in New York City. In 1842 he was appointed superintendent of the State Lunatic Asylum at Utica, New York, the first New York State public institution for the mentally disordered. This hospital, under his inspiration and effort, became an outstanding training center for medical superintendents. His book entitled *Remarks on the Influence of Mental Cultivation Upon Health* had a remarkably wide American and European distribution.

Pliny Earle (1809–1892), in 1844, was appointed superintendent of the Bloomingdale Asylum in New York. In 1863 he became professor of psychological medicine at the Berkshire Medical Institution in Pittsfield, Massachusetts. This may have been the first chair of psychiatry in a medical school in this country, and it was certainly one of the very early additions of psychiatry to a medical curriculum in the United States. From 1864 to 1885, he was superintendent of the State Lunatic Hospital at Northampton, Massachusetts.

Dr. Earle was an able hospital administrator and an outstanding contributor to the literature on mental disease. He was well versed in the European psychiatry of the day, introducing new ideas from Germany and France. He published many statistical papers, psychiatric reviews, and historical essays, and lectured widely. In 1877 he published a statistical treatise entitled *The Curability of Insanity*. He had a critical mind and a far-reaching vision, recommending small hospitals for intensive treatment and separate ones for the incurable patients. He was also an early advocate of family care and occupational therapy.

Thomas S. Kirkbride (1809–1883), after receiving his medical degree from the University of Pennsylvania in 1832, became resident physician at Friends Asylum, followed by a residency at the Pennsylvania Hospital, and later by the appointment as superintendent of the new Pennsylvania Hospital, a position which he held for forty-three years during which time he was a progressive advocate of many reforms in the care and therapy of mental patients and served as an active participant in community affairs.

Dr. Kirkbride published many important books and articles. In 1847 he published an article on hospital construction which made such an impression that for at least fifty years the "Kirkbride type" of hospital building was adopted by many institutions. A notable number, if not most, of the "Kirkbride type" buildings are still in active use today in the older mental hospitals. Dr. Earl Bond[3] has written a most informative book, *Dr. Kirkbride and His Mental Hospital*, about this remarkable personality and his achievements.

William M. Awl (1790–1876), after some years in general practice, settled in Columbus, Ohio, in 1833, where he became active in the organization of a mental hospital, the Ohio State Asylum for the Insane. He became its first superintendent in 1838 and remained at this post for twelve years, when he was removed by political factions. He then returned to private practice and also became physician at the Ohio Institute for the Blind.

Although Dr. Awl possessed keen mental abilities, he wrote very little on mental disorders. He devoted much time and thought to the organization of the state asylum and the institute for the blind, and was concerned with the organization of the Ohio Medical Society.

Luther V. Bell (1806–1862) became superintendent of the McLean Asylum in Somerville, Massachusetts, when it had been in operation for nineteen years. He received his medical degree from Dartmouth at the early age of twenty, was in general practice for a time in New Hampshire, and also served in the state legislature, as well as participating in establishing the State Asylum at Concord before taking the post at McLean Asylum.

Dr. Bell wrote on a wide range of medical subjects, including an original description of a form of acute mania, which was named after him (Bell's disease). During his active professional lifetime he received many awards and

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honors and was a participant in a variety of local and national civic activities. He was the only one of the "original thirteen" to have served in the Civil War, during which he died, in 1862, in an army camp near Washington, D.C., where he was a medical inspector.

John S. Butler (1803–1890), after receiving his medical degree from the Jefferson Medical College in Philadelphia in 1828, entered private practice in Worcester, Massachusetts, until 1839 when he was appointed superintendent of the Boston Lunatic Hospital. Here, he soon instituted various reforms and striking improvements in the hospital treatment of patients. In 1843 Dr. Butler was elected superintendent of the Retreat for the Insane at Hartford, Connecticut, to succeed Dr. Amariah Brigham, who had gone to Utica, New York. Dr. Butler remained at the Retreat for nearly thirty years, during which time he demonstrated outstanding leadership and a progressive spirit. He remained active in medical matters for another ten years after retirement from hospital service.

Nehemiah Cutter (1787–1859) received his medical degree from Yale University in 1817 and entered private practice in Pepperell, Massachusetts, where he gradually built up a specialty of treating the mentally ill to the point of organizing a private hospital known as the Pepperell Private Asylum. This hospital was successful despite the prejudice extant against private mental institutions. The hospital burned down in 1853 and was not rebuilt; however, Dr. Cutter continued in a successful career as a practicing physician.

Charles H. Stedman (1805–1866) graduated from the Harvard Medical School in 1828, and in 1830 was appointed resident surgeon at the United States Marine Hospital at Chelsea, Massachusetts, where he worked for ten years. In 1834, being keenly interested in the theories of Gall and Spurzheim, he edited a translation of Spurzheim's book on brain anatomy.

Dr. Stedman started a private practice in Boston in 1840, and two years later he became superintendent of the Boston Lunatic Hospital, following the resignation of Dr. Butler. Here he proved to be an exceptionally able administrator and student of mental disorders. He was also particularly active as a staff member and consultant in medicine and surgery in various other hospitals in the city.

Samuel White (1777–1845) opened an office for private practice at Hudson, New York, in 1797 at the age of twenty years. He apparently never attended a medical school but gained his professional education by means of the apprentice system, which was possible in those early times. In 1830 he opened a private hospital, called Hudson Lunatic Asylum, where he functioned successfully until his death. From the historical fragments that have been recorded about his life and ideas, one may assume that he was progressive in thought, was accepted as an authority by his contemporaries, and that he utilized the best methods known in practice.

Francis T. Stribling (1810–1874) obtained his medical degree from the University of Pennsylvania in 1830. He was in private practice for a time in Staunton, Virginia, his native town, and at the age twenty-six years was appointed physician to the Western Lunatic Asylum of Virginia. Dr. Stribling left very little by way of published work, but he was an able clinician and was one of the early advocates of training for attendants, of prompt treatment for acute cases, and of occupational therapy.

John M. Galt (1819–1862) was a young man of twenty-two when he received his medical degree from the University of Pennsylvania in 1841, and in this year he was made the first superintendent of the Williamsburg Asylum which had been established many years before (1773). He was an unusually erudite man who read in many languages and was thus able to bring important psychiatric literature to the attention of American physicians. In 1846 he published a book entitled *The Treatment of Insanity* which contained a summary of about all of what was known of mental disorders. Other books and many articles came from his pen, and, although his life span was comparatively short, his was a powerful influence for progress since he advocated freely the proper keeping of records, the performance of autopsies, the value of research, and the need for changes in the legal

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aspects of psychiatry. He utilized in his hospital several of the adjunct therapies that are in vogue today.

Of these founders of the Association of Medical Superintendents of American Institutions for the Insane, six were in charge of state institutions, five directed incorporated hospitals, and two were the proprietors of private hospitals. From the intelligence of this remarkable group of men and the examples they set in their respective areas have developed many of our modern attitudes and endeavors in the specialty. At the time they formed their national association, European psychiatry, although still relatively young as a medical discipline, had progressed to a point where the mentally sick were no longer treated as monsters or criminals but as patients suffering from very serious disorders.

Another important powerful force in the evolution of American psychiatry, for many years after 1841, was Dorothea Lynde Dix (1802–1887) of Boston. This remarkable woman, a retired schoolteacher, became "shocked" by what she saw in the care of mental patients in certain places, where they were locked up in filthy cells and not only were neglected but often treated brutally as well. Through her widespread activities not only in the United States but also in Canada, the British Isles, and on the European continent, reforms were instituted successfully through various government agencies. She is credited with having been directly responsible for creating or extending the facilities of a total of thirty-two hospitals. In this country, twenty states built or enlarged mental hospitals as a result of her personal efforts. The Government Hospital for the Insane (now St. Elizabeths Hospital) at Washington, D.C., is among those that she aided in establishing.

On the second day of the second annual meeting of the American Neurological Association held at the College of Physicians and Surgeons in New York City in 1876, with sixteen members present, Dr. George M. Beard (1839–1883) presented a paper entitled "The Influence of Mind in the Causation and Cure of Disease and the Potency of Definite Expectation." This paper was remarkable in its originality, as it dealt clearly with what is now known as psychosomatic medicine. Such a presentation was new and startling, in fact, so startling that the famous neurologist, Dr. William A. Hammond, remarked during the discussion that, if the doctrine advanced by Beard was to be accepted, he "should feel like throwing his diploma away and joining the theologians."

According to the original report in the *Transactions of the Association*, "Dr. Beard maintained that disease might appear and disappear without the influence of any other agency than some kind of emotion. Mental qualities, like drugs, could neutralize therapeutics and they could also increase the effect of drugs. Fear, terror, anxiety and care, grief, anger, wonder and expectation were regarded as the most likely to produce disease." To the criticisms referring to mental therapeutics as being nothing new, Beard replied that he had not implied that psychotherapy was new, but that it had not been carried out in a systematic manner by the profession. Although there was much vigorous critical discussion and skepticism, the brilliant Beard, pioneer in the field, defended his position with confidence and ability. When Beard's famous paper entitled "Neurasthenia (Nervous Exhaustion) and Morbid Fears as a Symptom of Nervous Disease" appeared (1869), his term "neurasthenia" was gradually adopted over the whole world as "Beard's disease," and he was duly recognized as a great pathfinder.

Among the prominent American alienists of the 1880's were Allan McClane Hamilton, Walter Channing, John Chapin, John P. Gray, W. A. Hammond, and E. C. Spitzka. Dr. Hammond, usually considered as a neurologist, also taught psychiatry and wrote a book, *Insanity in Its Medical Relations*, which came into active use as a text. Dr. Spitzka, in 1883, published the *Manual of Insanity*, which included about all that was known and taught of the subject. Although the term "paranoia" (which means "mental disorder" in the original Greek) was introduced into medicine by Vogel in 1764 after which it had rather widespread applications, it was Dr. Spitzka of New York

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who, out of a welter of conditions and names, differentiated it as a specific disorder. It is therefore an American-named psychosis, as we use and understand the term today.

One of the strongest influences to bear upon American psychiatry was the work of Emil Kraepelin (1856–1926). He was professor of psychiatry successively at Dorpat, Heidelberg, and Munich and is generally considered to have been the greatest of all descriptive psychiatrists whose concepts increased and enriched the whole field. He was a systematizer who, following periods of active analysis of data, attempted a synthesis of scattered facts and ideas. Kraepelin had a large amount of clinical and laboratory material with which to work, and he made his studies according to the natural history method, in that he followed the course of mental disorder in the individual cases from the earliest symptoms on through to the termination. By means of this method, it became possible for him to make a new grouping of mental disorders on which some basis for prognosis, therapy, and prevention could be ascertained. He was after the causes, the course, and the outcome of mental disorders with reference to any pathological lesions and processes, and he was interested in any mental trends and clinical pictures that tended to terminate in various degrees of deterioration.

In 1883 Kraepelin published the first edition of his *Psychiatrie* which subsequently passed through several revisions and translations into other languages. The English translation of the book changed the whole aspect of classification of mental disorders in America. His outstanding contributions to the description and delineations of dementia praecox states and manic-depressive conditions have held a central position in psychiatric thought and practice from the time they were first introduced to the present day. His clinical descriptions of the psychoses can still be read with a great deal of profit by the student of psychiatry.

The concept of dementia praecox was later elaborated and expanded into schizophrenia by Eugen Bleuler (1857–1939) in 1911. Among this eminent Burghölzli professor's numerous original contributions which have vitalized psychiatry in all civilized areas are the psychology of dementia praecox (schizophrenia) including the phenomena of ambivalence and of autistic thinking and the delineation of the schizoid and syntonic personalities, and some later biophilosophical theories.

About one year after the birth of Kraepelin, a man was born who was not only to revolutionize psychiatry but to influence the philosophic thought of the whole world, namely Sigmund Freud (1856–1939). After a period of interest in neurology, Freud went to Paris to study under Charcot, who was the outstanding clinical neurologist of his day, and who had developed a system of hypnosis for the treatment of hysteria. After returning home to Vienna, Freud carried out some studies of his own, and in 1895 the *Studien ueber Hysterie* was published, followed by the *Traumdeutung* in 1900. These studies represented a new approach to the investigation of human motivation and to the phenomena of the unconscious. Freud had replaced hypnosis with his method of free thought association and dream interpretation.

Freud's technique made it possible, for the first time, for a physician to devote his time in attempting to understand the innermost working of the patient's mind rather than directing the patient's life in matters that were obscure to everyone involved. For a number of years Freud worked alone, but later, when well on his way to success and despite the great amount of opposition from critical contemporaries, students of the mind began to take an interest in the concepts, and a number of now-well-known names appear in the list of his special pupils, supporters, and co-workers. Among these are Karl Abraham, Sandor Ferenczi, Carl Jung, Alfred Adler, Wilhelm Stekel, Otto Rank, Hans Sachs, Paul Federn, and Ernest Jones.

Jung, Adler, Rank, and Stekel later developed some special modifications of psychoanalysis contrary to Freud's wishes. He insisted that these modifications were not really psychoanalytic and were of such a nature that they necessitated his breaking off professional relationship with these workers. However, these

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doctrines all found followers in America and elsewhere, as have the later modifications of some of Freud's theories and techniques such as those of Sandor Rado, Franz Alexander, Karen Horney, and Harry Stack Sullivan among others in this country.

In 1909 Freud made a personal appearance in America to lecture under the auspices of Clark University in Worcester, Massachusetts. It may be said that practically everything that Freud wrote has at one time or another been translated into the English language, but in those earlier years America became rather thoroughly acquainted with the Freudian literature through the efforts of Abraham A. Brill, who first translated Freud's works, and of Smith Ely Jelliffe and William A. White, both of whom were outstanding leaders in psychiatric thought and freely disseminated such knowledge through their prolific writings of books and articles. Psychoanalysis soon gained a wide acceptance and became gradually incorporated into psychiatric thought and procedure.

Psychoanalytic teaching and practice were organized and standardized by the establishment of psychoanalytic institutes and societies directed and supported by highly trained specialists in several large cities in America as well as abroad. The psychoanalytic literature which has accrued over the years reveals a considerable diversity of trends, but in the main they fall into two general categories—(1) that which includes investigations aimed to extend the field of metapsychology where the unconscious structure of the super-ego, the material gained by hypnosis, and the pregenital infantile frustrations are the principal topics, and (2) that which attempts to adapt current theories to clinical confirmation. There are now an ever-increasing number of able workers interested in testing the validity of the libido theory and other concepts pertaining to various psychiatric conditions, in understanding the physiological manifestations of mental attitudes by means of combined studies in cooperation with modern biological laboratory disciplines, and in establishing an interpretation of neurotic symptoms in terms of somatobiological activity.

A group of Fellows of the American Psychiatric Association formed a Section in Psychoanalysis within the Association in 1933, and a year later a symposium was given in this section on the relation of psychoanalysis to psychiatry, which marked the beginning of a new era in the history of psychoanalysis in America. The conclusions were to the effect that the psychoanalytic formulations of Freud were established as indispensable to the procedures of treatment and research, and that requirements of technique, the investigation of unclear or incomplete knowledge, and the application of therapeutic procedures to selected clinical groups were being continually studied and that it was to be expected that modifications of psychoanalytic conceptions would take place to a considerable extent.

Another prominent psychiatric development took place under the leadership of Adolf Meyer (1866–1950). He came to America from Switzerland as a young man, well trained in neuroanatomy, neuropathology, psychiatry, and philosophy. Following services as pathologist in state hospitals of Kankakee, Illinois, and Worcester, Massachusetts, he became director of the New York State Psychiatric Institute on Wards Island where, as early as 1906, he was working on his concept of integration with the total individual as a unit. From the beginning he emphasized the pathological evolution of the symptoms of psychiatric disorders in terms of all of the presenting facts. His was a dynamic system.

Later, in 1912, when Dr. Meyer became Director of the Henry Phipps Psychiatric Clinic and Professor of Psychiatry at the Johns Hopkins Medical School, he formulated through the subsequent years the reaction type of behavior and his concepts of social adjustment. He created a fresh, unique attitude toward the individual as a totality and brought the term "psychobiology" into the foreground. By training many psychiatric teachers in this discipline, he created a school of thought—particularly, the concept of psychobiology—which has had a notable influence on psychiatric developments, particularly in this country and Great Britain.

Early in the 1900's Elmer E. Southard

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(1876–1920), another great ferment in psychiatry, developed the psychopathic-hospital idea and also brought into the foreground the training of social workers in psychiatry. Adolf Meyer had brought social work into psychiatry as early as 1904, but in 1912 it was Southard who expressed clearly the social aspects of psychiatry and extended its interests into the training of social workers and into industrial hygiene. His famous book *The Kingdom of Evils,* with Mary C. Jarrett as coauthor, was published in 1922 after Southard's death. This book dealt with social case work, presenting 100 case histories together with a classification of social divisions of evil. In 1919 he said, "Social psychiatry is far from the whole of mental hygiene, for mental hygiene includes also the far more difficult and intriguing topic of the individual as related to himself and his organ processes." Here is reflected the keen interest he always had in the organic reactions of the body and brain which were the principal foci of his original researches.

It seems that the term "mental hygiene," in its generally accepted meaning, first appeared in the literature in 1843 in a book entitled *Mental Hygiene or an Examination of the Intellect and Passions Designed to Illustrate Their Influence on Health and Duration of Life* by Dr. W. C. Sweetser, Professor of Therapy and Practice of Physic at the University of Vermont. Dr. Isaac Ray also wrote a book ten years later entitled *Mental Hygiene.* He defined it as the art of preserving the health of the mind, and he emphasized that all methods of preserving mental health came under it. However, many years were to pass before the mental-hygiene movement became a force for psychiatric progress. In 1908 Clifford Beers published his book, *The Mind that Found Itself,* which created a tremendous interest. By his efforts, together with those of Adolf Meyer and others, the National Committee for Mental Hygiene was organized in 1908. Dr. Meyer suggested the name "mental hygiene" for this committee, which has now been changed to National Committee for Mental Health. It began with twelve charter members, among whom three were the prominent psychiatrists, August Hoch, Adolf Meyer, and Frederick Peterson; the famous psychologist, William James; and the Johns Hopkins internist, Lewellys Barker. In 1912 Dr. Thomas W. Salmon (1876–1927) was appointed director.

The chief aims of the Committee were clearly stated: (1) to work for the protection of the mental health of the public; (2) to strive to raise the standard of care for the mentally ill and for those in danger of becoming mentally disordered; (3) to promote the study of all types of mental illness and to disseminate information concerning their causes, therapy, and prevention; (4) to obtain from every available source reliable data regarding methods of dealing with mental disorders; (5) to enlist the help of the federal government to the extent desirable; and (6) to coordinate the existing agencies and to aid in the organization, in each state, of an allied but independent society for mental hygiene.

The dynamic concepts of Freud, Pierre Janet (1859–1947), and Adolf Meyer strongly emphasized psychotherapy. The early workers in America as well as elsewhere had considered psychotherapy in terms of moral treatment, occupational therapy, recreational activities, and similar procedures, but the followers of the exponents of dynamics, such as A. A. Brill, S. E. Jelliffe, and W. A. White, among others, basing their teachings on the concept that mental symptoms are the expressions or symbols of meanings that are obscure and hidden in the unconscious, made a widespread impact on psychotherapeutic practice which proceeded along the lines of what could be learned from a study of what was going on in the deeper recesses of the patient's mind.

Under the influence of some of Janet's ideas and formulations but contributing a number of concepts of his own, was the Boston psychiatrist Dr. Morton Prince (1854–1929) of Tufts Medical School. He worked with what he termed "co-conscious phenomena," adding much to the knowledge of hysteria, multiple personalities, and hallucinations. He never fully accepted the significance of the unconscious in the Freudian sense of its meaning, and he disagreed with Freud's theory of the

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libido. He founded the *Journal of Abnormal Psychology*. His famous case of a girl with multiple personality was studied for over seven years and published in 1908 under the title *Dissociation of a Personality*; it is probably the most complete report ever made of this phenomenon. Another interesting contribution to the literature was his *Experimental Study of Visions*. He applied psychotherapy within the framework of his personal concepts.

Trigant Burrow (1875-1951), originally a Freudian, organized his own special group of students in what he termed "phyloanalytic" investigations of human behavior and social adjustment. He stressed the defensive distortions of man's natural reactions through the dominance of visual-verbal part functions resulting in internal tensional disorders called neuroses. He developed a system of psychotherapy aimed at the reduction of these tensions.

Paul Schilder (1886–1940), coming to America after having had a distinguished career in Vienna, contributed to the knowledge of several areas of the psychiatric and neurologic fields. His concepts of integration and his development of the body-image significance in various mental states are among the subjects with which he enriched the literature. The work of Harry Stack Sullivan (1892–1949) and his associates systematically developed the theme of interpersonal relationships, which Freud had taken into consideration but did not develop or emphasize in the same way. The basis of some of Sullivan's conclusions stemmed from the assumption that parataxic illusions are derived from earlier anxiety experiences. To Karen Horney and Sullivan, neuroses were products of cultural environment and distorted interpersonal relationships rather than based on the preformed instincts, as Freud thought. Sullivan organized and published the journal called *Psychiatry*, which still serves as a useful medium for psychiatric thought.

In the field of therapy as well as those of pathology and diagnosis, a significant event was the obtaining in pure culture of the *Treponema pallidum* in 1911 by Hideyo Noguchi (1876–1928), and in 1913 Joseph W. Moore (1879–1957), of New York, and Noguchi demonstated the spirochete in the brain tissue of patients dying of general paresis, thus proving that this mental disorder was precipitated by a form of syphilis. Following this laboratory demonstration, general paretics were treated by the arsenicals and other drugs used for syphilitic disorders, but without marked success. In 1918 Julius Wagner von Jauregg (1857–1940) of Vienna announced his now-well-known malarial therapy for general paresis. This treatment, strikingly successful as compared to other known procedures, promptly came into general use, and the first to apply it in America was the staff of the St. Elizabeths Hospital in Washington, D.C., from which the first paper in English on the results of this treatment was published, as far as I am informed.[25]

During World War I psychiatry was brought more prominently into the foreground and received a long-neglected consideration among the other medical specialties. At the beginning of the war the government called upon the National Committee for Mental Hygiene for aid, and this organization was exceedingly fortunate to obtain and recommend the services of Dr. Thomas W. Salmon (1876–1927), who had a remarkable organizing ability. Through his efforts it was demonstrated that psychiatry could contribute a great deal to the efficiency of the armed services by recognizing and treating the war neuroses. Salmon and his associates in the Army, with its numerous civilian as well as military personnel problems, were instrumental in pointing out the relationship of these problems to medical and social disciplines. By extraordinary patience and hard work, Salmon overcame seemingly insurmountable obstacles and problems. He had confidence in the future of psychiatry and was always alert to defend it against any unfair criticism. He profoundly influenced the growth and course of psychiatry in America, and it may be pointed out that what he did for the Army has stood the test of time, as his methods are still more or less in force and, in the minds of some, are still the best available, having been so proved in World War II and in the Korean campaign.

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One of the most significant and practically important phases of the mental-hygiene movement to the credit of American psychiatry was the creation of child-guidance clinics, which started with William Healy (1869–) in 1909 in the institute devoted to the study of juvenile problems in Chicago. This was the pioneer child-guidance clinic, although the term was not coined until 1922. The Boston Psychopathic Hospital, opening in 1912, accepted children from the first, as did the Phipps Psychiatric Clinic in Baltimore where a special outpatient children's clinic was active as early as 1913. The Allentown State Hospital in Pennsylvania was also a pioneer in this field, with a clinic under way in 1915. Child-guidance clinics developed rapidly in other cities and areas under such well-known specialists as Lawson Lowrey (1890–1957), David Levy (1892–), Frederick Allen (1890–), J. S. Plant (1890–1946), and Douglas Thom (1887–1954) and are continuing to grow in size and distribution, as the needs for the study and correction of the behavior disorders of childhood are still greater than the available facilities.

Researches of many types have been carried on from early times, particularly on nervous-system anatomy and functions, but intensive organized research, as such, on mental disorders is of comparatively recent development. For example, in 1884 Dr. I. W. Blackburn of Philadelphia, an excellently trained pathologist with a particular interest in the relationship between the brain and mental diseases, was appointed special pathologist at the Government Hospital for the Insane (now St. Elizabeths Hospital). He was the first full-time pathologist in a mental institution in America (at least I can find no record of an earlier full-time appointment of this kind). He published twenty-five papers and books during a period of twenty-five years, many of them illustrated by his own hand, since he was a skilled artist as well as a scientist.

Probably the first large-scale stride toward organized systematic psychiatric research in this country was made in 1895 by the establishment of the Pathological Institute of the New York State Hospitals as an integral part of the state hospital system. Located at first in New York City with Dr. Ira van Gieson (1865–1913), a neuropathologist, as director, this institute was later constructed on the grounds of the Manhattan State Hospital on Ward's Island where it remained for many years under the successive directorship of Adolf Meyer, August Hoch (1868–1919), and George Kirby (1875–1935). In 1929 the old institute was replaced by a modern building constructed as a unit in the Columbia-Presbyterian Medical Center and named the New York State Psychiatric Institute and Hospital. During the past sixty years this institute has been unique, since it has been supported for the sole purpose of research.

The Boston Psychopathic Hospital built in 1912 under the direction of Elmer Southard (1876–1920), the State Psychopathic Hospital under Dr. Albert M. Barrett (1871–1936) constructed in 1906, and later the Colorado Psychopathic Hospital under Franklin Ebaugh (1895–) are among the earliest centers with active research units employing full-time research workers. From these beginnings acting as stimuli, there have been many similar developments in university and hospital centers. Moreover, the philanthropic foundations have devoted large sums of money to train young research workers in the psychiatric field, to support investigators already in key positions, and to finance laboratories where original studies could be carried out. In 1934 the Scottish Rite Masons of the Northern Masonic Jurisdiction began their support of research projects in schizophrenia, which has continued to the present day with accomplishments that have served as an example of the progress that may be expected with the growth of research interests and financial aid.

The work of Sir Charles Sherrington (1857–1952) of England on the physiology of the nervous system and of Walter Cannon (1871–1945) of America on the relationship between the emotions and the vegetative nervous system, as well as the investigations of the followers of Pavlov's (1849–1936) concepts and to a lesser extent those of Kretschmer (1888–) on bodily conformation have served as a background upon which the struc-

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ture of "psychosomatic" or "comprehensive" or "total" medicine has been erected and expanded in recent years. The term "psychosomatic medicine" has been known for at least 100 years, but in the sense of the modern clinical application and theories in psychopathology and medical problems it is rather distinctly an American development in which Adolf Meyer and Smith Ely Jelliffe contributed a great deal.

Here it is well to remember that George Beard of New York described a syndrome in 1868 which he called "neurasthenia" and under which he included pathological fatigues and so-called nervous exhaustion. He said, "While modern nervousness is not peculiar to America, yet there are special expressions of nervousness that are found here only: and the relative quantity of nervousness and of nervous diseases that spring out of nervousness are far greater here than in any other nation in history and it has a special quality." These disorders, regardless of whether there were more of them in America than elsewhere, were the disorders to which Silas Weir Mitchell (1829–1914) of Philadelphia devoted much thought and therapy. He ascribed them to deficiencies in fat, blood, and other elements and recommended complete rest as the cure. From the general interest in so-called functional disorders came one of the special roots now known as psychosomatic medicine.

Forensic psychiatry, as such, has developed slowly in America through the years despite the fact that there have been outstanding pioneers with constructive concepts and writings. Beginning with Isaac Ray's book in 1838, one finds interesting and pertinent references to the relationship between psychiatry and the law, and recommendations for dealing with these complicated problems. In more recent years the publications and personal influence of such authorities as L. Vernon Briggs (1863–1942), William A. White (1870–1937), Bernard Glueck (1884–), Winfred Overholser (1892–), and Gregory Zilboorg (1890–) have made excellent contributions to the subject in ways that have favorably modified some of the practical legal procedures.

Since World War I, industrial psychiatry, school and college psychiatry, and other penetrations of psychiatry into public affairs have made notable strides that have led deeper into the understanding of emotional phenomena. Clinical psychology, occupational therapy, and social-service activities, all of which are valuable psychiatric auxiliaries, have shown remarkable progress. In the field of clinical psychology, the use of the Rorschach and other projective techniques became established and were freely applied to psychiatric problems. The social worker, from the first, proved to be practically indispensable in investigating the home situation, in the problems of hospital patients and of the child-guidance field, and in interpreting the nature of the problem to the family as well as aiding in the readjustment of the improved patient in the community.

Occupational therapy, in the broad sense of its original definition ("any activity, mental or physical, definitely prescribed and guided to hasten recovery from disease or injury"), has always accompanied enlightened, humanitarian treatment, especially in the field of mental illness. It may have begun in the United States with the opening of the Pennsylvania Hospital in 1752, when the board of managers provided wool-carding and spinning equipment "to employ such Persons as may be capable of using the same." Activities ranging from music, games, and arts and crafts to industrial or housekeeping tasks and education were utilized as an essential feature of the nineteenth-century "moral treatment" as mental hospitals opened in Philadelphia, New York, and Boston. Nursing personnel frequently supervised these activities, though no formal preparation for such leadership was available until Susan E. Tracy established a course for student nurses at Adams Nervine Hospital. By 1917, when the Society for the Promotion of Occupational Therapy (later the American Occupational Therapy Association) was formed, two more training centers were functioning. Three other schools, originated during World War I to train "reconstruction aides" for Army hospitals, continued to grow and were among those accredited in 1938 by the American Medical Association.

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Graduate therapists, like their predecessors, worked in various hospitals and rehabilitation centers, using a wide range of activities to promote patients' recovery from physical as well as mental illness.

As late as the 1930's it was advocated by many that psychiatry was not a science but an art, since the personality of the psychiatrist bulks so large in the practice of mental medicine, and psychiatry could never free itself from its philosophic elements. Regardless of what was thought and said, an "American school" was developing, and by 1937 it had the following characteristics, most of which have persisted.

The American school had started to use the new shock therapies which later became so widespread in application, and it had also recognized the great possibilities of sociology and cultural anthropology as contributors to psychiatric knowledge. However, this American movement was not merely a composite eclecticism, but it was beginning a positive frontal attack upon the problems of mental medicine which was new, frank, and critical. It advocated treating all behavior, thought, and feeling of an individual as real or actual performance or, in other words, as a personality experience. The differentiation of human performances and capacities is just as much a real dynamic phenomenon as is any feature of somatobiological processes or of social culture. It also emphasized proceeding along the following general lines in dealing with a particular psychiatric problem: (1) the correction of all recognized defects in the soma of the patient; (2) the establishment of adequate rapport between physician and patient; (3) the careful study and evaluation of familial, economic, and social situations; (4) the detailed investigation of the personality problem; (5) the attitude toward and adjustment to reality; (6) the ventilation of conflicts and desensitization of the patient; (7) the institution of re-educational training; (8) the formation of an adequate philosophy of life; and (9) the desirability of follow-up studies.

The American school recognized and attempted with considerable success to correct the lack of adequate instruction and training in psychiatry in many of the medical schools; in fact, in most of the medical centers, psychiatry was inadequately represented. However, despite these educational handicaps, a greater number of medical students sought postgraduate training, and the number of women physicians entering psychiatry became notably larger since earlier strong prejudices against them had subsided considerably. It is a matter of interest to note that in 1890 a law was passed by the New York State legislature authorizing the appointment of at least one woman physician in each state hospital. Obviously, we have come a long way during the last half century. The lack of sufficient knowledge of mental hygiene and of the psychic components of disease on the part of the general practitioners, and the lack of proper psychiatric information among the clergy and the population in general was also well recognized, and movements were started to try to correct these deficiencies.

In recent years, and particularly since World War II, more adequate methods and techniques suitable for attacking vital problems have appeared and are still in various stages of evolution. In scrutinizing the past in an attempt to perceive the simple beginnings and origins of the present-day science of man, one should remember that each worker, regardless of his individuality, is in some degree dependent on the thought and practice of his time, uses to some extent formulations suggested by others, and is stimulated and influenced by the particular interests of his friends and colleagues.

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CHAPTER 2

RECENT AMERICAN PSYCHIATRIC DEVELOPMENTS

(Since 1939)

George Mora

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DURING THE LAST TWO DECADES, psychiatry has undergone a more extensive development than any other field of medicine. The challenge of discovering and explaining more of the various aspects of man's behavior, individual or collective, normal or pathological, has nowhere been met with greater enthusiasm than in the United States. Data have been collected in such volume that it would disorient even the most diligent and patient researcher. A brief chapter on this development can throw light only on certain aspects—the better-defined ones—leaving others in shadow. It will achieve its purpose if it conveys an impression of the developmental trends of the manifold aspects of psychiatry. Only the very last part of the chapter will deal with some general issues which go beyond the geographical and temporal limitations of the two decades under consideration. This has seemed a natural conclusion for a chapter which is intended to be essentially a historical account of this field of medicine. As such it aims to represent the dynamics and the historical continuity of a process, to understand the present situation on the basis of the past, and to anticipate some of the future developments on the basis of the present.

One final point of explanation belongs in the introduction to this chapter: in many

sections dealing with special aspects of psychiatry—such as the different schools of psychoanalytic thought, the development of pharmacological therapy, etc.—some of the people who have made particularly significant contributions in these fields have been mentioned. Full source information, however, has not been provided in either text or bibliography. This omission was a deliberate one, first, for reasons of space limitations, second, because the separate chapters dealing with these subjects in detail provide full bibliographic references. It seemed more economical of effort, therefore, to limit the references for this chapter to the points outlined in the note preceding the bibliography.

¶ General Trends of Psychiatry

National Recognition

The condition of psychiatry at the end of the third decade of the century presented a characteristic picture of a transitional phenomenon—the end of one period and the introduction of another. The stable structure on which psychiatry was based in this country, from the founding of the American Psychiatric Association in 1844 to the beginning of the century, seemed to undergo a process of intimate revision. For many years the field of psychiatry had been divided into two main schools, the organic and the psychobiologic—the first emphasizing psychological parallelism or reduction of psychic phenomena to organic causes, the second—represented especially by Adolf Meyer and his disciples—emphasizing the importance of environmental as well as biological factors in the causation of psychological disturbances.

It was only in the late thirties that an initial, still timid, trend toward a better integration of psychiatry into the social structure of the American culture started to become evident.

A slow, but significant, development of the administration policies of mental hospitals, an attempt to integrate such institutions into the community through an intensive program of aftercare, a beginning of the recognition of the value of the training of personnel working with mental patients at every level, from the psychiatrist to the social worker, the nurse, and the attendant—all this, even if limited to isolated areas in the country, pointed to a greater flexibility of approach to mental patients and to an initial broadening of viewpoints, harbinger of further developments.

Research in psychiatry also entered into a new phase in the third decade of the century. New fields—especially psychosomatic medicine, shock therapies, electroencephalography, child psychiatry, criminology, alcoholism—became major areas of investigation. Equally significant, even if outside the strict realm of psychiatry, were the studies of psychological tests (especially projective techniques), of the experimental neuroses, of the ecological aspects of psychiatry, to which representatives of allied disciplines contributed in a joint effort. Clinics for mental patients in which psychotherapeutic methods of different kinds were employed more frequently were organized all over the country in a relatively short time. In the thirties, child psychiatry too went through a period of tremendous development, at times more as a response to emotional demands than to scientific demands. The International Congress of Mental Hygiene and the White House Conference on Child Health and Protection, both held in 1930, were representative of this new interest in the preventive aspects of psychiatry in a broader cultural context.

At the base of these new trends was the recognition, brought about by the psychoanalytic school, of the importance of early emotional experiences for later psychological disturbances. It was during this period that a large number of outstanding psychoanalysts emigrated to the United States from Europe, following antisemitic persecution. The impact of their thinking hastened the acceptance of psychoanalysis as an essential part of psychiatry from a genetic and symptomatological as well as a therapeutic viewpoint. The consequence was a broadening of the view of the psychiatrist, decreasing the barrier between

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normal and abnormal in psychology and making possible a formulation of the patient-therapist relation that proved to be of high pragmatic value.

These new trends counteracted the tendency of psychiatry to remain rooted in a biological substratum, and brought a new phase in the relationship between neurology and psychiatry. The introduction of the shock therapies in the late part of the thirties revived that perennial problem in a more empirical, yet still obscure fashion, for the psychiatrist as well as the neurophysiologist. Insulin, Metrazol, and electric shock therapies doubtless constituted a major event in American psychiatry, in spite of the different responses they elicited in scientific milieus. The emphasis on psychotic patients raised by the developments of shock treatment counterbalanced the emphasis on neurotic patients brought about by the psychoanalytic therapy, and contributed to create a better integration and a more meaningful platform for further developments.

World War II acted as a catalyzing agent in the growth of psychiatry. Under its impact, new developments took place, as the need of the moment called for the application of psychodiagnostic and psychotherapeutic procedures on an extensive basis. Clinical psychologists and social workers were employed extensively in this program, which was later carried on by the Veterans Administration.

The new techniques of evaluation and of treatment proved to be quite useful even in normal peaceful conditions, and they tended to foster a more flexible attitude toward short-term psychotherapy, in contrast to the long-term psychotherapy of the classical tradition. This was also the result of a general trend toward an interdisciplinary approach to scientific problems. As the boundaries between normal people and neurotics became less rigid, a more cooperative and understanding attitude developed among members of the same staff in relation to individual roles played in connection with the patient. This development was particularly evident in the new fields of child psychiatry, group therapy, and rehabilitation, in which psychologists and social workers took active and determining parts.

From a general viewpoint, the psychological problems posed by the war were carried over and better defined in the transitional period that followed the end of the war. The importance of psychiatry gained nationwide recognition. This fact, aside from some negative aspects arising from oversimplified and unilateral attitudes, soon revealed its first positive consequences. Many aspects of basic importance for the mental hygiene of the country, such as the prevention of mental disorders, the rehabilitation of veterans in need of psychiatric help, the training of a sufficient number of psychiatrists to meet the most essential needs, were recognized by the federal government as problems of national importance. Some of the programs operated by private agencies—such as the Rockefeller Foundation and the Commonwealth Fund—became integrated on a larger national basis.

The Vocational Rehabilitation Act of 1942 constituted a considerable step forward in mental hygiene. But even more important was the National Mental Health Act, enacted in 1946, authorizing the creation of the National Institute of Mental Health in Bethesda, Maryland, in 1949. The program outlined by the National Mental Health Act focuses on three main functions—research in the field of mental diseases, training of personnel, and assistance to the states in developing their mental-health programs. Though the goals to be achieved are still distant, a considerable amount of information has already been gathered by statisticians and social scientists in regard to mental conditions. Another accomplishment of the Institute has been the organization of the National Governors' Conference on Mental Health, to provide maximum educational and training facilities at a regional level. Many states have created a central state board, known as state boards or boards of institutions. Practically all the states have organized divisions of mental hygiene within the departments of welfare or departments of mental hygiene or mental health, and some states have taken a leading position in mental-health programs. New York, for instance, established a Mental Health Commission in 1949 and passed a Mental Health Act in 1954,

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from which New York City particularly received great advantage.

¶ The Mental Health Movement

Mental health, a concept widely accepted since the foundation of the National Association for Mental Health by Clifford Beers in 1909, has been subjected to increasing criticism in an attempt to bring it into a more scientific frame. Various authors have focused attention on the relative definitions of the normal personality and of mental health; on the vagueness of the essential aims of mental-health programs, too frequently resting on assumptions; on the dubious role of ideas; on the inappropriate use of psychodynamic formulations; and, in general, on the uncertainty concerning basic factors—i.e., factors influencing community acceptance, concepts and theories to be employed in the study of mental health, theories of what undermines and of what maintains mental health.

Undoubtedly, the difficulties in the field of mental health cannot be overcome easily, in spite of universal agreement on the value of its three main practical aspects—promotion, prevention, and education. The focusing on these problems is of historical significance, however, in that it allows definition of the direction of future scientific developments, especially in regard to scientific objectivity and controlled experimental conditions. As an example of this trend, the "indexes of mental health" represent a definite achievement, hopefully to be followed by others. The collaborative book edited by Ruth Kotinsky and Helen L. Witmer, *Community Programs for Mental Health*, presents the most recent viewpoints on the above-mentioned aspects of mental health.

¶ Research and Methodology

Historically, psychiatry originated as a purely empirical science, and this trend has continued through the development of psychoanalytic practice. This explains the fact that, in spite of a tremendous amount of data gathered under difficult conditions by a large number of researchers, the field still suffers from a fundamental lack of skill, of methodology, and of technique in organization and evaluation of the material studied. This becomes even more evident if psychiatry is compared with psychology, in its clinical and social fields, where methodology of research has been carefully investigated.

This criticism is especially valid today, when psychiatric literature is increasing to tremendous proportions and when many psychiatric centers of different kinds dedicate effort and time to research. The results of a survey, *Collaborative Research in Psychopathology*, published by the Group for the Advancement of Psychiatry, in 1954, are impressive in their emphasis on the basic instrumental deficiency which still weakens a sound program of methodological research. This seems to justify the despairing note sounded by Lawrence Kubie, in 1952, that "research in psychiatry is starving to death."

Of course, the fact that the subject of psychiatry is the individual in its totality is itself responsible for some of these difficulties and for other factors of basic importance in psychiatric research. It is enough to mention as major points the lack of a universally accepted concept of normality of the human being, the semantic difficulties caused by the use of the same symbols with different meanings by different schools or from different viewpoints (phenomenological, structural, genetic, functional), the uncertainties and the ambiguities of the classification of mental diseases (present even in the *Diagnostic and Statistical Manual on Mental Disorders* published by the American Psychiatric Association in 1952). Some variables of psychiatric research, as for example the characteristics of the experimental group versus the control group, the interference of the biological and of the cultural process with the psychopathological process, the emotional aspects of the personality of the researcher (as pointed out by Frederick Redlich and Eugene Brody in an interdisciplinary report[132]) are extremely difficult to control. The above study by the Group for the Advancement of Psy-

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chiatry has been very useful in attempting to clarify the different aspects of research in psychiatry. The historical period under consideration has not, however, produced the needed clarification on research and methodology.

¶ Psychopathology

Anxiety and Related States

The problem of anxiety has been considered an essential one to human life ever since man first reflected on his condition and on his destiny. St. Augustine, Pascal, Kierkegaard, and many other thinkers of the past have offered answers to this crucial problem of human existence. But only in the last few decades has the problem of anxiety been considered essential for the comprehension of psychiatric conditions, and explanations of it advanced by different schools.

Freud's revised formulation of anxiety (1926) as a signal of danger from within, with symptoms considered to be special types of defenses called out by anxiety, still remains an epoch-making contribution to psychopathology. In following years, psychiatrists investigated the problem of anxiety from different viewpoints on the basis of clinical material. As to the contributions made by neurologists, Kurt Goldstein's description of the "catastrophic reaction" in organic patients as a defense against overwhelming anxiety remains the best attempt made to approach the difficult problems presented by the behavior of these patients.

The contact of American medicine with psychoanalysis, when the latter became more accepted in this country, encouraged the investigation of anxiety on an experimental basis. Both trends of American medicine, the biological and the social, contributed to this development. As an expression of the first trend, Sandor Rado—influenced by the classical work of W. B. Cannon on the physiological changes in pain, fear, and rage—introduced the concept of emergency behavior as explainable in the light of the hierarchic organization of levels of emotional thought and of unemotional thought.

Cultural anthropologists affirm, instead, that anxiety appears when something within the person threatens his relation to significant people, and that the societal pressures under which individuals live are the real causes of repression, resentment, and hostility. Both theories agree that secondary anxiety grows out of the very defenses originally erected against anxiety and that a vicious circle between anxiety and defenses is then created—a viewpoint that has marked importance in the Karen Horney formulations.

Hans Selye's description of the "stress syndrome" or the "general adaptation syndrome" as including all the more specifically induced changes determined by a specific syndrome within a biological system had the effect of directing the problem of anxiety to a more experimental basis. His continuous development of research on endocrinological secretions in relation to stress (hypothalamic-sympathetic-adrenal medullary system and hypothalamic-hypophyseal-adrenal cortical system) constitutes a remarkable example of an effort toward a general systematization of all biological forces of the organism. So far, however, the influence of this research on psychiatry has been limited, in spite of Selye's recent attempt to present it in the frame of a general philosophy of life.

More important for psychiatry have been the observations reported by Stewart Wolf and Harold G. Wolff on the effects of anxiety on gastric secretions as an experimental way of investigating sympathetic discharges caused by fear from parasympathetic discharges caused by anxiety.

Neurophysiological research has continuously paralleled the clinical observation mentioned above. The recent trend of this research has been to investigate both the "downward discharge" from the cortex to the hypothalamus and the "upward discharge" from the hypothalamus to the cortex experimentally (with the use of the strychnine method or neuronography, for example).

Further progress in this question has recently been made by Daniel H. Funkenstein and his collaborators, who studied the different effects

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of epinephrine and norepinephrine in relation to anxiety, whether this be due to unexpressed anger (anger-in) or expressed anger (anger-out). Other biochemical studies have recently tried to correlate "free anxiety" to the rise of the 17-hydroxycorticosteroids in the blood or to the quantity of hippuric acid secretion.

So far, however, this type of research is indicative more of the complexity of the task than of the results achieved. Two recent methodological papers by David McK. Rioch and Roy Grinker on the experimental approach to anxiety, in animals and in human beings respectively, point out independently the complexity of the variables that must be considered. The present research trend is to study the system of anxiety in transactions with other psychological organizations, either intrapersonal (perception system, endocrinological and vegetative system) or interpersonal (adjustment to groups).

The human—and thus variable—aspect underlying the complexity of the expression of anxiety is perhaps the motivating force which has led several students of this field, among them Kurt Goldstein, Hans Selye, Daniel H. Funkenstein, and Rollo May, to infer conclusions about human personality and its environment on the basis of their own psychopathological concepts. This phenomenon—certainly not a casual one—indicates the need for a better delimitation of methodology of research.

Formal Mechanisms

Whereas the majority of the works on psychopathology deal with the motivations and the content of the symptomatology, a group of authors have stressed the study of the *forms* of the symptoms, in addition to dynamics. According to most of these authors, the *forms* and the *transformations* have to be studied ontologically, phylogenetically, and in relation to the dynamic mechanisms.

As Silvano Arieti stated: "The study of formal mechanisms reveals *how* we think and feel. The study of dynamics of psychoanalytic mechanisms reveals *what* we think and feel and the motivation of our thinking and feeling. Both the formal and the dynamic approaches are necessary if we want to understand psychological phenomena fully." The application of the formal approach, as differentiated from the psychodynamic, to the study of mental patients, is a relatively new development.

Observations on the formal mechanisms, especially of dreams, language, and primitive cultures as related to psychotic patients, had already been made by early psychoanalysts, especially Alfred Storch, who reported on the primitive archaic forms of inner experiences and thought in schizophrenics.

Jacob Kasanin, who introduced the Vigotski test in America, Eilhard von Domarus, who studied the logic of schizophenic patients (a subject expanded later by Arieti), and especially Kurt Goldstein, who described an "abstract" and a "concrete attitude" (the latter prevailing in brain damaged and schizophrenic patients), have made extensive contributions to the study of formal mechanisms. Other contributions to this problem, especially from the psychological viewpoint, were made by H. Werner in his *Comparative Psychology of Mental Development*.

Arieti stressed the importance and expanded the investigation of the formal mechanisms in schizophrenic patients from a clinical viewpoint. This material, important even from a historical angle, presented in his book, *Interpretation of Schizophrenia*, throws light not only on some aspects of schizophrenia so far overlooked but also on the mechanisms of dreams, of verbal associations, of infantile and paleologic thinking. It thus represents a development of considerable importance, especially as it opens a new field of investigation in the borderline area of traditional logic and modern psychology and represents a further clarification of the intricate problem of schizophrenia.

¶ The Psychoanalytic Movement

Psychoanalysis was the major influence on psychiatry in the first half of this century. The two theoretical frameworks are now so thoroughly integrated that it is almost impossible to isolate the original psychoanalytic contributions from the total context of psychiatry.

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Furthermore, the significant events of the psychoanalytic movement are so close to us in time and so colored by the personal position of the authors and the philosophies of the various post-Freudian schools that one cannot pass a judgment of historical value on this movement. The few historical contributions published so far reflect this provisory character or clearly indicate their derivations from a particular school.

Typical of this, for instance, are such collections as *Twenty Years of Psychoanalysis,*[6] written by the staff of the Chicago Institute for Psychoanalysis as an expression of Franz Alexander's school; *Midcentury Psychiatry,*[145] edited by Roy Grinker as an attempt to intergrate psychoanalysis with the biological and social sciences; Clara Thompson's *Psychoanalysis: Evolution and Development,*[159] written as an expression of the new neo-Freudian cultural schools; and finally, Clarence Oberndorf's *A History of Psychoanalysis in America*[124] which is a more autobiographical and chronicle-like essay. The provisory character of all these studies is also present, although perhaps to a lesser degree, in the extensive literature published in 1956 at the occasion of the Freud centennial. Even the most significant papers of this series, such as the four addresses by Ernest Jones,[82] or the articles edited by Nelson in *Freud and the 20th Century,*[174] must be viewed from such a historical perspective.

The process of historical evaluation has been further complicated by the esoteric approach of the movement in the sense that it developed in part as a reaction to the hostile attitude of the opposers, and in part as a result of the pioneering spirit of the analysts. On the other hand, psychoanalysis cannot isolate itself from the living currents of the American culture if it wants to survive and to contribute further.

The history of the psychoanalytic movement of the last twenty years is in fact the history of a twofold struggle for both identity and integration. Fortunately, the movement has not exhausted itself in this sterile struggle, except perhaps in a few instances, but, rather, has initiated a process of slow integration and of revision of basic psychoanalytic principles in the context of psychiatry in general. The pragmatic orientation of American culture has been an instrumental factor in this process.

It is obviously impossible, within the limits of this chapter, to present the full implications of the manifold contributions growing out of this process. Only the most important trends of the psychoanalytic movement will be reviewed in their historical perspective: (1) the integration of psychoanalysis with the biological and social sciences; (2) methodological and experimental advances; (3) ego psychology; (4) developments in psychoanalytic therapy, unorthodox, and neo-Freudian schools; and (5) the organization of psychoanalytic associations in the United States. This subdivision has both strengths and weaknesses, but it has been maintained because of its practical value.

Psychoanalysis and the Biological and Social Sciences: an Integration

The integration of psychoanalysis with the biological and social sciences represents an important development in both the theoretical and the practical aspects of the psychoanalytic movement. The old schema of nineteenth-century philosophy, essentially materialistic, that had constituted Freud's theoretical bias in the formulation of his concepts gave way to more flexible and pragmatic concepts, for example, homeostasis, adaptation, integration, organization, autonomy, and communication.

Such recent theoretical elaborations as Bertalanffy's dichotomy—"open" systems of the living organisms and "closed" physical systems—and Wiener's cybernetics—based on the feedback mechanism of the nervous system (or the study of the patterns of interaction between cortical and subcortical nervous functions)—have provided an impetus for the re-elaboration of theoretical constructs of psychoanalysis. One can mention, briefly, among the most recent contributions to this re-elaboration: (1) George Engel's studies on homeostasis and behavioral adjustment, (2) Therese Benedek's studies on the organization of psychic energy, (3) Thomas French's work on the integrative process, (4) Sandor Rado's formulations on adaptational psychodynamics, (5) Donald O. Hebb's studies on the organization of behavior, and (6)

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Jules Masserman's work on dynamic integration.

The classical concepts of psychoanalysis—instinct, equilibrium, conflict, topography and economy of the psychic apparatus, anxiety, defenses, psychosexual development, as well as many others—are being reviewed in the light of these theoretical frameworks. Although this process is in an early stage, there are indications that it will exert considerable influence on the psychoanalytic movement generally. A more unitary concept of health and disease, extremely significant for psychopathology, is already evident in the theoretical formulations of such researchers as Arthur I. Mirsky, Roy Grinker, Sidney G. Margolin, M. Ralph Kaufman, Harold G. Wolff, John Romano, and many others. These researchers are attempting to take into account both the biological and the sociological dimensions of the human personality.

Methodology and Experimental Advances

Experimental validation of psychoanalytic principles has been impaired by all sorts of difficulties, both of a technical and of a professional nature. Yet, it was natural that—in view of this country's empirically oriented approach to personality as compared with the more metapsychological approach of the European tradition—attempts would be made toward such an experimental validation. These attempts are still in the initial stage. The difficulty of translating the experimental findings on animals and young children to normal adults, the ethical implications of submitting human beings to stressful situations, the strict confidentiality that surrounds the patient-analyst atmosphere, are all factors contributing to the difficulties of experimental validation.

In spite of the problems, however, the literature of the last two decades reveals a definite trend toward the experimental approach, with both animals and human beings. Among the best-known studies are those of Jules Masserman on the results of different types of "psychotherapy" employed in "neurotic" animals, Neal E. Miller's studies on rats, Howard S. Liddell's research on experimental neuroses, and the very recent experiments by Arthur I. Mirsky on the mother-child relationship in monkeys.

Experiments with infants and young children attracted attention some years ago, especially after the classical studies on sibling rivalry and affect hunger by David Levy, the extensive research by Robert Sears and his collaborators, and the famous observations on hospitalism, anaclitic depression, and autoerotism by René Spitz. Today the interest in this type of research, as well as in dreams and hypnosis, remains active, but its methodological ground is increasingly questioned. Rather, the interest is centered on the problem of anxiety.

There is no question, however, that many of the observations are still fragmentary and need further investigation. As Ernest R. Hilgard stated recently, "Experimental work thus far bears most directly on only the most superficial aspects of psychoanalysis, while many of its deeper problems are scarcely touched."

Of the many authors who have approached the problem of experimental research in psychoanalysis, Lawrence S. Kubie has perhaps been the most active. Kubie has touched upon a series of important aspects: qualitative and quantitative measurement of the relation between conscious and unconscious levels of symbolic activity; careful study of free associations; study of the relation between various psychological levels through unconscious material; validation of interpretations; investigation of the problem of the validity of chronological sequences. Kubie has suggested the creation of a research institute of psychoanalytic psychology for recording the psychotherapeutic process with minimal distortion and analyzing qualitatively and quantitatively the material gathered under these conditions.

Ego Psychology

From a historical viewpoint, Freud's fundamental studies on the ego and the mechanisms of defense constituted the beginning of the development of ego psychology. Metapsychological schemata, as derived from Freud's formulations, comprised the dynamic, eco-

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nomic, and structural points of view. Even if operationally useful, however, the dynamic interplay of the three basic structures of the id, the ego, and the super-ego, left unsolved the important problem of the genesis of the ego.

Following Freud's formulation of an undifferentiated state of the id-ego, Heinz Hartmann attempted in a number of papers to define the developmental stages of the ego from this matrix. He considers the influence of (1) congenital ego-characteristics, (2) primary instinctual drives, and (3) external realities essential for the development of the ego.

Hartmann defines the ego as the substratum of the personality in terms of its function, especially the control of the apparatus of motility and perception (internal and external), the contact with reality, and the inhibition of primary instinctual drives. This definition implies, besides the genetic, the adaptive point of view—namely, the mediating function of the ego between present reality and needs of other psychic systems—a concept originally anticipated by Herman Nunberg. The adaptive functions of the ego are related to the theory of the ego autonomy to which David Rapaport brought essential contributions. In terms of Rapaport's latest formulations, the optimal functioning of the organism requires the constant balance of mutually controlling factors, ego-autonomy from the id and ego-autonomy from the environment.

Beside these basic developments of ego psychology, other aspects have been investigated in the historical period under consideration. Among the most important are (1) the role of the somatic ego (Willi Hoffer's interplay of mouth-hand, Anna Freud's ego integration) derived from the original concept of body image of Paul Schilder, the process of separation between the self and the environment; (2) the concept of "area of the ego free of conflicts" as a structural function originally started as a defense mechanism; (3) the concept of "ego strength" as an empirical measure of the level of integration and self-realization of the ego; (4) the concept of desexualized and aggression-free energy as "neutralized energy" and conversely, of sexualization and aggressivization of the ego-functions with non-neutralized energy; and (5) the role of introjection and identification in the building of the ego.

Another major aspect for study has been the mother-child relationship as a basic factor in the development of a flexible and adaptable ego. This relationship has been investigated especially in relation to the differentiation between the self and the world which takes place from the original symbiosis of the mother and the child. The contributions of Therese Benedek on the physiological stages of these dual interactions, of Thomas French on the supporting role of confidence in the development of the infant, and of René Spitz on the pathological development of the child following severe disturbances of this dual relationship (hospitalism) are among the most important of the last two decades.

From an over-all viewpoint, ego psychology originally initiated in the strict realm of psychoanalysis and is developing gradually in the direction of classical developmental psychology.

New Developments in Psychoanalytic Therapy: Unorthodox and Neo-Freudian Schools

It was to be expected that *Karl Jung's* analytical psychology, so full of symbolisms and of esoteric material derived especially from the Eastern tradition, would meet great resistance in the United States. In fact, this country has been influenced remarkably little by Jung's complex formulations, in contrast to England where occult and parapsychological sciences have a long historical tradition. Some of Jung's best pupils, such as Michael and Frieda Fordham, are in England. In this country, the study of the unconscious which occupies a great deal of Jung's writings was quickly overcome by the study of the egodevelopment, defense mechanisms, and the transference situation. Only recently has the distribution of Jung's collected works, as well as selections of *Eranos Yearbooks* been initiated in this country by the Bollingen Foundation, perhaps more for scholars than for practical psychotherapists.

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If one excludes the collective and the foreign presentations (for example, the work of Jolande Jacobi and Frieda Fordham), American original expositions of Jung's doctrine are limited to Ira Progoff and Frances Wickes.

Alfred Adler's influence in this country is more difficult to ascertain, especially if one considers not its totality but some of the particularities of his work. Because of the popular character of many of his writings, some ideas which he originated have been integrated in other scientific elaborations or have become part of universally accepted practices. Typical is the approach used in child guidance or the emphasis on discussion of psychological problems in groups—for example, in meetings of the parent-teachers association. Similarly, the short-term psychotherapy as used by Adler is now extensively used by some psychoanalysts, although from a different theoretical viewpoint.

Even more limited not only chronologically but geographically has been the influence of *Otto Rank*, especially since he emigrated to the United States in the early thirties. Specifically, Rank's influence has been strong among the social workers of the Pennsylvania School of Social Work, where he taught for some years. It is from Rank that the so-called "functional school" of social work, represented especially by Virginia A. Robinson and Jessie Taft, has derived. Through his intensive life, Rank's concepts were influenced considerably by the fact that his orientation was essentially artistic. Out of this orientation he derived many brilliant intuitions—but intuitions never validated through scientific investigations. Rank's fundamental preoccupation with the study of artistic intuition became more evident in his latest productions, as Fay B. Karpf shows in the monographic study, *The Psychology and Psychotherapy of Otto Rank*.

Because of their restricted historical influence on the psychoanalytic movement, no detailed mention can be made here of less well-known psychoanalysts who also detached themselves from Freud's school, such as Wilhelm Stekel, Sandor Ferenczi, Wilhelm Reich, and Theodor Reik, the last two of whom emigrated to this country. Of this group, only Reik exerts some influence in this country, especially in New York City. The popularity of his books and the group of lay analysts that he has gathered around his journal, *Psychoanalysis*, and the National Psychological Association for Psychoanalysis largely account for this influence. The volumes by Munroe[121] and Progoff,[128] among others, provide extensive surveys of the viewpoints of the various schools.

At present, the Freudians remain the main group in the psychoanalytic movement. They represent a tradition of seriousness of research and of clinical investigation which continuously influences the whole field of psychiatry. This large group of Freudian psychoanalysts, who constitute the American Psychoanalytic Association, has been subjected to the impact of both forces—biological and sociological—of American culture. The majority of Freudian psychoanalysts, however, continue to be engaged in the classical themes opened by Freud's own contributions. The literature of these authors is remarkable for its deepening of theoretical concepts, refinement of the therapeutic techniques, and clarity of the clinical descriptions, rather than for originality.

In many quarters, there is a feeling that a more radical revision of many concepts advanced by Freud is necessary, not only because of his own *Weltanschauung*, derived from nineteenth-century philosophy but also because of his long-term therapeutic approach. There are signs even among the most orthodox Freudian analysts, of attempts to adapt themselves more realistically to the urgent need with which psychiatry is confronted in this turbulent century.

The literature on the different aspects of psychoanalysis has become so imposing as to justify the task, recently undertaken by Alexander Grinstein, of editing an index of psychoanalytic writings in several volumes. The contributions of the major representatives of the Freudian movement range from theoretical studies on personality development, through descriptions of clinical patterns and of treatment of neurotic and psychotic patients, to excursion in the fields of sociology, metaphysics, and the expressive arts.

Some of these contributions can already be

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considered of historical value. Although, as mentioned in my introduction to this chapter, the bibliographic sources for this material are not provided, the following listing allows some idea of the variety of the subjects under investigation and the researchers most interested in each:

The psychology of women: Helene Deutsch
Psychosomatic functions of women: Therese Benedek
Psychosomatic disorders: Franz Alexander, Carl Binder, Felix Deutsch, Flanders Dunbar, Thomas French, Roy Grinker, and others
Ego development: Heinz Hartmann, Ernest Kris, Rudolph Loewenstein
Emotional disturbances in childhood: O. Spurgeon English, David Levy, Gerald Pearson, Emmy Sylvester
Family dynamics: Erich Lindemann, Nathan Ackerman
Psychotherapy of psychoses: Frieda Fromm-Reichmann, Gustav Bychowski
Psychotherapy of delinquents: Kurt Eissler
Cultural anthropology: Abram Kardiner
Various clinical matters: Kenneth Appel, Greta Bibring, Phyllis Greenacre, Ives Hendrick, Robert Knight, Lawrence Kubie, Maurice Levine, Bertrand Lewin, Sandor Lorand, Jules Masserman, Karl and William Menninger, Herman Nunberg, Clara Thompson, Gregory Zilboorg, and many others

These contributions are more remarkable for their acceptance of the basic Freudian postulates than for their differences which are certainly understandable in view of the variety of backgrounds and culture found in this group. This acceptance creates a feeling of internal consistency and justifies linking these researchers into a common denomination. Individual differences are present, but not to the extent of creating a definite schism in the movement.

Only *Alexander* and his school have deviated considerably from the original Freudian formulations, on practical rather than theoretical issues. The short-term psychotherapy carried on in the Chicago Institute for Psychoanalysis differs a great deal from long-term orthodox analysis.[6] In spite of these differences, Alexander and his co-workers still consider themselves part of the main Freudian current.

A more decidedly autonomous position has been taken by the so-called "neo-Freudian school" represented essentially by the Washington School of Psychiatry and by the William Alanson White Institute of New York. The impact of American cultural and sociological currents, represented by such men as George Mead, Edward Sapir, and others, had a tremendous influence on the work of Harry Stack Sullivan, Karen Horney, and Erich Fromm. The theories presented by these authors differ considerably from each other.

Sullivan's "theory of interpersonal relations" puts the emphasis on the child's early interaction with the mother and other meaningful figures, on the "self-dynamism" of the personality, and on the role of "participant observer" assumed by the therapist. His historical value, however, consists even more in the extension of psychotherapy to psychotic patients, strictly connected with the investigation of the countertransference of the therapist toward such patients.

Horney's emphasis, in line with Alexander's school, is on the present situation of the patient, with relative unconcern for his early childhood. Her major contribution lies in the study of the interplay between neurotic defenses and cultural forces, a subject that lends itself rather easily to generalizations and appealing statements which tend to overlook the biological substratum of the personality.

Fromm's contribution is a passionate and brilliant dialogue of the author with the central themes of human social philosophy, viewed from the perspective of the American democratic scene. The topics of the personality types, of freedom versus authority, of selfishness versus mature love, among the most significant, emphasize the dynamic relation of man to society, which creates new needs for man and at the same time prevents their fulfillment.

Historically, neo-Freudianism has deviated from the Freudian system much more than seemed probable in the intentions of its supporters. Only portions of the basic Freudian concepts of personality (such as the theory of instincts, the Oedipus complex, the influence of the super-ego, etc.) have remained in the work of these neo-Freudians. But probably the

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sharpest difference between the two schools lies in the neo-Freudians' view of man adjusted to his society—a fundamentally optimistic view—as opposed to the Freudians' pessimistic picture of man struggling between his impulses and the strictures of the super-ego. Although for the moment it is not possible to pass a definite judgment on the future influence of neo-Freudianism on American psychiatry, there is no doubt that this movement has brought a fresh approach to the problem of human personality and has satisfied the need of many American students for a more sociologically oriented type of psychodynamics.

The Organization of Psychoanalytic Associations

The development of the psychoanalytic movement underwent dramatic phases, as illustrated in Ernest Jones' *Life and Work of Sigmund Freud*. Although the details of this development, which covers half a century, cannot be mentioned in this chapter, an examination of it reveals that the main issues constantly involved throughout the years have been those of the establishment of professional standards for psychoanalysts, training of future analysts, and consistency of theory and practice.

The American Psychoanalytic Association's declaration of autonomy from the International Psychoanalytic Association, in 1938, was a natural consequence of the influx of European analysts and of the interruption of relations with European societies caused by the rise of the totalitarian regimes and, later, the war. This move increased the level of professional standards and training and strengthened the ties with other scientific organizations, particularly the American Psychiatric Association. At the same time, the move created favorable conditions for an increasing influence on psychoanalysis of American sociological concepts, a development that ultimately led to neo-Freudianism. This trend toward secession was started by Karen Horney with the foundation of the American Institute for Psychoanalysis in 1941 and probably influenced the further development of the psychoanalytic movement. In 1946 the American Psychoanalytic Association changed the status of the individual societies from constituent members to affiliates, permitted the establishment of more than one society or one institute in any one locality, freed each institute from connection with the society, and finally, in 1951, became incorporated under New York State law. These decisions had the effect of encouraging the founding of new societies, such as the Association for Psychoanalytic Medicine, the Columbia University Psychoanalytic Clinic, and the Psychoanalytic Institute of the State University Medical Center in New York City; at the same time, they strengthened the connection between psychoanalytic institutes and medical schools.

This reinforced even further the feeling of mistrust and rejection which the American Psychoanalytic Association always expressed toward lay analysts, in contrast to the more lenient attitude of such European psychoanalytic associations as the Swiss and the British. The Association has taken an official position of admitting only physicians as candidates for training. Originally only a restricted number of well-known lay analysts, such as Ernst Kris, Berta Bornstein, Beata Rank, and Eric Erickson, were accepted as members.

The question of training analysts has become a crucial one—especially since a professional standards committee was established—and has raised considerable discussion and controversy. Although there is general agreement that theoretical psychoanalytic concepts should be taught to psychiatric residents, there is a difference of opinion as to whether a homogeneous form of didactic analysis should be required for all residents or only for future analysts. Similarly, there is disagreement as to whether institutes for psychoanalysis should be independent of medical schools.

It is apparent from these discussions, however, that it has become more and more difficult to differentiate orthodox psychoanalysis from psychoanalytically oriented psychotherapy, theoretical from practical issues. Certainly, to quote Robert Knight,[88] "The spectacle of a national association of physicians and scientists feuding with each other over training standards and practices, and calling each other orthodox and conservative or deviant and dissi-

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dent, is not an attractive one, to say the least." The impression of a rigid conformism in some expressions of the psychoanalytic societies has been noticed by many. Oberndorf, for example, commented[124] that "the rigorous, somewhat conventionalized training program that developed at the various institutes during the fifth decade . . . sometimes leads to stereotyped thinking and codified, even mechanized interpretations." Appel remarked[13] that "rigidity, dogmatism, assertion, conviction, authority, indoctrination, so prevalent in many psychoanalytic institutes," favors only passive submission on the part of the candidate and satisfies his need of achieving a supposed higher professional status by becoming a psychoanalyst.

Whether the psychoanalytic movement will be able to maintain its original integrity and still become an integrated part of the American culture cannot now be predicted. At this point, the historian can only note the growth of its influence in the past twenty years, and observe, in current terms, the opposition between the tendency toward conventionalism and that toward re-evaluation of basic issues.

¶ Therapy

Physical

Shock Therapy

The introduction of shock therapies was one of the most important events in psychiatry in the last two decades, and one of the factors that contributed to create a natural chronological subdivision in the development of psychiatry, at least in this country. Shock therapies were introduced here in the following order: hypoglycemic treatment by Manfred J. Sakel in 1938, Cardiazol therapy by J. Ladislas Meduna in 1938, electric convulsions by Lothar Kalinowsky and Renato Almansi (following their training in Rome under Cerletti) in 1939.

A considerable body of data has been accumulated around the subject of shock therapy; the scientific validity of these data, however, has been questioned in many quarters because the original hypotheses regarding the effects of shock—both physiological and psychological—have never been experimentally established.

In general, the concepts concerning the practical application of the shock therapies—particularly insulin and electric shock—have been widely accepted, at least in the absence of other more rational forms of treatment. Much of the available data deals with the problem of the type of patient best suited to shock therapy, and, in the attempt to reach a more valid selection of cases, some special tests were introduced. Technique of administration of treatment has also received much attention, and many variations have been attempted, with rather meager advantages, however, over the original technique. Most hospitals use electric shock therapy rather than deep coma insulin, because the latter involves such high costs. And electric shock can be—and is—utilized even in ambulatory practice.

The data on shock therapies have been gathered, for the most part, by researchers committed to the physiological rather than the psychological approach. In recent years, however, the literature has grown to include some studies of psychodynamics. The psychological importance of the regression on the patient, the close contact between the patient and therapist, the experience of symbolic expiation, death, and rebirth by the patient during treatment, and the importance of other factors in the psychodynamics of the individual case are some of the themes dealt with in the psychological studies that have been published.

Shock Treatments, Psychosurgery, and Other Somatic Procedures in Psychiatry, by Kalinowsky and Hoch, remains the basic textbook on shock therapy. Chapters by Cerletti, Sakel, Meduna, and others who have pioneered this field appear in the recent historical volume, *The Great Physiodynamic Therapies*.[138]

Psychosurgery

The first lobotomy was successfully performed by Egas Moniz in 1936; then, in the early forties, Walter Freeman and James W. Watts introduced psychosurgery in this country. In spite of the large amount of data reported since that introduction, controversy over this therapeutic technique has raged undiminished on theoretical and practical as well as moral grounds.

Even the specialists in the field have become

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progressively more selective and restrictive in their criteria for suitability of patients for psychosurgery; this applies to mental disease in general, as well as to severely painful somatic conditions, with the exception perhaps of psychomotor epilepsy. Through the years, a considerable modification of the original surgical procedures has been introduced. The difficulties in collecting good physiopathological data and the scarcity of the postoperative anatomical reports account for this relatively rapid change in techniques. With the rise of tranquilizing drugs, psychosurgery has shown a certain decline. Some authors state that these drugs produce a "functional" lobotomy. Whether, in the future, tranquilizing drugs will entirely replace psychosurgery is difficult to say, although at the moment the trend is in that direction.

Walter Freeman and James W. Watts, John N. Fulton, and Milton Greenblatt and Harry C. Salomon have published important monographs on the subject of psychosurgery. In 1951 the United States Public Health Service published a collection of papers on the subject, and additional papers can be found in *Psychiatric Treatment*.[17] Walter Freeman[51] has presented an important survey of twenty years of leukotomy.

Pharmacological Therapy

Although pharmacological therapy in psychiatry is as old as psychiatry itself, only in the last few years has the pharmacological approach achieved significant developments, producing substantial modifications in some of the basic aspects of the management of psychiatric patients.

The emphasis on hormone therapy in the second and third decades of this century also had repercussions in the field of psychiatry. The successes originally reported with hormonal therapy have been followed by increasing skepticism, in spite of the extensive research carried on in some institutions (e.g., by Hudson Hoagland and his associates at the Worcester Foundation). A recent review by Roy G. Hoskins[138] recognizes the limitations of the results.

In the forties, under the impact of the war and the need for short and intensive treatment, the emphasis shifted to Sodium Amytal and other chemical compounds. Besides its value for differential diagnosis, its use was especially emphasized in narcocatharsis, narcoanalysis, and narcosynthesis. The use of Sodium Amytal in medicolegal cases to obtain more unconscious material through loose free associations, became a fairly common trend that has drawn increasing criticism from both the legal and the medical professions on ethical as well as scientific grounds.

Of the three major groups of drugs—tranquilizers, sedatives, and anti-depressants—which today constitute the field of psychopharmacology, chlorpromazine and reserpine continue to be used more extensively than the others in a large number of mental conditions, with frequent symptomatic improvement. We actually know little of the mechanism of these drugs, in spite of the wide program of research carried on all over the country—a program reflected in the literature already available.

It is the consensus of many that the extensive and indiscriminate use of these drugs, supported by an overwhelming propaganda campaign, has encouraged a tendency to overlook the importance of psychodynamic factors in relation to psychopharmacology, such as the basic personality of the patient, the importance of oral gratification, the role of interpersonal relationships connected with the administration of the drug. The claim, by many researchers, that the drugs facilitate psychotherapy has been challenged by as many others. Although it is still too early to pass judgment on their value, the historian cannot avoid finding similarities between the recent developments in psychopharmacology and other earlier movements that proposed a basic relation between organic and functional aspects of psychiatry. From this viewpoint, the present discussions about the value of psychopharmacology lose much of their animosity and acquire significance in the broader context of the basic philosophy of psychiatry.

Individual Psychotherapy

Many issues concerning psychotherapy have already been dealt with earlier, in the section on the psychoanalytic movement. Although

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it must be pointed out that psychoanalysis, first developed as a psychotherapeutic method, laid the foundations for modern psychotherapy, this does not imply that psychotherapy refers only to the Freudian movement. In many quarters, even among orthodox analysts, there is recognition of the value of the so-called "psychoanalytically oriented psychotherapy" as applied by the representatives of different schools or by many considered to be "eclectic."

After the natural enthusiasm of the past two decades for Freudian techniques, the tendency is now toward better differentiation between the conditions that require a long-term approach and those treatable by a more eclectic approach. We find increasing acknowledgment of the fact that psychotherapeutic results are strikingly similar regardless of the theoretical framework followed by each therapist, that the personality of the therapist is more important than his adherence to a particular school of thought, that psychoanalytically oriented psychotherapists are qualified to treat the large variety of conditions that demand a flexibility of approach outside the rigid lines of the Freudian techniques.

No doubt considerable clinical data are available for validating the claim that different psychoanalytic techniques have produced improvements in many patients. Nevertheless, psychotherapy remains an empirical science for a number of reasons: (1) the difficulty in evaluating results quantitatively (a difficulty increased by the resistance of the American Psychoanalytic Association to the experimental approach); (2) the multiplicity of uncontrollable variables, and of objectivizing the personal involvement of the therapist created by the transference situation. It is possible that in the future better tools for research will be found, but so far our measures of human behavior, normal as well as pathological, are too approximate to justify any definite assertion on the value of the different therapeutic techniques. Hoch and Kubie,[59] perhaps better than anyone else, have pointed out the limitations and the uncertainties that characterize the present psychotherapeutic situation.

A reading of papers on psychotherapy (for example, *Progress in Psychotherapy*,[59, 107, 108] *Psychiatric Treatment*,[17] among many others) tends to encourage a position of relativism toward the apparently homogeneous results claimed by the variety of psychotherapeutic schools.

Perhaps such a feeling of relativism should be an essential attribute for any judgment on psychotherapy. To quote Zilboorg[173] "Take your theory, keep it, work with it. But don't be a missionary of your theory. . . . Exclusiveness of one's own theoretical bias is the dangerous factor in the therapeutic situation." Such statements are not meant to support vagueness and eclecticism of approach, but are rather a simple affirmation of the tendency in contemporary American psychiatry, toward integrating classic Freudian principles in a largely eclectic psychotherapeutic approach. It is this common psychotherapeutic approach, tacitly accepted by practically all those engaged in psychotherapy, that makes communication among different psychotherapists possible and that contitutes a neutral ground on which theoretical constructions can be built.

Psychotherapy and Schizophrenia

American psychiatrists, and especially some of the outstanding psychoanalysts, first attempted to treat schizophrenia with psychotherapy. Following the early work of Sullivan and Federn in the thirties, other researchers, particularly Fromm-Reichmann, Bychowski, Redlich, and Arieti, published data claiming positive results in this area of mental illness.

Although the theoretical formulations they advanced to explain their results present differences, a factor common to all of them is the importance given to the early emotional development of the individual and to his interplay with the parental figures and the social environment. The mother-child relationship is considered the center of this complex interplay of dynamic forces, but is viewed in a broader social frame than that of the English psychoanalytic school led by Melanie Klein. Although the multiplicity of early psychological events is stressed in the literature, the concepts tending to emphasize a one-to-one causality (such as the concept of the "schizophrenogenic" mother) are subjected to re-eval-

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nation and criticism. (Although interesting, John N. Rosen's technique of treatment of schizophrenic patients based on "direct analysis" which aims at a direct interpretation of the unconscious conflicts, aside from any social influence, has elicited considerable criticism.)

The most important aspect of the development of psychotherapeutic techniques for the treatment of schizophrenia lies in a new attitude toward patients created by its fundamental concepts—primarily, in the recognition that the countertransference of the therapist requires careful investigation. The mixed feelings of helplessness, rage, and rejection aroused in the therapist by the apparently absurd phenomena of schizophrenia are finally being analyzed and overcome. Although most therapists are deeply interested in the development of this technique, it has, so far, necessarily been applied to a limited number of cases only. Its broader significance has been its effect on mental institutions, where it has encouraged a tendency toward a more individual, understanding, and respectful approach to the treatment of psychotic patients.

Brief Psychotherapy

In Alexander's "brief psychotherapy," the treatment emphasis is on creating a "corrective emotional experience," working through the actual conflictual situation of the patient, especially with the help of supportive methods (contrary to the uncovering methods of classical analysis). Alexander's therapeutic approach overlaps to a great extent—as he has stated himself—with the psychoanalytically oriented approach, and therefore the same consideration can be applied to his system. Alexander's outstanding pupils include Maurice Levine, Henry Brosin, Milton Rosenbaum, Martin Grotjahn, George Ham, and Thomas Szasz.

Hypnotherapy

Hypnotherapy, as a therapeutic technique based on hypnosis, has maintained a definite autonomy. Considered historically as the matrix of the psychoanalytic technique, hypnosis lost importance in psychotherapy in this country until its revival during World War II, in the treatment of acute mental disorders. The success obtained by such short treatment, validated further by the work of English scientists, spurred an increase of hypnotherapeutic practices in this country. The Society for Clinical and Experimental Hypnosis was organized in 1949, the same year that saw the publication of a journal with a similar title. The theoretical basis and the therapeutic techniques of this school—one slightly different from the other—have been discussed by such authors as Margaret Brenman and Morton Gill, Lewis R. Wolberg, John Watkins, and Harold Rosen. In general, one feels that the movement lacks methodological principles, especially in relation to the indications for hypnotherapy, probably because of the vagueness of the theoretical framework.

Conditioned Reflex Therapy

Many complex factors (heavy influence of psychoanalysis in this country, reciprocal mistrust between American and Russian psychologists, etc.) explain the general rejection of psychotherapeutic techniques based on Pavlov's conditioned reflex methodology. W. Horsley Gantt, who, with such other experimental psychiatrists as John C. Whitehorn, Ernst Gellhorn, Howard S. Liddell, William S. Reese, and David Mck. Rioch, founded the Pavlovian Society in 1955, recently attempted to formulate the Pavlovian principles for psychiatry. This formulation, as well as other presentations of Soviet psychology[148] and psychiatry,[172] failed to explain the very essence of the psychological phenomenon—the emotional condition of the person due to the interplay of internal events and of external resonances. This omission accounts for the disinterest of American psychiatrists in this psychotherapeutic approach, particularly in a historical period characterized by the emphasis on the unconscious processes underlying human activity.

Communication and Learning Theory

Outside the realm of psychoanalysis, but more in line with the American emphasis on the value of symbolic logic, of language, of interactional systems and the like, are the

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theoretical formulations by Jurgen Ruesch and Gregory Bateson of communication as the "social matrix of psychiatry." Although these formulations are still too recent to allow any historical judgment, they seem to be an expression of the "operationalistic" tendencies largely diffused in psychological quarters. As such, they are subjected to the same type of criticism leveled against conditioned reflex theory—namely, a lack of understanding of the basic inner condition of the patient. So far, they have met, if not open resistance, an attitude of caution.

Client-Centered Therapy

A more popular movement is the so-called "client-centered therapy" developed by Carl Rogers in the early forties and expanded by many of his pupils. Rogers' contention is that "the individual has within himself the capacity and the tendency, latent if not evident, to move forward toward maturity" and that the role of the therapist is only to favor such a spontaneous process in a climate of "nondirective" approach. Client-centered therapy has found support in many quarters, especially among clinical psychologists, probably because it has represented a way of overcoming the intransigent attitude manifested by the American physicians toward laymen practicing psychotherapy. The historical value of this therapeutic method lies essentially in the fact that it has made psychotherapy accessible to the many people in need of it. The theoretical postulates of "client-centered therapy," in spite of attempts to present them through systematic research (as in the book, *Psychotherapy and Personality Change*, edited by Carl R. Rogers and Rosalind F. Dymond, and published by the University of Chicago Press in 1954), are rather weak and not too original. The concept of a spontaneous tendency toward maturation in the personality obviously has a long tradition in psychiatry, and the presence of a transference situation in the interaction between therapist and patient cannot logically be denied. Perhaps the contribution of "client-centered therapy" belongs to the field of counseling rather than to psychotherapy and should be considered as such by the historian.

Group Psychotherapy

From a historical viewpoint, whereas individual psychotherapy is largely the product of European thought, group psychotherapy is, instead, a recent and typical expression of American thought. In a broad sense, group psychotherapy is the result of the interaction between the imported highly individualized psychotherapy and the typical socially oriented expressions of American culture.

This explains the immediate success of group psychotherapy in this country, despite the fact that it was developed on empirical grounds, with almost no theoretical construction. The early "classes" of tuberculous patients inaugurated by J. H. Pratt in Boston in 1905, the lecture classes for mental patients organized by Edward Lazell at St. Elizabeths Hospital in Washington in 1919, the groups gathered by Trigant Burrows in the twenties, the lecture groups initiated by C. Marsh in New York in 1930, the early "impromptu theatre" of J. L. Moreno in the thirties, have all been a succession of empirical attempts, based on different principles, arising out of occasional circumstances.

Only with Kurt Lewin's introduction, in the thirties, of "field theory," did the dynamic phenomena of human groups start to be scientifically investigated. Lewin's pupils continued his work at the Department of Social Relations at Harvard University and at the Center for Group Dynamics at the University of Michigan at Ann Arbor, and the practical results of these new currents have become known in the application of group work to institutions and collective setups of different kinds.

Some main currents of group psychotherapy have crystallized during the past twenty years: analytic group therapy, introduced by Louis Wender and Paul Schilder in New York in the early forties, attempts to apply psychoanalytic technique in the free atmosphere of the group; the "psychodrama" of J. L. Moreno permits the patient to act out his conflicts on the stage through the use of particular techniques (auxiliary ego, mirror, double and role reversal, etc.); group therapy with emotionally disturbed children, introduced by Samuel R.

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Slavson in the thirties at the Jewish Board of Guardians in New York, allows patients to work out conflicts within the context of the play situation.

Group psychotherapy—either these formalized techniques or other more eclectic approaches—has been applied during recent years to all kinds of groups assembled on different principles (symptoms, therapeutic aims, individual and social roles, etc.). This tendency represents a danger to the original purpose of therapy—for it can dilute the therapeutic effects for the individual if group work becomes a vehicle for examining collective emotional experiences—as, for example, happens in such organizations as Alcoholics Anonymous.

The American Association of Group Psychotherapy and other parallel organizations on an international level attempt to define the boundaries of their field through meetings and through scientific research (especially in the two journals *Group Psychotherapy* and the *International Journal of Group Psychotherapy*). The historical survey by Dreikurs and Corsini[49] offers an accurate picture of the various viewpoints on this technique.

¶ Developments in In-patient and Out-patient Facilities

The developments of the last two decades in the field of hospital treatment of mental patients, although obviously connected with the developments in social psychiatry, are, historically, of such significance that they can to a certain extent be compared with those that occurred at the end of the eighteenth century. Once again, because of the influence of many factors still difficult to evaluate, society is reflecting on its attitude toward mental diseases in an attempt to overcome the prejudices that interfere with the understanding of such conditions. This understanding is based, however, on "scientific" as well as humanitarian grounds, a combined approach so typical of American science.

The factors responsible for this new development should probably include the gigantic problem of rehabilitation faced by the Veterans Administration at the end of the war, the educational campaign promoted by mental health specialists at every level of national life, the new concepts of interactional relations developed by group dynamics and social psychology, and finally the psychopharmacological advances in the treatment of chronic mental patients.

The events of historical significance which have initiated this movement include the project for a "day hospital," first outlined by D. Ewen Cameron in 1947, the Mental Hospital Institute organized by the American Psychiatric Association in 1948, the creation of the two sections on Hospital Administration and on Rehabilitation the following year and of the Committee for the Certification of Hospital Administrators in 1953. The psychiatric aspects of rehabilitation were emphasized with the passage of the Vocational Rehabilitation Act in 1954. The program of "family care" for patients able to leave the mental hospital expanded considerably. The program for training psychiatric nurses and, later, aides and attendants working in mental institutions, was enlarged and measures were taken—either through the United States Public Health Service or the National Mental Health Act—to overcome the shortage of nurses, still critical all over the nation. Finally, diagnostic and therapeutic work in psychiatric departments of general hospitals or in out-patient departments has expanded not only because of direct organizational and financial assistance from different sources (medical schools, Veterans Administration, United States Public Health Service) but also because of the more understanding and cooperative attitudes of communities.

On another level, these external events reflect, of course, the profound impact of psychoanalysis on Western culture. For, as psychopathology began to be understood and as self-knowledge increased, the superstitious terror surrounding mental illness was swept away, and the resistance to facing the psychological problems of man decreased.

During the last two decades, a much higher degree of flexibility in the treatment of mental

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patients has developed. Many of the barriers between them and the community have disappeared. Since the early studies by Stanton and Schwartz—*The Mental Hospital*—and Maxwell H. Jones—*The Therapeutic Community*—the different aspects of the therapeutic community have been studied with the help of scientific methods, including sociometrics—for example, the social implications of "milieu therapy," the system of communication in mental hospitals, the therapeutic implications of "closed" versus "open" wards, the value of techniques of occupational therapy, the relation between the therapeutic community and the outside community, the specific problems posed by particular groups of patients ("chronic," adolescent, alcoholic, addicted, sex deviated, criminally oriented, etc.).

The role of the different staff members (hospital administrator, psychiatrist, psychologist, social worker, psychiatric nurse, chaplain, dietitian, librarian) and especially of personnel more in contact with the patients (psychiatric aides, volunteers) has been given great attention. The importance of the interaction between patients and their families and between patients and staff members has also been stressed from the dynamic, sociological, and cultural viewpoints. The complexity presented by the study of these problems has brought forth an interesting new development—the introduction of sociology in mental hospitals. The program of research carried on by such public and private organizations as the Russell Sage Foundation, especially in some hospitals (for example, the Massachusetts Mental Health Center), is meant to explore this area further.

It is almost impossible to grasp all the implications that this development—at its present initial stage—will have for psychiatry in the future, in relation to psychodynamics on the one side and sociology on the other. The most important aspects of this new field have been discussed by Alfred Stanton and Morris Schwartz, Raymond Fuller, Louis Linn, Milton Greenblatt, Richard York, and Ivan Belknap, among many others, and are reviewed further in the APA reports *Progress and Problems in Mental Hospitals* and *The Psychiatric Hospital*, and in the report *The Therapeutic Use of the Self* published by the Group for the Advancement of Psychiatry.

¶ Special Fields of Psychiatry

Mental Deficiency

There has been a move in the past twenty years to define mental deficiency as a symptom common to a heterogeneous group of conditions, independently of its etiology, anatomicopathology, and clinical manifestations. The importance of the concept of "aclinical" or "undifferentiated" defectives as a "subcultural group" in a sociological sense, falling at the extreme left (I.Q. of 70-75) of Galton's curve of the intelligence of the general population, has gained increasing acceptance.

The improvement in the research methodology of mental deficiency, with the application of statistical methods of genetic research to clinically isolated types, has resulted in the clarification of several hereditary forms. Amaurotic idiocy, phenylketonuria, gargoylism, and hepatolenticular degeneration are now considered of recessive nature, and tuberosclerosis and other forms are considered of dominant nature.

In the attempts made toward a better nomenclature and classification of the different forms of mental deficiency, the multiplicity and complexity of the pathogenic factors are continuously stressed. Research on the impact of environmental factors—prenatal, natal, and postnatal in origin—as well as on the influence of different noxiae (avitaminosis, anoxia, X-ray) is being carried on in different centers. The emphasis of the twenties and the early thirties on postencephalitic conditions has now switched to a variety of subclinical conditions (such as toxoplasmosis) in the mother capable of causing mental defect in the offspring. Other important problems, however, remain obscure: the defect due to incompatibility of the Rh factor, the pathogenesis of mongolism, and especially the importance to

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be assigned to birth trauma in the etiology of mental defect.

The description of the psychological manifestations of brain-damaged children, evolved with the help of special psychological tests based on gestalt psychology, is a relatively recent development, due essentially to the work of Kurt Goldstein, Heinz Werner, Alfred A. Strauss, and Lauretta Bender. The broadening of psychological perspective on many forms of mental deficiency has contributed to the increasing acceptance of the concept of "pseudo feeble-mindedness" as inclusive of all the clinical forms of apparent mental defect due to emotional deprivations, frustrations, and insecurity. At the same time, the study of children's psychoses has focused on the uncertain boundaries between mental deficiency and primary autism.

The progress made in the knowledge of the pathogenesis of some mental conditions is responsible for recent therapeutic achievements, for instance, phenylalanine-free diet in the treatment of phenylketuronics. Independently of the specific pathogenesis, the multiplicity of the factors interplaying in each case has brought psychotherapy into use for mental deficiency in many clinics and special institutions.

Perhaps the most important achievement in the field of mental deficiency, in the period under consideration, has been the more enlightening and practical attitude toward mental deficiency on the part of families, schools, and communities. Many of the old prejudices have been replaced by sound programs, such as the opening of special classes in public schools, the agricultural colonies under public welfare supervision, boarding-home family care, and sheltered shops. This has been accomplished largely because of the acceptance of mental-health principles at different levels, from small group discussions and therapy meetings to national organizations such as the National Association for the Help of Retarded Children. Similarly, employment agencies have become more active in assisting mentally retarded in different ways—qualifications for job placement, and follow-up.

In line with these developments, the *American Journal of Mental Deficiency* has enlarged its interest especially toward educational and sociological aspects. Recent literature in this field includes works by Harry J. Baker (1953), J. Edward Wallin (1949, 1955), Clemens E. Benda (1952), Karl C. Garrison (1950), Merle E. Frampton and Elena D. Gall, Eds. (1956). The American Foundation on Mental Deficiency is the expression of the scientific investigations carried on in this field in many research centers, among which are the Vineland Training School, in New Jersey, the Fernald School, in Waverly, Massachusetts, the Letchworth Village, in New York, the Wayne County Training School, in Michigan, and others.

Alcoholism

Only recently has the problem of alcoholism been faced in its entirety by different groups of researchers, with the recognition of alcoholism as a disease rather than a penal problem. This different attitude toward the problem has been the main factor underlying a number of initiatives of national significance: (1) the organization of the section of alcoholic studies at Yale University's Laboratory of Applied Physiology in the late 1930's, followed by the foundation of the *Quarterly Journal of Studies on Alcohol* in 1940 and the opening of the summer school of alcoholic studies in 1943; (2) the creation in 1941 of the National Research Council on the Problem of Alcohol; (3) the creation of the National Committee on Alcoholism in 1944; (4) the organization of the National State's Conferences on Alcoholism; and (5) the foundation of the National Association for the Advancement of Instruction on Narcotics and Alcohol, in 1951. On a state level, following the example of Connecticut, the majority of the states of the union have organized programs for alcoholics.

Research on alcoholism has covered a great range during the period under consideration, from biochemistry to psychoanalysis and sociology. The interrelation between vitamin deficiency, specific metabolic disturbance, and alcoholic consumption has given rise to a number of hypotheses—all of which are still subjected to a great deal of criticism. The

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introduction in 1949 of Antabuse (subsequently called disulfiram, an abbreviated term for tetraethylthiuram disulfide) has, on the other hand, been considered a landmark in the history of alcoholism.

Most clinicians today, however, incline toward the use of pharmacological therapy combined with psychotherapy. The practical successes of various forms of group therapy, including Alcoholics Anonymous, have pointed out the importance of psychodynamic factors in alcoholism. And a study of male alcoholics and their wives, in group psychotherapy, stresses the importance of interpersonal dynamics. Theoretical explanations of alcoholism from a psychoanalytic viewpoint were advanced several years ago by Robert Knight, Ernest Simmel, and L. E. Wexberg. These explanations have been reformulated by Giorgio Lolli as unsatisfied needs for love and tenderness—unsatisfied because of the taboo on tenderness and because of social isolation and loneliness. Increasingly, the research on alcoholism from a cultural standpoint—its role in divorce, in crime, in industry, in automobile accidents—merely emphasizes the need for a thorough understanding of the psychodynamics of the disease.

Child Psychiatry

Psychoanalysis was the first discipline to focus on the emotional development of the individual personality and on its deviations. The work in the field of juvenile delinquency in connection with the courts and correctional institutions pointed out the need for prevention and early diagnosis and treatment of juvenile offenders. Areas of specific interest for mental hygiene and psychiatry also became progressively better delimited by many family and social agencies throughout the country. These facts, as well as others such as the progress of developmental and educational psychology, brought additional support to the value of the work already accomplished in child psychiatry.

Historical surveys[20,85,119] agree that child psychiatry originated through the efforts of William Healy in Chicago and Boston and was later continued by the Demonstration Child Guidance Clinics and by the Bureau of Child Guidance in New York City. Owing to the success of these enterprises which at least partially met the tremendous need of the communities, many other child-guidance clinics were established. At about the same time, child psychiatric wards began to be opened in some hospitals, and such pediatricians as Charles A. Aldrich and Benjamin Spock became known for their interest in emotionally disturbed children.

In spite of the differences in disciplines and training among the people working with, diagnosing, and treating children, and in spite of the uncertainty of the roles of the members of each clinic, a trend toward a certain homogeneity in dealing with individual cases as well as with problems became more and more manifest. The structures and the functions of the multidisciplinary "team" became better defined. The same differences in background of team members contributed to create a high degree of flexibility in diagnosis and treatment, which was particularly indicated for conditions as variable and plastic as emotional disturbances of childhood.

Through the years, the research and the experience of the specialists have clarified many issues in the psychopathology of childhood. The value of the multidimentional approach in each case has been progressively recognized and emphasized. In line with this, the active cooperation of the parents, especially of the mother, is now universally stressed as a necessary requirement in the treatment of each case. Furthermore, the area of cooperation has been extended to include other environmental aspects of the child's life (school, recreation, camp, etc.).

At the same time, much progress has been made in the techniques of the intake process, diagnostic procedures, play therapy, and case work with parents. The empirical definitions of the severity of the pathological process, of the need, length, and type of treatment, of the personality of the parents, of the prognostic judgment, and of many other variables are being clarified and refined. An aspect once severely neglected—the follow-up of cases dis-

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charged by psychiatric centers—is now receiving considerable attention.

Research is being carried on in many specific areas of child psychiatry, only a few of which can be mentioned here. With the recognition of "primary autism," the syndrome first described by Leo Kanner in 1943, there was a focusing on the onset of psychotic conditions in children—a fascinating, but difficult, problem. In another area—that of the neuroses and psychoneuroses—the condition of early emotional deprivation, empirically observed in the past by some pediatricians, has been clarified experimentally by the research of René Spitz and Margaret Ribble. Other researchers are working on the areas of symptomatology (enuresis, reading disability, school phobia, pseudo feeble-mindedness, etc.), etiopathology (patterns of mothering, prenatal and paranatal factors, etc.), family relations, the application of psychological tests. The problem of diagnostic categories in child psychiatry is still under discussion, in spite of the recent attempt (1957) of the Group for the Advancement of Psychotherapy to clarify it.

In the area of therapy, the general methodological principles of Anna Freud seem to have achieved more acceptance in the United States than those of Melanie Klein. The treatment program being carried on by Beata Rank and his collaborators at the Putnam's Children Center in Boston—an attempt to treat "atypical" children intensively—has attracted considerable attention. In the literature, the overall studies by Frederic Allen (*Psychotherapy with Children*), Lauretta Bender (*Bellevue Studies in Child Psychiatry*), and Hyman S. Lippman (*Treatment of the Child in Emotional Conflict*) are of major importance.

The problem of delinquency has also been given increasing attention, especially in certain areas such as New York and Chicago, although at times more under the pressure of public concern than on the basis of sound methodology of research and therapy. Ben Karpman, Sheldon and Eleanor Glueck, Harris B. Peck, A. K. Cohen, and F. J. Cohen have all published important material in this field.

In general, the psychodynamics and psychotherapy of adolescents, including delinquents, have been neglected; up to now only a few valuable studies have been published, for example, *Psychotherapy of the Adolescent*, by Benjamin H. Balser. Many authors feel that group rather than individual psychotherapy is more effective in the treatment of the emotional conditions of adolescence.

After the reports by Fritz Redl and David Wineman (*The Aggressive Child*) and Bruno Bettelheim (*Love Is not Enough, Truants from Life*), the idea of placing severely emotionally disturbed children in residential treatment centers received increased support. It has become evident that the families of many of these children are too disturbed to be able to participate effectively in the treatment of outpatient clinics, and that the child needs separation from his environment and intensive treatment for a prolonged time in order to show substantial improvement. Some institutions of this type have already been opened—for example, the Bradley Hospital in Providence, Rhode Island, the Orthogenic School in Chicago, the Southard School in Topeka, Kansas, the Ittleson Center, in Ittleson, New York—and others are in the process of being opened. Currently, however, the great majority of children with emotional difficulties are treated in psychiatric clinics for children. In 1950, 1,228 of such clinics were functioning, many in the eastern part of the country.

Psychosomatic conditions and psychological aspects of physical and handicapped conditions in children are also under investigation, especially in child psychiatric wards of general or pediatric hospitals. Careful studies on asthmatic children, on ulcerative colitis, on allergic conditions, on psychological aspects of tonsillectomy have already been published.

Although in this country child psychiatry is not recognized as a separate specialty of medicine, as it is in Switzerland and Sweden for example, a number of fourth-year residencies in child psychiatry are available in some centers, with the specific aim of preparing future directors of clinics. These centers, either clinics or institutions, are approved by the American Association of Psychiatric Clinics for Children, organized in 1951 in New York, which functions as a coordinating and evalu-

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ating office. Besides this, many child psychiatric centers are approved for the third year of residency, thus offering many psychiatrists an opportunity to gain additional experience, especially in psychodynamics and family relationships. The Academy of Child Psychiatry, representing the outstanding representatives of the discipline, was organized, and finally, in 1957, the American Association of Residential Treatment Centers was founded.

Geriatrics

In recent years the problem of old age has attracted the attention of statisticians as well as of specialists in public health and insurance. The trend toward increase of the average life span has had repercussions even in regard to mental health. The focus on the psychological aspects of geriatrics, however, is so recent that there is still considerable variety of approach to these problems among different authors, partly because of the many socioeconomic issues involved—for example, the question of arbitrary retirement, which is criticized as ignoring the importance of individual differences.

Compared to the increasing attention given to social issues in relation to geriatrics, the knowledge of the physiopathological mechanisms involved in the senile brain disease has not shown significant progress in the period under consideration. An important recent event in geriatrics has been the recognition of the beneficial therapeutic influence of tranquilizing drugs in the management of disturbed, anxious, and agitated patients. This has contributed to a considerable change in the philosophy of hospitalization for old people.

Together with the emphasis on pharmacological therapy, there is a growing trend toward considering the importance of emotional factors related to previous events and personality patterns as precipitating events in the pathogenesis of senile psychoses.

This tendency is reflected in the attempts to stress the value of psychotherapy for old people and to understand some basic issues of the psychology of the aged, such as self-destructive impulses, preparation of the aged for death, and psychological care of dying patients.

All of the research tends to indicate that both aspects—the psychological problems of individual personality and the socioeconomic issues of the aged as a group—are practically inseparable and should be approached from a unitary viewpoint. As a result, we find an emphasis on the psychological aspects of group life and social adjustment rather than on individual personality. Many of the specialists who are working on the problem from a strictly psychiatric point of view also stress the value of group therapy and group work as the best available method of treatment for psychological problems of the aged.

This issue will probably receive more attention on an organized social level as it becomes a growing problem in the community. Even now, such states as California and Florida, which have large communities of aged, and such agencies as the Veterans Administration, which has a static population of twenty million people whose problems of aging will put new strains on the agency's responsibilities, are showing a growing sensitivity to the question.

Detailed information—statistical and economic as well as psychological—is available in the literature already published on the subject. Among the writers who have made contributions in this field are Oscar Kaplan, Susan Kubie and Gertrude Landau, M. Derber, R. S. Kavan, O. Spurgeon English, and Maxwell Gitelson.

Military Psychiatry

The influence of military psychiatry, which was almost unknown at the beginning of World War II, has extended to all the other areas of psychiatry in the past fifteen years. For many physicians, the psychiatric training and experience thrust upon them by the war provided the motivation for entering the field as specialists, and this fact may help explain the pervasive postwar influence of military psychiatry.

As the theater of World War II enlarged to include many nations and fronts, and as the United States began to transform its industrial

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machine into a military weapon, psychiatry, too, was called into the service of creating a wartime army. (As to the question of the contribution psychiatry could make, it is significant that 850,000 men were rejected by the Selective Service System during the war for psychiatric defects, and 43 per cent of all Army discharges were for neuropsychiatric disorders.)

Specifically, the utilization of psychiatry in the war was centered on five main objectives: (1) selection of mentally fit recruits for the armed forces (through social service, psychological tests, etc.); (2) detection and separation, at the earliest possible time, of psychiatrically bad military risks; (3) prompt and effective treatment of psychiatric casualties, in both training camps and combat areas; (4) plans for rehabilitation of psychiatric casualties upon their return to civilian life; (5) maintenance of mental health and furtherance of good morale among men in the armed forces.

Of the different objectives mentioned, diagnosis and treatment of military psychiatric casualties deserves special consideration. A definite psychiatric syndrome—"combat neurosis" (so-called by Rogers Smith) or "combat fatigue" or "combat exhaustion"—was intensively studied in soldiers who broke under the impact of unusual stresses. Joseph D. Teicher later suggested the substitution of "traumatic" and "war neurosis" for these terms. Eli Ginzberg and his collaborators later established that the important factor is not a psychoneurotic vulnerability, but the stress and strains previously affecting the soldiers. The psychodynamics of soldiers under stress during combat and after were investigated by Abram Kardiner and Roy Grinker. Other problems, such as chronic alcoholism and sexual aberrations, were the object of studies and discussions in regard to policies and regulations, with slow but steady acceptance of psychiatric considerations. This was largely due to the enlightening work of consultation and advice that many outstanding psychiatrists offered to the Surgeon General during the war.

With regard to therapy of military psychiatric casualties, the contingent necessities of the war (shortage of qualified psychiatrists, need for returning the men to the war theater, lack of adequate facilities, etc.) pointed out the value of "short-term repressive treatment in the total therapeutic atmosphere of the group," to quote Albert Glass. This short sentence summarizes the trends prevailing in therapy: short-term therapy, even pharmacologically inducted (narcosynthesis), and group therapy in its different types, in either in-patient or out-patient departments. This approach was considered especially useful in preventing the syndrome of psychiatric hospitalization.

The favorable results obtained with this approach were tested again during the Korean conflict. The literature on this is considerable and includes many aspects of the problem, including such new ones as the psychological problems of "brain washing" and of disaster.

Chapter 12, "Traumatic Neuroses of War," includes an extensive list of the literature relating to military psychiatry.

Legal Psychiatry

The interest in legal psychiatry has been confined to a limited group of specialists, in spite of the attempts made to bring many basic issues to the attention of a larger audience. Unfortunately, important areas of this field are still controversial, in spite of the progress of the last two decades. The diagnostic category of "sexual psychopaths," the value of psychotherapy to delinquents, questions relating to parole and probation programs and to commitment of mental patients, attitudes toward juvenile offenders, eugenic laws concerning mental patients and defectives—these are some of the issues that have been subjected to research and investigation.

Two main issues persist, however, those of criminal responsibility and of the psychiatric expert's testimony. These were the subject of a thoughtful report in 1954 by the Group for the Advancement of Psychiatry. As far as the first point is concerned, the results of the application of the Briggs Law in Massachusetts, which provides for a compulsory mental examination in a variety of cases involving severe offenders and recidivists, have been very encouraging (Peter B. Hagopian, 1950). As to the second, Zigmond M. Lebensohn, among

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many others, has articulated the need for a better relation between psychiatrists and lawyers, and suggestions have been advanced for special training in legal psychiatry. There is the feeling in many quarters, both medical and legal, that psychiatrists could be better employed by courts, correctional institutions, and probation agencies. Encouraging steps have already been made in some cities; in New York, for example, consultive mental-health services for courts have been in operation for some time.

The most important event in legal psychiatry in a number of years, however, was the decision of the United States Circuit Court of Appeals for the District of Columbia in the case of Monte-Durham vs. United States, in 1954. The court decided that, as an expert witness, the psychiatrist is expected to give a full account of the mental condition of the patient, in contrast to the old M'Naghten rule which has been criticized as inadequate and legalistic (the full report of the court decision appeared in *Mental Hygiene*, Vol. 40, 1956, pp. 304-317). This decision stimulated discussion—largely favorable—in many journals.

For more details, the reader is referred to the monographs by David Abrahamsen, Walter Bromberg, Henry Davidson, Henry Weihofen, Manfred Guttmacher, as well as to the general reviews by Ben Karpman and Thomas Szasz and to the collaborative work *Psychiatry and the Law*, edited by Paul Hoch and Joseph Zubin.

In recent years, through the efforts of Gregory Zilboorg, the American Psychiatric Association established the Isaac Ray Award, to be assigned each year to a specialist particularly distinguished in the field of psychiatry and law. Four volumes of lectures already have been published, in the following order: 1953, Winfred Overholser; 1954, Gregory Zilboorg; 1955, John Briggs, Jr.; 1956, Henry Weihofen.

Industrial Psychiatry

Industrial psychiatry was for a long time an almost unknown field of psychiatry, cultivated only by a few pioneers. This was in open contrast to the tremendous development of industry in this country. Several facts can be held responsible for this state of things: the majority of psychiatrists were not available in industries during the war because they were drafted by the armed forces; the average businessman has remained skeptical of the complicated and imponderable formulations of psychiatry; psychiatrists themselves—too busy in private practice—have not been too enthusiastic about working in industries.

A marked interest has now developed in this field, among psychiatrists and individuals employed in industries, at the top as well as the bottom level. The American Psychiatric Association established a Committee on Industrial Psychiatry. The Menninger Foundation has a special team for research in industrial psychiatry (Department of Industrial Mental Health). Conferences on Industrial Mental Health were held at Cornell University in 1955 and 1956 under the auspices of the New York State School of Industrial and Labor Relations. The same school makes available fellowships in industrial psychiatry. Some psychiatrists are already employed full time in industries.

The major areas of interest for mental health in industry are (1) methods for prevention of emotional difficulties, (2) occupational neuroses, (3) placing of the handicapped in industry, (4) psychosomatic conditions, (5) alcoholism, (6) accident proneness, (7) absenteeism, (8) psychiatric role of the industrial nurse, (9) problems of aging workers in industry, and (10) psychological aspects of compensation. Obviously, the psychiatric approach in industry can help considerably to decrease expenses.

Direct psychiatric help to the employee remains, of course, the favored area of work for the psychiatrist; such programs have been in existence for many years in a few industries—at Du Pont de Nemours in Delaware, for instance. Friedrick W. Dershimer, among other specialists in industrial psychiatry, has stated that it is better to treat a patient under stress than to remove him from his job. Rehabilitation of industrial workers constitutes another big area of industrial psychiatry, especially after the Vocational Rehabilitation Acts Amendments of 1943.

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In the last few years, following the increasing interest in human relations, communication, and group therapy, psychiatry is getting more acceptance from both executives and labor unions; these days, many issues are dealt with on a psychological rather than a moral level. The psychological problem of communication between managers and labor is complicated by the manifold roles each group must play—leading, for example, to divided loyalties of employees. Group psychotherapy seems to be a useful procedure for treating psychological problems in executives.

More extensive and detailed information is available in the studies by Thomas A. Rennie and his collaborators, Friedrick W. Dershimer, Charles C. Burlingame, and in the report (No. 20) issued by the Group for the Advancement of Psychiatry. D. E. Cameron and H. G. Ross, and W. D. Ross have published significant monographs in this field.

¶ Collateral Fields of Psychiatry

The collateral fields of psychiatry have developed, especially in the last two decades, as an expression of the acceptance of psychiatry in many aspects of the national life.

Only a brief mention can be made here of the significant developments in the areas of (1) genetics, (2) neurology, (3) psychology, (4) education, (5) social work, (6) anthropology, (7) sociology, (social psychiatry), and (8) religion and psychiatry.

Although the application of *genetics* to psychiatry has never been too popular in this country—as in some European countries—because of many factors, a considerable amount of data has been accumulated in recent years by the Division of Genetic Research of the New York Psychiatric Institute, under the leadership of Franz Kallmann. The results of his studies, presented in a series of papers and a recent monograph, concern the genetic etiology of schizophrenia in twins. Other mental conditions also have been submitted to genetic investigation, but with less success. Limited interest has been directed to the eugenic aspects of psychiatry, an issue which remains controversial, as one can see from the different legislation in many states of the Union.

The growing interest in the relation of *neurology* to psychiatry can be attributed partly to the results of the application, in chronological sequence, of electroencephalography, then of psychosurgical procedures, and finally of the new psychopharmacological substances. We see today a renewed interest in all aspects of brain physiology and pathology. The problems of the cortical organization, of the brain stem (reticular activating system), and of the limbic system (visceral brain) in relation to the cortex (and functionally to consciousness and sleep); the various techniques of electroencephalography, experimental neurophysiology (electrostimulation, neuronography), and psychosurgery; the biochemical researches on brain pathology, the investigation of the mechanisms of pain; the description of the temporal lobe syndrome are among the most important and frequently discussed topics of the last two decades. Among the researchers who have contributed greatly to these studies are Horace W. Magoun, Wilder Penfield, Herbert Jasper, Ralph W. Gerard, Stanley Cobb, Ernst Gellhorn, James W. Papez, Frederick A. Gibbs, and others. It is the definite impression of many that in the long run, aside from present-day disputes and controversial issues, the renewed interest in brain mechanisms will result in a permanent *rapprochement* between neurology and psychiatry.

In the field of *psychology*, the last two decades have been characterized by the developments in clinical psychology, due especially to the program of research, training, and practice organized by the Veterans Administration during and following the war. The extensive use of psychological tests (especially the projective ones), the elaboration of new theories of personality (as those advanced by Henry A. Murray, Gordon W. Allport, Kurt Goldstein, Raymond B. Cattell, John Dollard, and Neal Miller), the formulation of the relation of dynamic concepts of personality to cognitive ones (namely of unconscious drives to cognitive processes), of the relation of the individual to group-derived and social categories (namely the expansion of social psy-

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chology, following the early topological concepts by Kurt Lewin)—all these are among the important themes of clinical psychology. The names of David Rapaport, Henry A. Murray, David Shakow, Saul Rosenzweig, Frederic Wyatt, Gordon W. Allport, Clark L. Hull, Gardner Lindzey, O. Hobart Mowrer, Gardner Murphy, Robert R. Sears are prominent for their work in this field.

With the acceptance of clinical psychologists as necessary members of the clinical team, especially in child psychiatric and outpatient departments, and following the emphasis on therapy brought up by Carl Rogers' nondirective approach and by the development of counseling, guidance, and group psychotherapy, the relation of psychology to psychiatry in matters of psychotherapy became a matter for discussion in many quarters, either at an intra- or an interdisciplinary level, but remains highly controversial. The "dialogue" between psychology and psychiatry (to quote David Shakow[144]) is far from exhausted, and is a typical expression of the still undefined aspects of both the professional role of the clinical psychologist and the boundaries of his field.

In *education*, there has been a continuous trend toward the introduction of mental health principles in schools and a greater acceptance of the principles of individual, familial, and social dynamics. The importance of a wholesome school atmosphere, leading the pupil to a greater security and a feeling of belonging, of worth, and of dignity, as well as the importance of the teacher-child and the teacher-family relationships have been generally recognized. Progressive methods of education have been studied in relation to mental health aspects, and such extensive projects as "human relation classes" have been highly successful. Psychiatric attention is being extended to every school level, including colleges and universities. The psychiatric approach to older students, started by Clements Fry at Yale University, has been successfully applied to many other universities, as one can notice from the extensive bibliography by David H. Funkenstein and George H. Wilkie, and from the recent monograph by Dana L. Farnsworth.[50]

In the field of *social work*, greater cooperation between social workers and psychiatrists has developed, especially in set-ups such as clinics, out-patient departments, and courts. The extension of the services covered by social workers and the greater flexibility of roles achieved in many clinics have brought up the important point of the relation between case-work treatment and psychotherapy. This issue has been widely discussed (e.g., in the report of the Commission on Social Work presented at the New York Academy of Sciences by Luther E. Woodward in 1955[12]) but is far from solved. And the difficulties in solving it are illustrated clearly by the contrasting philosophies of "diagnostic case work" and "functional case work."

In *anthropology*, the pioneering work of Ruth Benedict, Margaret Mead, and Edward Sapir stressed the importance of cultural patterns and their variations for the development of the personality and its abnormalities. In spite of the recognized need for better reciprocal understanding between psychiatry and anthropology, the students of this new field still remain limited in number. In the two decades under consideration the work of Robert Linton, Jules Henry, Gregory Bateson, Clyde Kluckhohn, Marvin E. Opler, A. Irving Hallowell, George Devereux, Eric H. Erickson, John Dollard, Cora du Bois, and Abram Kardiner have been the best representatives of this field.

The development of *sociology* in relation to psychiatry (*social psychiatry*), although recent, has been very rapid. From the early work of such sociologists, psychologists, and psychiatrists as George Mead, Ernest R. Groves, Richard Cabot, William I. Thomas, Thomas D. Eliot, Trigant Burrow, Kimball Young, William A. White, Harry S. Sullivan, James L. Plant, Robert E. Park, and Laurence K. Frank, the basis was created for an interdisciplinary approach to sociological problems in psychiatry. Since then, this new approach has evolved in a sounder experimental direction, as illustrated by the ecological study on mental disease by Robert Faris and Warren Dunham. The conferences by the Social Science Research Council in 1950, the establishment of a chair

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of social psychiatry at Cornell University in 1950 (occupied by the late Thomas C. Rennie until 1956), the organization of the Society for the Study of Social Problems in 1951, and, finally, the foundation of the *International Journal of Social Psychiatry*, in 1955, indicate the growing importance of social psychiatry in American research. The emphasis of this field has been directed toward the ecological factors of mental disorders (such as cultural and racial conflicts), the theory of social isolation, the psychiatric implications of social mobility, the influence of civilization, and more recently of social stratification on mental disorders. The basic concepts of personality development and of the clinical psychiatric pictures and even the fundamental concept of psychological normality have been reviewed from this sociological viewpoint. The field is in a typically transitional stage, as evidenced by the collection of papers edited by Arnold M. Rose, *Mental Health and Mental Disorder*, and more recently by Leighton, Clausen, and Wilson, *Explorations in Social Psychiatry*, and by Hollingshead and Redlich, *Social Class and Mental Illness*. For the historian this field is moving toward a further greater development in the near future.

Finally, the *relation of psychiatry to religion*, obviously colored by Freud's strong antireligious attitude, is now being subjected to more objective investigation. The joint efforts of psychiatrists and churchmen in the study of the religious phenomenon, either considered intimately as expressed in consciousness and guilt, or externally as expressed in a system of values, have resulted in the clarification of some basic points. Following the important differentiation made by the Swiss psychiatrist Charles Odier between unconscious and conscious sources of guilt, the borderline areas of interest for psychiatrists and churchmen have been submitted to thorough investigation. The importance of moral and religious issues for the mental health of the patient have been emphasized in a number of publications by representatives of different confessions. This new convergent interest in religion and psychiatry has resulted in the organization of the American Foundation of Religion and Psychiatry and of the National Academy of Religion and Mental Health and the publication of two special journals.

¶ Psychiatric Education

Throughout the country, psychiatric principles in undergraduate teaching of medical students have been introduced. This tendency appears to be the result of the emphasis on the study of the "total personality" and of "humanized" medicine.

Efforts are made by the medical schools to select students with stable personalities, and psychiatric help is offered to those who are unable to function adequately. As far as the teaching program is concerned, psychiatry is taught more and more as part of the comprehensive curriculum rather than as a specialty subject. In 1948, a report on medical education by the Group for the Advancement of Psychiatry recommended the teaching of psychiatry during all four years of medical education, with emphasis on personality development, unconscious motivation, and dynamic consideration of clinical cases. Some medical schools (Western Reserve, Colorado, Pennsylvania, Tennessee, and Harvard), with the help of special organizations such as the Commonwealth Fund and the Kellogg Foundation, have embraced in their curriculums a program of "comprehensive medicine." This includes a careful study and appraisal of the personality of the patient in his own environment, achieved through home visits and the application of basic psychiatric and case work principles. Other medical schools have opened departments of "behavioral sciences" (Syracuse) or give courses in "human ecology" (North Carolina). Other aspects of this problem can be found in the report of the first Conference on Psychiatric Education held at Cornell University in 1951 as well as in a curriculum of studies recently outlined by the Committee on Psychiatric Education of the American Psychiatric Association.

In regard to postgraduate teaching, the need

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for organizing a program on a national basis became evident at the end of the war. Training in psychiatry, first carried on by private foundations (Rockefeller Foundation, Commonwealth Fund), especially under the leadership of Alan Gregg, was later taken over by the federal government. The Veterans Administration and some large institutions such as The Menninger Foundation continue to maintain an extensive program of training. As a result, the American Board of Psychiatry—established in 1934—formulated definite requirements for the specialty of psychiatry. A limited number of institutions are approved as accredited training centers in the attempt to make the formal postgraduate three years' training as homogeneous as possible all through the country. This problem is complicated by the fact that many residents are foreign graduates and that some of them return to their original countries after their training. The most important aspects of postgraduate training were discussed at the Second Conference on Psychiatric Education, held at Cornell University in 1952, and more recently by the Committee on Medical Education of the Group for the Advancement of Psychiatry. The reports of these conferences stress the importance of dynamic understanding of cases, of facilities in psychotherapy, and of adequate supervision. Personal analysis, although not a necessary requirement, is recommended as a means of acquiring better insight and self-knowledge, especially in regard to psychotherapy. This has brought up the question of whether analytic institutes should be part of departments of psychiatry or should be independent. Different points on the training for psychoanalytic practice have been discussed in a symposium (published in 1954) in the *International Journal of Psychoanalysis* and in *Psychoanalysis and Psychotherapy* by Franz Alexander. Another symposium dealt with the more general topic of qualifications for psychotherapists. Some states have tried to solve the problem of postgraduate psychiatric training by unifying all the psychiatric facilities existing in the state. Other information on postgraduate education, although partially outdated, is available in the volumes by F. G. Ebaugh and C. A. Rymer, *Psychiatry in Medical Education*, and by H. Witmer, *Teaching Psychotherapeutic Medicine*.

¶ American and European Psychiatry: an Appraisal

Because science cannot be limited by geographical or political boundaries, an attempt to correlate and compare American with European psychiatry must be an artificial one. Psychiatry, in particular, was largely a product of European thought and was transplanted to this country either through exchange of literature or through the direct work of some of the best representatives of many European nations permanently established in this country.

There is no doubt, however, that all European scientific movements—including those of psychological and medical sciences—having once arrived in this country, were then influenced by the characteristic pragmatic orientation of American philosophy. This approach explains the benevolent acceptance of new methods and systems in this country, provided they pass the test of efficiency and operational value.

The difference in the philosophical approach to the personality problems, more theoretical in Europe and more practical in America, however, remains quite broad even today. The difficulties of communication (languages), the experience of the war, a typical atmosphere of reciprocal mistrust (from which Freud himself did not escape), and the persistence of prejudices of many kinds, all tend to create a barrier between the two continents. This barrier persists even in spite of the American participation in international meetings, of the extensive program of exchange of teachers and students, and of the considerable interchange of information.

It is not possible, in view of the limits of the present chapter, to consider, even superficially, the causes of this phenomenon. Of the different explanatory attempts made, that by Gordon W. Allport[8] is perhaps the most comprehensive and at the same time the most stimulating. It is based on the following points:

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(1) The Lockean tradition (empirical) is dominant in England and in America—the Leibnitzian and Kantian (intellectual), on the Continent; (2) Continental theories tend to focus on the "whole man"; Anglo-American theories, by contrast, are more often concerned with parts of the whole—with traits, attitudes, syndromes, factors of performances; (3) American approaches, more than the British, are marked by a tone of meliorism and optimism, whereas many Continental approaches are characterized by a note of fatalism and pessimism; (4) social interaction received greater importance in American than in Continental theories; (5) Anglo-American typologists are currently more interested in "brain models" than are Continental typologists; and (6) the ideal of rigorous positivism seems to prevail in Anglo-American psychology to a greater extent than it does on the Continent.

No matter how much consent or disagreement Allport's ideas find on both continents, his formulations are remarkable for their clarity and sincerity. Though American himself, Allport, in fact, makes a plea for the importance of basic European contributions to essential psychological issues in different typologies, psychometric and psychodiagnostic methods, developmental psychology, gestalt formulations, and, above all, psychoanalytic theory and practice. This is only one side of the question, however, because the American contribution to these very same issues has been marked, if by less creativeness, then certainly by great enthusiasm and freshness of approach. It is therefore not possible, even in view of recent developments, to pass a judgment of historical significance—even less, a judgment implying a hierarchy of values and of priorities.

Some authors—for example, Henri Ellenberger[44]—have attempted to isolate and describe the main differences between American and European psychiatry. Like all statements of broad significance, these descriptions suffer the defect of generalization, and therefore must be considered as referring to trends and currents rather than achieved positions.

In Europe, the emphasis is still predominantly on diagnostic categories—in Germany as a result of the Kraepelinian tradition, based on the predominance of pathology of the nineteenth century, and in France as a result of the brilliant clinical school of descriptive medicine also of the same period. The differences in historical traditions and national characteristics among European countries have produced equivalent differences in terminology, so it is difficult to compare and equate clinical findings. In America the emphasis is on practical considerations, essentially of therapeutic value, and a standard nomenclature—in spite of its limitations—is accepted because of its pragmatic value. Where European psychiatrists speak of mental diseases, implying by this term definite and static entities, American psychiatrists usually speak of "reactive conditions," a concept which includes a more dynamic and total consideration of the individual in his relation to the environment.

In line with this, certain areas of research, such as psychiatric genetics and constitutional typologies, have been investigated with greater attention through detailed statistics in Europe (especially in the Scandinavian countries, Germany, and Switzerland) than in America. Among the factors which have contributed to this trend are the stability of the population and the relative homogeneity of racial groups. In the United States, the concept of multiple causality is generally accepted, resulting in the multidimensional diagnosis and therapeutic approach used in institutions as well as in clinics. As an expression of this cultural frame, psychiatry—as a science dealing with emotional disturbances—is now accepted without too many prejudices among large groups of the population in this country.

It has therefore been said that psychiatrists in America treat conflicts, whereas in Europe they treat symptoms. No matter how naïve this formulation may appear, psychiatric issues in Europe are still dealt with either in the context of a strict patient-doctor relationship, or in the very impersonal and bureaucratic approach of state institutions. The response of the community to psychiatric problems is still a fragmentary and uncertain one, although the personal attitude toward emotionally disturbed individuals of many people working in the community either at a professional

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level (nurses, attendants) or at a nonprofessional level (for instance, churchmen) is frequently colored by warmth and charitability of spirit. This, perhaps, helps one to understand why, in spite of limited scientific knowledge and scarce funds for research, therapeutic results in European institutions (mental hospitals, rehabilitation centers, treatment homes for emotionally disturbed children and delinquents) are often superior to those achieved in American institutions. Some approaches, applied in Europe for some time, are not yet used in this country—for instance, the "flying team" employed by A. Querido in Holland to treat acute psychiatric emergencies.

European psychiatry has undergone a considerable development since the end of the war. A review of European literature is impressive for the picture it shows of a ferment of ideas, even though only a few of them will stand the test of time. One has to consider, however, that these developments, especially of the psychodynamic school, are expressions of a restricted group of researchers and a limited number of centers. The majority of European psychiatrists, isolated from the rest of the scientific world during the years of the war, are still anchored to the old-fashioned organistic school and quite indifferent to the insights of the psychodynamic school. Instead, many laymen from a variety of backgrounds, particularly psychologists and educators, have enthusiastically (but at times uncritically) embraced the basic principles of psychodynamics —either Freudian or not—and today constitute a large segment of the European psychoanalytic societies. This is in sharp contrast to the American psychoanalytic societies, which are restrictive toward representatives of nonmedical professions.

Considering the problem in its general aspects, one sees in this country a fairly homogeneous acceptance of the basic postulates of the psychodynamic school, which makes possible a common platform of mutual understanding for practical purposes of clinical diagnosis and treatment. In Europe, on the other hand, a variety of different psychotherapeutic approaches, each using a difficult and at times philosophical nomenclature: "Autogene training" (J. H. Schultz), "*Méthode du rêve éveillé*" (Robert Desoille), logotherapy (Viktor Frankl), phenomenological and existential psychiatry, and, finally, reflexological psychiatry are among these approaches.

It is not possible, in the limits imposed by this chapter, to touch even superficially on the particularities of these different currents. Besides the chapter on existential psychiatry in this handbook, additional material can be found in the monographs published in this country by Ulrich Sonnemann and J. H. van den Berg. Unfortunately, almost all the material so far published, except in rare cases (Erwin Strauss's work on obsession, Medard Boss's monographs on sexual perversions and dreams, Viktor Frankl's work on logotherapy, translated in this country in 1955), has to be read in the original languages. Most of the important clinical contributions by Ludwig Binswanger, Roland Kuhn, and Jakob Wirtsch, the phenomenological descriptions by Eugène Minkowski, Henrious C. Rümke, and F. J. J. Buytendijk (on pain, femininity, and the human movement), the "anthropological" contributions by Viktor E. Gebsattel and by the new Viennese school of "deep psychology" (Igor Caruso and Wilfred Dain), as well as the papers published in the yearbook *Situation* in Holland from 1954 on, still remain outside the reach of almost all American psychiatrists. The same can be said of the important articles that periodically appear in such journals as the French *Evolution psychiatrique*, the German *Jahrbuch für Psychologie und Psychotherapie* and *Psyche*, and the Swiss *Schweizer Archiv für Neurologie und Psychiatrie*.

The essential themes of the existential movement center around a strong defense of the intimate *Erlebnis* of the individual, considered in itself and in relation to the dual modalities of human existence. The individual unrepeatable situations in which the human being is "engaged" in his "being-in-the-world" are submitted to phenomenological investigation. The meaning of individual destiny, of responsibility toward life, and of the "decision" of the subject toward the basic issues of human life—such as freedom, happiness, love, work, suffering—is studied through the "inner biography" of

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the individual and the deviations of his *condition humaine*. Psychotherapy means the "encounter" of the therapist with the patient in the situation of "genuine presence"—the only path to a fecund "understanding."

It is easy to see from all of this why the existential approach to psychiatry has frequently been criticized for its lack of "objectivity" and has so far played almost no rôle in this country. This seems obvious to the historian, considering the pragmatic philosophy underlying American psychiatry. It is more difficult to predict the future mutual influence of American and European psychiatry. The cultural and historical differences of the two continents—endowed with two different types of creativity[8]—seem to slow the effect of the improvement in communications, which normally tends to demolish barriers and differences of opinions.

These barriers are even higher and more difficult to overcome if one considers psychiatry as currently practiced in the Soviet Union. In spite of the scarcity of the reports,[101, 146, 172] there is ample evidence that the themes underlying Russian psychiatric philosophy and especially psychotherapy—persuasion, re-education, work therapy, rest treatment—are quite different from those underlying American psychiatry. In their complete neglect of unconscious motivations and in their emphasis on the processes of the highest nervous activity, they are perhaps more adequate to the Eastern tradition.

The influence of local cultural and historical traditions is also evident in psychiatry as practiced in other countries, as indicated in the reports which are appearing in the American literature, in particular in the collection *Progress in Psychotherapy*.[59, 107, 108]

No matter how strong these local traditions are, the historian has the impression that a marked movement of confluence is present among the different schools, accelerated, perhaps, by the urgent problems posed by the treatment of great numbers of mental patients in large countries. The similarities of the philosophies responsible for the development of socialized medicine cannot be overlooked. Its influence is evident in all fields of medicine, including psychiatry, in spite of the fact that psychiatry, and especially psychotherapy, traditionally resists any direct attempt toward socialization. During the period considered in this survey, American psychiatry has exercised a leading influence among the civilized nations of the world, with the exception of Russia. It is the hope of many that this influence will continue in the near future and that a better reciprocal understanding will take place, in line with Allport's recent statement that "the genius of both [American and European] regional trends is needed to achieve an optimal integration of psychological science."

¶ An Over-all View of Modern American Psychiatry

The impact of the main events of the development of psychiatry during the past twenty years is still so much a part of our daily psychiatric thinking, and the men who have contributed to these events are still so close to us in sharing a common *Zeitgeist*, that the duty of the historian becomes an extremely difficult one. The difficulties of the historian of contemporary events—the inability to detach himself from the stream of events and the tendency to limit himself to the function of a chronicler—are quite obvious. These difficulties, practically impossible to overcome, perhaps explain why over-all historical surveys of the last two decades of psychiatry have not yet been attempted.

A number of historical studies have been published in recent years. In 1944, the centennial year of the founding of the American Psychiatric Association, two volumes[11, 75] appeared, containing important historical studies by Richard H. Shryock, Winfred Overholser, Samuel W. Hamilton, John C. Whitehorn, William Malamud, Albert Deutsch, Edward Strecker, Thomas V. Moore, Gregory Zilboorg, Clyde Kluckhohn, George S. Stevenson, Franklin G. Ebaugh, and others.

These, however, limit themselves to consideration of events up to the end of the third decade of the century, a turning point in the history of psychiatry. Surveys of the last two

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decades of psychiatry, considered either in its general trends or in its special fields, are still extremely rare, in spite of the imposing editorial activity of recent years and of the increasing interest in historical issues. The reviews on the general trends of American psychiatry, as for instance, by Nolan Lewis[97] and Paul Hoch,[77] are isolated examples, and do not claim sound historical methodology.

Ilza Veith[163] stated, "It is astonishing that medical historians have so far been rather neglectful in their study of psychoanalysis and its founder." Like another medical historian, Erwin H. Ackernecht,[2] Veith goes on to state that the disinterest in the history of psychiatry is not a temporary, but a traditional, one. And this disinterest has existed as much among psychiatrists as among medical historians.

It has to do with a number of obscure reasons, which psychoanalysis has started to investigate. In a brilliant essay, "A Critique of Psychiatry," Alan Gregg[70] focused on these complex reasons: the horror of mental diseases diffused among all the people of the world and the consequent inference of moral lapses as causes for early pathological signs; the tendency to think of mind or spirit as separate from the body; the ambivalent attitudes of society toward psychiatrists; the isolation of psychiatry from general medicine and from the stream of contemporary culture. Furthermore, psychiatry is so intimately related to the scientific, cultural, ethical, and religious currents that accompany its development that it becomes almost impossible to disentangle the history of the one from the others.

Turning now to studies on the history of psychiatry done by psychiatrists, we find these equally scarce, in spite of the fact that "the historical approach is more important to the study of psychiatry than to the study of any other branch of medicine," according to Mark D. Altschule.[10] There is, however, a growing tendency among psychiatrists to recognize the importance of historical studies.

Bromberg,[31] Farrar,[51] Galdston,[61] Lewis,[96] Riese,[134] Zilboorg[176] and more recently Margetts[104] and Mora[119] have made interesting contributions in the field. Freud's centennial served to focus on the importance of such studies[3, 84, 82, 153, 173] and Jones's monumental biography of Freud[81] helped further to stimulate historical interest among other psychiatrists, although their number is still limited.

The reasons behind this relative disinterest in historical issues are complex and difficult to formulate, especially if one recalls that psychiatry—having for its object the human mind—has traditionally been closer to the humanities—and thus to history—than have other branches of medicine. Originally, traditions in psychiatry stemmed from those of the mental hospital superintendents of a century ago—a tradition of scholarliness, paternalism, and humanitarianism. And from those principles arose the highest expression of "moral treatment," which antedated many forms of modern psychiatry. But, in the last part of the nineteenth century, when emphasis shifted toward classification of disease and the neurological approach to psychiatry, this tradition faded. Psychiatry risked losing its essence in the riddle of generalities (as in the concept of neurasthenia) or in phrenological subtleties, or in the confusing formulations of new esoteric religious groups.

In spite of these dangers, psychiatry survived because of the impact of such factors as studies in psychology and education, and in the psychobiological and social aspects of mental disorders. At the basis of all this is the democratic attitude of American society, which made possible the official introduction of Freud's ideas in this country in 1909. The historical significance of this open-minded attitude cannot be overestimated. The uninterrupted tradition of training, research, and treatment in psychiatry, reinforced by its willingness to incorporate the contributions coming out of European research, made it possible to avoid the schisms in the psychiatric movement that occurred in many European countries.

Today psychiatry enjoys a popularity in American culture—in literature, on the stage, on the screen (as one can see, for instance, in Brosin,[33] and in the more recent collection of papers, *Freud and the 20th Century*,[174]) which has elicited concern among many scientists. On the one hand, there is the danger of over-

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secularization of psychiatric principles, typically reflected in the mental health movement. To quote John R. Seeley,[42] this movement, "with one foot in humanism and the other in science, seeks to perform many if not most of the functions of the relinquishing institutions," to fill "the power vacuum created by the bankruptcy of other institutions." On the other hand, there is the danger of isolation and overspecialization, expressed by the reciprocal ambiguity of psychiatry toward medicine and the biological sciences and by the timid renaissance of "neuropsychiatry."[99]

The last two decades have produced two contrasting developments: the general conservative attitude of the Freudian schools and the increasing influence of sociological issues on overall psychiatry. Both trends have been attacked vigorously on several grounds—the "great psychiatric revolution" brought about by psychoanalysis by Percival Bailey in his 1956 Academic Lecture at the American Psychiatric Association, the modern sociological influence by Pitirim A. Sorokin.[150]

In spite of the progress made in psychiatry—as expressed in the development of the different fields considered above—the historian's responsibility is to advance a strong plea for meditation on the essential themes of the history of psychiatry. Today, these essential themes (the importance of faith and belief in any form of treatment, the tendency for or against restricting mental patients, and finally the relation between mind and body) represent themselves through contemporary events. It is difficult, however, for anyone to isolate these themes from the complexity of everyday life. From a historical viewpoint, the influence of the criticisms cannot be judged until decades later.

Because psychiatry is both science and art, and the human being is its subject, no matter how important the emphasis on many aspects of psychiatry may be, every real advance is related to the personality of the psychiatrist—to his motivations, his ability to disregard prejudices and preconceived ideas, the flexibility of his thinking, his modesty and his capacity to accept criticism and suggestions, his responsiveness to the issues of his contemporary culture. Freud's life and work remain the prototype expression of the psychiatrist, in the humanistic sense, in spite of the fact that his gigantic stature makes him out of reach for the majority of others.

In him the early stages of the historical trends of psychology and psychiatry—a progressive passage from curiosity to research, to greater knowledge, to adequate responsibility—were expressed at the highest degree. The two decades considered in this chapter could be characterized by the greater knowledge achieved by psychiatry. If this is, indeed, as it seems to be, the long-range trend, then the common hope of the psychiatrist and the historian should be that the last stage, that of adequate responsibility, will soon be achieved by American psychiatry.

A brief list of bibliographic sources of literature in the history of psychiatry and psychoanalysis precedes the bibliography for this chapter. The bibliography itself is a brief selection from published material in three specific areas: (1) historical data of the last twenty years; (2) studies dealing with general aspects of psychiatry—e.g., philosophical foundations of its methodology; and (3) contributions to the understanding of psychiatry abroad, particularly in Europe. The latter two represent material that will not be touched on in other chapters.

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CHAPTER 3

THE BIOLOGICAL BASIS OF HUMAN BEHAVIOR

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IT IS HELPFUL to the student of human behavior to become familiar with its biological background so that he can see behavior as one among the several functions of the human organism rather than as a separate and special activity. Besides achieving perspective, he will also find, in phylogenetic precursors of human behavior, discrete homologies which will help him to dissect out and comprehend the unitary elements of human behavior which are otherwise so elusive. In this section we shall be concerned with the central nervous system as agent and behavior as the modality whereby the human organism traverses its span from creation to death.

¶ The Instincts

Terms and Concepts

The term "instinct" is derived from the Latin *instinctus*, which means impulse. In prescientific literature the term was invoked to account for the apparent directiveness and purposiveness of the behavior of unintelligent creatures. Among those attempting a truly scientific study of behavior, the term "instinct" fell out of favor because it might be taken for a solution to the problem of the form and motivation of behavior rather than a statement of it.

The principle of teleology (from the Greek, *telos*, end) soon contaminated the concept of instinct. As a principle, teleology implies that all vital phenomena subserve ultimate goals or ends. In its original context the term referred to a philosophic quest for the ultimate purpose of existence. It has also been applied, however, to interest in the fact that living organisms show a tendency to act in such a way as to arrive at end points which, to the human observer, are fixed and stereotyped, as if the organism were guided by a consciously known purpose. Used in the latter way, the terms "purpose," "goal," "end," and "aim" may legitimately be employed to describe a behavioral tendency. Unfortunately, some of the proper scientific op-

position to the earlier use of the term has adhered to the more recent use and has tended to discredit both it and the instinct concept to which it applies directly. Because tendency and internal motivation cannot be ignored in the study of human behavior, the term "drive" was introduced into several modern psychologies, and, indeed, the term "instinct," as used in psychoanalytic psychology, is taken as a translation for Freud's term, *Trieb*.

The student of human behavior will be interested in the discipline of ethology (from the Greek, *ethos*, custom or habit) which has been created by a small number of European biologists during the past half century. It is based upon extensive and meticulous observations of the behavior of animals in their natural habitats. Besides providing a large body of behavioral data, the ethologists have also begun to construct a theory oriented about evolution, survival value, and phylogenesis. In their theory, as in modern psychodynamic theory, instinct is restored to a central place in behavior determination, motivation is seen as internal, motivation responds to external triggers, and motivational forces conflict.[60, 61, 93, 96, 97] In the United States, on the other hand, the study of animal behavior has been concerned with mechanisms rather than with patterns and tendencies, and with the impact of the environment rather than with internal forces (cf. Refs. 6, 7, 47, 66, and 83, and the contrasting views of Ref. 52).

Instincts in Animals

Let us turn to the study of instinct among animals as worked out by the ethologists. Tinbergen[96] (p. 112) defines instinct ". . . as a hierarchically organized nervous mechanism which is susceptible to certain priming, releasing and directing impulses of internal as well as external origin, and which responds to these impulses by coördinated movements that contribute to the maintenance of the individual and the species."

It is known that the central nervous system is responsible for the regulation of many functions of the organism that are determined by the conditions and requirements of the internal milieu. When he says that an instinct is a "nervous mechanism," Tinbergen implies that the regulation of the organism's transactions with his environment, including his conspecifics, is also performed by the central nervous system.

The expression "hierarchically organized" means that each fragment of the behavior pattern is mediated by a discrete structure, and that these fragments, in normal behavior, are integrated into patterns by other structural mechanisms which coordinate the activity of several of these discrete structures. For example, the consummatory thrusts of the coital act are mediated by the lowest levels of the spinal cord, yet the entire body is involved in the coital act, and the proper positioning and activation of each of the body structures is presumably arranged by a superordinate center in the hypothalamus (cf. Hess[43] for a discussion of the motor functions of the hypothalamus). Moreover, the entire coital sequence is called into action only by structures which are concerned with the timing and releasing of instinctual behavior. It seems that animals of each sex are constitutionally endowed with a full set of neuromuscular mechanisms, subserving the behavior patterns of both sexes. The definitive sexual performance is determined by the impact of other constitutional factors, and of hormones, on the central nervous system.[6]

The ethologists distinguish between "priming" impulses and "releasing" impulses. As a result of the former, the instinctual mechanism accumulates *vis a tergo*, or potential to act, whereas the latter permit this potential to discharge in action—they trigger the performance.

Among the priming influences are endocrines. The extent and mode of hormonal influence on behavior are set out systematically in Beach's excellent work *Hormones and Behavior*. His conclusions support Tinbergen's view: ". . . the hormone is to be regarded, not as a stimulus to behavior, nor as an organizer of the overt response, but merely as a facilitating agent which increases the reactivity of specific neuromuscular systems to stimulation."[6, p. 198] Beach also calls attention to the fact that, with ascending phylogenetic status,

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hormonal influences become progressively less important for behavior determination, while "extraphysiologic influence" increases in importance.

Tissue needs constitute a second source of priming influence in the case of nutritive, excretory, and defensive instincts.[66] These are presumably conveyed to the brain by neural mechanisms or by alterations of concentrations of solutes in the blood. To what extent reproductive instincts, too, may be primed by internal sensory and chemical data (aside from hormones) is not known.

The third source of internal priming is intrinsic activity of the central nervous system. Tinbergen adduces much experimental evidence to substantiate his position that activity may arise spontaneously within neural tissue.[96] Though in 1930 Kubie found it necessary to introduce the concept of a reverberating circuit to account for continuous activity within the central nervous system (see also Ref. 55), it is now generally recognized that nervous tissue beats spontaneously even with no input. It is this internal priming which Tinbergen considers responsible for the internal origin of motivation, that is, for growth of potential for action, apart and aside from tissue needs and endocrine influences.

The instinctual behavior that is set in motion is generally fairly complex and protracted. Goals are achieved by sequences of acts, each initiated at the proper time with respect to environmental opportunity and to the instinctual behavior which has preceded it. The initiation of action, then, depends upon release by sign stimuli, which act as triggers. The sign stimulus acts upon an innate releasing mechanism (IRM) which, it now appears, may be provided constitutionally or by experience.[83] The sign stimuli are relatively simple perceptible configurations inherent in the fixed environment, in prey or predators, or in other members of the same species. The initial searching or appetitive acts alone may be initiated internally without an external trigger, following adequate priming.

Whereas some sign stimuli release instinctual acts from block, others serve merely to orient the animal to its object. The tendency to orient is called "taxis."

Immediately following the consummation of an instinctual act, the releasing sign stimulus is least effective, and to be effective at all it must be specific and ideal. As time passes, the animal's susceptibility to release becomes greater, and the releasing configuration may be somewhat less typical. When there has been no consummation for an unusually long period, the instinctual act may discharge spontaneously, even in the absence of any releaser. This spontaneous discharge is known as a vacuum activity. It is primarily the time course of this readiness to discharge that persuades the ethologists to assume that motivation is essentially internal in origin, and that the external event serves merely as a trigger.

The "coordinated movements" to which Tinbergen refers in his definition constitute the instinctual act itself. The consummatory act is always unitary, discrete, rigid, and stereotyped. The appetitive behavior which precedes it comprises a large number of searching, orienting, and approaching acts, combined more or less flexibly. While in his earlier papers, Lorenz seems to consider the consummatory act itself as the instinctual performance, in more recent writings[61] he accepts Tinbergen's view that the instinctual act is comprised of a series of appetitive acts leading up to and including the consummatory act.

Tinbergen's definition states that the instinctual act "contributes to the maintenance of the individual and the species." It has been created out of the pressure of evolutionary selection and serves a biologic function. It is misleading, in my opinion, to designate as adaptation the fact that instincts have a biologic function. The organism, by means of its instinctual mechanisms, exploits the environment for its individual and species needs—in the sense that a predator exploits rather than adapts to his prey. It is for this reason, I believe, that the concept of adaptation is conspicuously absent from Freud's writings.[76]

How do the ethologists reconcile with their view of instinctual behavior the fact that animals can learn? They believe that learning

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cannot modify the individual instinctual acts themselves; it can only suggest new sequences and arrangements for acts, expand or narrow the range of adequate releasing stimuli, and fill with data gaps that are constitutionally provided (in the sense that animals seem to have a "faculty to acquire" information about local topography). For a discussion of learning within the context of ethologic theory, the student may consult Thorpe's excellent survey.[93]

Imprinting, described by Heinroth and studied by Lorenz,[56,60] is a process, observed among some birds and fish, whereby the young acquire the image (or rather, its template) which will subsequently come to serve as a releaser of filial or sexual behavior only as a result of confrontation soon after hatching. For example, a graylag gosling, if it is cared for by and exposed to only a human after hatching, will thereafter take humans as parents and ignore other geese. This phenomenon has not been observed among mammals.

An animal may learn to ignore a signal of danger if the signal is never followed by any actual danger. This kind of learning is called habituation.

Simple or classical conditioning is the process whereby an essentially irrelevant stimulus comes to serve as the releaser of an instinctual act after it has been exhibited to the animal a number of times concurrently with an innate or already acquired releaser. For example, in Pavlov's classical experiment, the sound of the bell acquires the capacity to release ingestive acts because it is associated with the presentation of food which is the innate releaser of these acts.

If an animal is rewarded by being given the opportunity to perform a consummatory act, such as eating or drinking, every time he performs some irrelevant act, he will learn to perform the irrelevant act when there is a need for the reward. This kind of learning is called instrumental or operant conditioning.[88] The entire sequence may be made effective only in the presence of some preliminary signal, and a series of acts rather than a single act may have to be performed before the reward is obtained. In any case, a sequence of acquired preliminary appetitive acts is artificially associated with a consummatory act.

An animal may acquire familiarity with his environment under the pressure of only "curiosity" drives, that is, appetitive manipulative and exploratory acts. This process is called latent learning, and the information so acquired may be transferred to the service of other instinctual patterns as orienting information or learned performances.[85]

When an animal observes another animal of the same species performing an instinctual act, it may perform the same act. This phenomenon is called social facilitation.

Principles for Extrapolation to Humans

If the ethologic theory of instincts is to be extrapolated to humans, certain biologic differences must first be taken into account. Although among inframammalian classes and among lower mammals reproductive behavior is regulated by hormonal "priming" of the instinctual apparatus, animals further advanced in the phyletic series show a relative emancipation from the seasonal timing effected by the hormones. Human reproductive behavior seems to be entirely free from such influence and continues at the same level of motivational intensity the year round.

The term "retardation" was introduced by the Dutch anatomist Bolk to denote the fact that the human seems to live out his life cycle more slowly than do his phyletic antecedents. Bolk also observed that the earliest phases of the life cycle of subhuman primates were represented by a disproportionately large fraction of the human life cycle. The term "neoteny" signifies that characteristics of the adult human are homologous with features of the fetal or juvenile animal (Ashley Montagu). For example, the whiteness of Caucasian skin and the Mongoloid epicanthus may be considered to be persisting traits of the subhuman primate fetus.

Although the concept of neoteny was developed to account for physical features, it probably applies to elements of behavior as well. For example, the ventro-ventral position

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in copulation, which is peculiar to humans in mature reproductive behavior, is also encountered among immature chimpanzees. The shift from the ventro-ventral position to the ventro-posterior one, as the chimpanzee matures, is probably to be correlated with the fact that the vaginal orifice of the immature female presents anteriorly, whereas in the mature female it presents posteriorly.[17] Lorenz[58] suggests that the attachment of the domesticated dog to its human master is a persistence into adult life of the wild animal's childhood attachment to its mother.

Roheim[82] and, more recently, Weyl,[98] have suggested that the neotenic principle may profitably be applied to psychodynamic theory. In other words, although the consummatory acts of adult human reproductive behavior must be characteristic of the mature animal, some aspects of the instinctual disposition of the human adult may be derived from features of the behavior of the juvenile animal. Consider the continuity of human reproductive behavior. Psychoanalytic experience has taught us that there is no essential discontinuity in the motivational basis of the filial, mating, and parental aspects of human reproductive behavior, as there is in the animal (although there is a suspension of the child's sensual desires during latency, his emotional attachment to his parents continues undiminished); nor, in the human, do we encounter the seasonal flourishing and waning of reproductive behavior which many animals exhibit. This continuity may be a consequence of the principle of neoteny, namely that the entire gamut of human reproductive behavior is perhaps driven by the motivational impetus of the filial behavior of the animal. Because of this continuity, features of the behavior of the child will tend to persist and contaminate adult behavior. Hence, the adult requires a special device to suppress obsolete behavior patterns. In my opinion, this is the biologic basis of primal repression.[31] It is by virtue of primal repression that the child foregoes the use of oral and anal activities as the mode of relating to the person he loves in favor of genital and nonphysical (sublimated) activities.

When animals are domesticated, they are protected by man from the rigors of an exposed existence, and many of their requirements are anticipated and provided. As a result, the evolutionary selection pressure for an efficient, tightly organized instinctual apparatus decreases and there ensues what Lorenz[56] calls a "mutational loss of behavior elements." Since the human is also, in a sense, a domesticated animal, two consequences of the mutational loss are important in determining the final form of human instinctual behavior: namely, rudimentation and plasticity.

In the wild animal the consummatory act is a rigidly structured, discrete performance, the individual elements of which cannot be dissociated from each other. In the human, on the other hand, although the final movements of the consummatory act must be retained if his instinctual goals are to be achieved, the full fixed sequence is not necessary. For example, in the animal, mounting, intromission, and ejaculation are inseparable elements of a unitary coital act; in the human, only the final pelvic thrusts and orgasmic contractions are automatic, whereas the preceding moves are variable and separable. This fragmentation and de-automatization of the consummatory act has been called, by Lorenz,[60] rudimentation. Coitus interruptus becomes possible only by virtue of rudimentation.

Instinctual behavior consists of a series of appetitive acts and a final consummatory act, each triggered by the experiences encountered in the course of the performance of the preceding act. The repertory of appetitive acts which are available for any instinctual tendency and their sequential arrangement become much more variable in the higher animal. The result of this variability is plasticity.[60] The application of plasticity to the solution of problems has been called insight.[85] The combination of insight with a greater capacity for latent learning may be considered the basis for intelligence. Learning, insight, and intelligence are therefore not incompatible with instinctual behavior and may, in fact, be seen as derived from some of its essential elements.

Finally, the extrapolation of instinct theory from animal to man must take into account the fact that in man we assume that behavior

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is expressed in and controlled by psychic function, whereas we do not know to what extent a similar proposition may be true of animals. Moreover, we must take care that we compare with the behavior of animals only the overt behavior of man, and not his psychic function directly.

The Form of Instinct in Humans

If we apply these principles of extrapolation to the instinct theory of animal behavior, we obtain suggestions for a theory of human instinctual behavior which is remarkably similar to that which Freud elaborated on the basis of his clinical experience. Although others, before and since, have suggested that instincts govern human life, only Freud has successfully developed his theory from, and applied it to, human psychopathology. The most complete statement of Freud's instinct theory (except for consideration of the death-instincts, *vide infra*) will be found in his *Three Essays on the Theory of Sexuality*. Whereas Lorenz emphasizes the rigidity and stereotypy of the consummatory act and Tinbergen emphasizes the sequential arrangement of instinctual acts, Freud is concerned, in his description of the erotic instincts, with a persevering tendency of the subject to unite with his object and so to effect a physical contact of erogenous zones. I shall present here, briefly, a version of the psychoanalytic theory of instincts in which I shall try to make the homologies with animal behavior evident. (For a fuller discussion, the reader may refer to my paper on the erotic instincts.)[73]

The fundamental equation for translating from behavior to psychic function is that the instinctual need or tendency is represented psychically as a wish.[53] Whereas Freud dissected the instinct into source, object, and aim (impetus will be discussed below), I shall attempt a somewhat finer analysis of the instinctual wish into subject, object, role, contact apparatus, and technique.

The subject of every instinctual wish must be the self. The instinctual tendency applies to the subject individual himself, impelling him to enter into relations with others.

The object of the instinctual wish is the person or object upon which the subject wishes to act (or by whom he wishes to be acted upon). Whereas for the animal the instinctual object is often an inanimate thing (such as nesting material or vegetable food), the instinctual objects which are significant in human psychopathology are always other humans. For the animal[67] as well as for the archaic ego of the human infant,[68] the object is perceived not as a second individual but merely as a collection or "mosaic" of sign stimuli.

I have suggested[72] that it is useful to distinguish between a direct and an indirect object. Although in the case of the animal it may not be especially enlightening to call the prey a direct object and the predator the indirect object of its own predation (in the sense that the predation is performed for its benefit), in human psychology the distinction is more meaningful. It is important that the psychiatrist be able to distinguish between a sexual liaison which is established out of love for the partner and one which is meant merely to assure oneself of one's own sexual attractiveness. In the latter case, the partner is the direct object of the act, but it is performed for the sake of oneself as indirect object; it is essentially a narcissistic act. Similarly, the parents and, later, the intrapsychic representation of parental authority, the super-ego, are often the indirect objects of acts which are apparently concerned only with the self or with nonparental objects.

The subject may wish to act upon the object or he may wish to be acted upon by the object. In the former case we may speak of an active wish, in the latter of a passive wish. Some wishes concern action upon oneself; they are reflexive wishes. In a medial wish one desires to be something or possess some attribute. These qualities—active, passive, reflexive, and medial—refer to the role which appears in the instinctual wish. Reflexive and medial wishes are called narcissistic.

"Homeostasis" is a term coined by Cannon to denote the tendency of the organism to maintain certain physiologic variables, such as the concentrations of metabolites, within narrow limits. Since some instincts serve tissue

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needs,[49] their success is required for homeostasis. Hence, a significant deviation from a normal homeostatic level may become an important priming influence in generating motivational impetus. One may regard such tissue-need instincts as having the self as indirect object; that is, they are reflexive instincts in one sense, though in another sense they may be transitive. Homeostasis probably plays no role in sexual or social instincts.

I suggested above that one could pass from a consideration of instinctual behavior to psychic function by means of the equivalence —instinctual need becomes wish. Although this equivalence is probably valid for optimal states of psychic function, it is clearly invalid for at least two states, namely, early infancy and psychosis. In earliest infancy (before the age of six months) there is probably no psychic concept of an external object.[91] We believe that the infant is aware only of his own feelings of satisfaction or distress; in other words, psychically he is narcissistic.[68] Yet he performs, with the assistance of a responsive mother, a complex series of transitive acts. In the depressive phase of early schizophrenia, the patient has become entirely narcissistic, refusing to acknowledge the existence of external objects. When he resumes interaction with others in the stage of restitution, it is only by projecting upon others fragments of the image of himself.[68] Thus his actions become transitive, while he remains psychically narcissistic. Some of the narcissism of the infant is given up when the mother is recognized (at six to eight months) as an independent, autonomous object individual.

The consummatory act of a transitive instinct involves the apposition of a surface organ of the subject individual with one of the object individual. Hence a full statement of the contact apparatus of an instinctual wish must include a pair of anatomical structures. The contact apparatus of the subject upon which the psychic wish is projected (as if it were the mouth that wished to suck) was called by Freud the source of the instinct.[32] The initial contact apparatus combination is mouth and breast, the latter entering the wish (as opposed to the act) only to the extent that narcissism has been overcome. In a second phase of infantile development, the sensations attending defecation and its control become the focus of instinctual pleasure so that the anus, the buttocks, and the nose appear in narcissistic and transitive wishes. In a third phase the external genitalia assume the principal role in instinctual wishes. Because in this phase only the genital of the boy is recognized as a definitive structure, the girl's organ being seen as a mutilated one, the phase is called phallic. There follows a period (latency) in which no wishes for physical contact appear in consciousness. Latency is terminated by the advent of puberty when the actual genitalia are recognized and made the central focus of physical desire. It is also true that sexual interest may be triggered by perceptions received by sensory organs and by skin sensations in general, so that sexual wishes may include these as the preferred contact apparatus.

Finally, we must consider the actual act or performance—the method by which the subject relates to the object—the technique. The ethologists distinguish between appetitive and consummatory acts. The latter are the acts in which the instinctual goals are realized—the actual feeding, the actual coitus, and so on. The former include all the acts which lead up to the consummatory acts. With respect to human instinctual techniques, I believe it is helpful to distinguish appetitive techniques, that is, those that aim to find or attract the object; preparatory or approach techniques, that is, those that aim to reach the object; and consummatory techniques. Appetitive techniques would include, for example, searching, investigating, exhibiting, and calling attention to oneself. Approach techniques would include methods of physical approach such as pursuing, trapping, attacking, running, jumping, and climbing; methods of influence such as argument, persuasion, courtship, seduction, and deception; and methods of creation such as agricultural, manufacturing, and testing techniques, logical planning and thinking, and artistic invention. Consummatory techniques include, for example, sucking at the mother's breast, cleaning the infant, coitus, and perhaps also parturition. I emphasize these techniques

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because I believe they are constitutionally provided elements of instinctual function, and so they appear in dreams, neurotic symptoms, and recreation even in those individuals whose lives are otherwise sedentary and require little physical activity.

Freud's term "aim" includes role, technique, and the contact apparatus of the partner. Thus, the aim of the infant's feeding instinct is to suck at the mother's breast.

One of the most momentous differences between animal and human instinct life is the greater plasticity of the latter. Although it is true that, especially in higher animals, instinctual sequences permit some substitution and flexibility, the degree of freedom for creating novel and original combinations of instinctual elements in humans far exceeds that found in animals. We should expect the plasticity if the assumptions proposed above, about neoteny and the motivational pattern of human instinctual behavior, are correct. It will be recalled that I suggested that, whereas among animals each phase of instinctual behavior had its own separate existence and was driven by a discrete impulse, in humans the entire instinctual structure was derived from the infantile filial relation to the parent, and all instinctual behavior that came into being thereafter was obtained simply by ringing changes on the individual elements of the filial instincts. Hence plasticity is necessary for the maturation of the instinctual apparatus.

However, the virtue of plasticity in instinct life is not only the possibility of maturation with respect to drives; after the full maturation has taken place, the individual has available to him, at the same time, a large number of possible modes of discharging the same instinctual impetus. His versatility arises in two ways. First, in certain circumstances he may resort to modes of behavior that were appropriate in the past but have had to be given up as they became obsolete. This reactivation of old modes of behavior is known as regression. Regression occurs in neurosis, in cases of physical illness or disability, and also, within limits, in normal life. For example, when confronted with frustration in a love attachment, it is common for an individual to revert to the kind of relation he had with one of his parents and treat the partner as he would treat the parents, by seeming to be helpless, by demands, by hostility, and so on, which might or might not be appropriate to the current situation. Again, when frustrated in a heterosexual romance, an individual might return to cultivating homosexual interests he once abandoned. Similarly, when genital activities are obstructed, sexual desire may seek expression in pregenital modalities, which, to a limited extent, appear even in normal love-making.

The second source of versatility in human instinct function is the availability to each instinctual drive of a wide repertory of elements, most of which may be phylogenetically derived from other drives, and which in lower animals are therefore unavailable except in their constitutionally given contexts. Now Lorenz speaks of certain locomotor and manipulation patterns as "tool reactions"[57] because they serve each of several instinctual patterns equally well. On the other hand, there are many techniques (and this is especially true of consummatory techniques) which appear in the service of only a single drive in animals, but in humans can be employed for any of a number of purposes; in other words, in humans almost all techniques become tool reactions. Hence the human has a larger collection of tool reactions than the animal. For example, in lower animals, begging is restricted to the filial feeding situation (though in some species it appears also in courtship), biting to the predatory situation, and sucking to the mammalian suckling situation, yet, in humans, begging, biting, and sucking are techniques used not only in their respective, original patterns, but are also in social, mating, parental, reflexive, and sublimated creative or intellectual activities (*vide infra*).

Impressed by the destructiveness of World War I, by the cruelty of many aspects of human behavior, and by the sadism and masochism evident in all neuroses, Freud, in 1920, suggested that humans, in common with all other animals, were driven by an instinct for destruction and death. Although the instinct was effective internally in the first instance, as a practical matter of survival it was deflected

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outward against other creatures. It is my impression[71] that what Freud called the erotic instincts, namely the reproductive, socially unifying, and generally constructive tendencies, are homologous with the intraspecific instincts of lower animals, whereas the death-instincts are homologous with the interspecific instincts of lower animals, namely, instincts of predation and possibly, also, instincts of defense against predation. The problem of destructiveness among humans seems to arise from the fact that it is not excluded from intraspecific relations as completely as it is among animals. First, predatory techniques such as pursuing and fighting are available to intraspecific tendencies only to a limited extent among animals, but they are without restriction among humans. We say that in humans they are libidinized. Second, although humans as well as animals are influenced by instinctual surrender mechanisms,[58] these seem to be less consistently effective among humans. Third, predatory tendencies, in addition to techniques, can be liberated, among humans, not only in food-getting situations, in instances of frustration or attack, but also as a result of neurosis. If it is true that what Freud called death-instincts in humans are homologous with predatory instincts, then they may truly be said to represent the tendency toward disintegration which pervades living organisms (as well as inorganic material), or at least the struggle against disintegration—a struggle which proceeds by obtaining nourishment at the expense of other living creatures, but which is only partially and temporarily successful.

The Execution of Instinctual Activities

When, in 1923, Freud replaced the concept of the topographic psychic apparatus (unconscious, preconscious, conscious) with the structural model (id, ego, super-ego), he defined id and ego in terms of their roles in the operation of the instincts. The id, he said, is the locus of the instinctual drives, the area in which specific patterns are activated. It is concerned only with the needs of the organism, and it creates the motivation for the instinctual satisfaction of these needs. The ego, on the other hand, is a functioning system concerned with arranging for and presiding over the execution of the instinctual drives activated by the id. It includes the perceptual apparatus which informs it of appropriate opportunities for instinctual gratification, and it controls the entire motor apparatus, which, at its convenience, it bends to the service of the instincts. Freud[30] suggested that this distinction between the source of instinctual behavior and the executive agency of the instinctual apparatus might apply in the study of animal behavior too.

It does not suffice to define the ego in such a way that homologous structures are presumed in animals and human. We must proceed to describe the differences between the ego of the animal and the ego of the human. In the mature human the ego prevents the execution of some of the id drives, out of developmental necessity, as a result of past experience, out of concern with its own feeling of comfort or discomfort, or in deference to the super-ego. In animals, especially lower animals, such inhibition of instinctual action out of internal necessity probably does not occur. This gap between the ego of the animal and that of the human is bridged by a hypothetical phase of ego-function suggested by Nunberg.[68] The ideal ego, he said (p. 126), is the ego of the infant which proceeds to gratify, in whatever feeble way it can, all instinctual needs formulated in the id. As a consequence of maturation, the ego acquires the capacity to interpose obstacles to instinctual gratification. The archaic ego of the lower animal may be considered homologous, therefore, with the ideal ego of the human infant.

Though it is charged with obtaining instinctual gratification, the mature human ego differs from the animal ego in that it precludes the gratification of many instinctual needs and at least modifies most of those that are permitted to achieve gratification. For example, even fully gratified needs, such as those for nourishment, excretory activities, infant care, and coitus, are nevertheless circumscribed by an elaborate etiquette. But the mature human ego does more than obstruct and restrict; it exploits even those instinctual needs that may not be gratified, abstracting from them elements

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such as impetus and technique, and diverting these to the performance of realistically useful acts for which no phylogenetic provision has been made. By the process of idealization,[28] the child eliminates the sensual components from his wishes for erotic gratification from his parents, and consciously retains only a tender love. By the process of sublimation, he "purifies" his physical desires in such a way that, though the instinctual technique is retained, the contact apparatus is excluded from the wish. Let us return to the example of sucking. Sucking, in lower mammals, is confined, either entirely or mostly, to the act by which the very young animal feeds at its mother's breast. As a result of the plasticity of the human instinctual apparatus, discussed above, sucking can be employed in the service of other instinctual needs. One need not suck at the mother; one may suck at oneself or a mate. One need not suck at the breast; one may suck at fingers, tongue, or genitals. One need not suck at anything animate; one may suck at food, cigarettes, or straws. One need not suck with the mouth; one may suck, or wish to suck, or imagine that one can suck with other of the body orifices. The ego may select among these several possibilities some substitute for the obsolete wish to suck at the mother's breast, a substitue which will provide at least some of the otherwise unavailable gratification. But the ego may go even further, and, by intellectualizing, it may conceive and construct sucking machines such as pumps; it may create the concept of suction or vacuum; it may even act by a process of suction—as, for example, by absorbing impressions. By such processes of dissociation, recombination, and intellectualization, the ego is able to defer the performance of consummatory acts to the end of a long detour path, or to divert some of the energy of a consummatory act to other forms of behavior. Substitutes for phylogenetically provided but repressed instinctual acts, which discharge the energy of these in a manner acceptable to the ego, are called derivatives. The selection, devising, and elaboration of derivatives are functions peculiar to the mature human ego. By derivative construction the ego contributes to character formation, social behavior, vocational and recreational activities, neurotic symptoms, and dreams.

The Structural Substrate of Instinctual Activities

The organic substrates of instinctual function have not been worked out with any certainty or even definiteness. This section will include some guesses and suggestions on the subject.

The problem of the ultimate pathways through which the instinctual act is mediated is not quite so formidable. Some elements of consummatory acts are activated via restricted segments of the spinal cord or brain stem, such as ejaculation—by the lower segments of the cord and its autonomic outflow; or chewing —by the pons. Other acts require the coordination of more than one segment, for example, defecation, vomiting, or fighting. This suprasegmental coordination is probably effected by the hypothalamus.[43] (Although the latter has been putatively assigned a number of different functions in behavior regulation, it is my opinion that, since it is a component of the ventral half of the neural axis, its function can only be motor, and, from the evidence at hand, concerned with the coordination of the several elements of the instinctual acts.)

But to what structures of the brain may we assign the patterning and activation of the instinctual acts? Certainly the patterning and, in lower animals, the activation of the acts cannot be ascribed to the cerebral cortex, for in lower classes of vertebrates there is little or no cortex. Since the striate body is the principal motor nucleus of lower vertebrates and its homologue in humans, the globus pallidus, is concerned with movement, I[75] have supposed that these might directly or indirectly be concerned with instinctual action.

In humans, to a lesser extent in other primates, and to some extent in some of the subprimate mammals, there is a segment of cortex lying anterior to the motor area (the frontal, premotor cortex), stimulation of which produces no immediate behavioral effect, though ablation produces profound changes in

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behavior. In general, the behavior changes that follow injury to this area include a decrease in interest in all but the most immediate environmental opportunities, a tendency to make little effort, a failure to sustain interest for more than a brief period, complete loss of interest in the presence of delay or detour, and, in humans, defect in planning and thinking ahead, absence of creative fantasy, impairment of initiative and perseverance, and disregard of remote consequences which is indicated by tactlessness, euphoria, and facetiousness. (A review of the literature and more extensive discussion will be found in my paper on the subject.)[74] All of the behavior changes, in my opinion, may be understood as manifestations of a decrease in the intensity of motivational drive, a decrease in the continuity of motivation, and a simplification of behavior patterns. I believe, therefore, that the premotor segment of the frontal lobe deals with continuity of motivation, plasticity of form, and derivative construction. I do not know whether the decrease in motivational intensity results from defective function of this area or from its dissociation from the globus pallidus.

¶ Impulse

The Concept of Instinctual Energy

The existence of an internal motivational impulse is a central assumption in instinct theory, both animal and human. The organism is seen not as a passive automaton which is galvanized into action by an impinging, energy-giving stimulus but rather as a spontaneously active entity which develops its own "readiness" (Nunberg's term) to act. The action itself is liberated when a proper environmental opportunity is encountered. Immediately after a consummatory act has been performed, the readiness is minimal. As time passes, the readiness increases, as indicated by the rate of searching and by the amount of obstruction the animal will overcome to perform the consummatory act. Moreover, when a drive acquires impetus but is prevented from achieving consummation, it seems to transfer its impetus to some other drive. Hence, both Freud and Lorenz compare the basis of this instinctual readiness to a fluid, which is discharged from a container by consummation of a drive, which increases in pressure with the passage of time, and which, when one channel of discharge is obstructed, will tend to discharge through whatever other channels may be available.

Freud called this hypothetical fluid psychic energy. Libido is the psychic energy of the erotic instincts; the psychic energy of the death-instincts has no name. Lorenz sees the impetus as a property not of the whole drive but of the individual pattern of behavior—it is an action-specific energy. Tinbergen speaks of "motivational impulse" which he treats as a concept similar to what the neurophysiologists call central excitatory state. The student should understand that although these writers speak of instinctual or psychic "energy," they do not imply that the function to which they refer is a direct or indirect correlate of actual metabolic energy. It is a vital function which impels to action, and in this way resembles true energy. Readiness to execute an instinctual act is not a function of metabolic energy but of priming, of rate of regeneration, and of recency of performance.

Although this distinction has not been consistently carried through, it will ultimately be necessary to distinguish potential, that is readiness, amount of energy, rate of regeneration, and rapidity of satiation. Miller, for example, studying rats who became obese following lesions of the ventromedial nucleus of the hypothalamus, observed that the overeating could be accounted for not by a more avid pursuit of food, nor by perseverance in overcoming obstacles, but more likely by slowness in becoming satiated or by rapidity in the rate of regeneration of hunger.

The Supply of Instinctual Energy

If we grant the reasonableness of assuming the existence of a motivating influence which has certain fluid properties, an instinctual and a psychic energy, how can we use this assumption? To my knowledge, no extensive attempts to develop a system of energetics have been made by the ethologists, although many of Lorenz' formulations seem to anticipate such

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an interest (cf. his "initial friction" and "inertia of reaction,"[57] p. 262). Freud, on the other hand, has consistently attempted to utilize his energy concepts in dealing with and explaining clinical phenomena. In my opinion some of the drugs recently introduced in the treatment of mental illness achieve their effects by producing certain changes which are best described as alterations in amount or potential of instinctual energy.[77]

I referred above to Freud's distinction between an id, which is the source of instinctual drive, and an ego, which acts as executive agent for the id. If we assume that all behavior is performed only for the purpose of satisfying instinctual needs, and since we have defined our energy concept so that it is seen as the sole carrier of drive, we infer that no behavior is possible without a specifically assigned quantum of energy. Moreover, we may infer that the impetus which is developed in the id must be transferred to the ego before action can begin. Upon this inference Freud based his theory of repression, namely, that instinctual drives can be denied execution if their impetus is prevented from passing from id to ego.[31] Psychoanalysts have also wondered whether the ego has energy available to it other than that provided by the instincts (Hartmann), though it is difficult to see how such an autochthonous ego energy can be imagined if we take into account our definitions of ego and psychic energy.

The results of ego depletion can be seen in melancholia: inertia, a feeling of emptiness and yet heaviness, retardation of mental processes, preoccupation with one's own feelings of discomfort (primary narcissism) to the exclusion of interest in objects, and also self-criticism and pessimism. The results of a plethora of energy supply to the ego can be seen in cases of preschizophrenic excitement: overactivity, a sense of buoyancy, hurried impatience, rapid-fire thinking, preoccupation with a libidinal object to the exclusion of one's own feelings, self-righteousness, and optimism. The former state can be brought about not only by depression following the abandonment or loss of a love object but also by the administration of reserpine or one of the tranquilizing phenothiazine drugs. The latter can be brought about by an accumulation of libido and also by the administration of iproniazid (Marsilid). Although the ego's energy is derived, in my opinion, ultimately from the drives of the id, the ego seems to have some storage capacity so that it sometimes seems to possess its own resources, as for example when an individual responds to an emergency despite fatigue or melancholia.

The Dissipation of Instinctual Energy

The impetus for the performance of an instinctual act subsides promptly after it has been performed.[32, 61, 96] The lethargy which generally follows coitus or a heavy meal is probably the result of the dissipation of drive energy. Moreover, the tonic functions of the ego, apperception, thought, self-observation, posture maintenance, and so on all probably "consume" energy.

The concept of an energy level in the human ego is a useful one. The level may be raised passively by experience of temptation, threat, or pain, and also, I believe, by sleep. The energy level of the ego may be lowered passively simply by its own activity and as a result of physical disorder. The ego may attempt to raise its own level by attention and by physical activity such as walking. It may attempt to decrease its energy level by diffuse and aggressive activity, by actions which gratify completely or partially the upward striving drives (for example, masturbation, nail biting, fidgeting), and by depressive withdrawals. Freud[20] believed that the mental apparatus endeavored to keep its quantity of excitation "as low as possible or at least constant." Menninger and Mayman[65] refer to this phenomenon as psychological homeostasis and propose a psychiatric nosology based upon the nature of the ego's attempts to reduce its energy potential.

Possible Physiologic Correlates of Instinctual Energy

Magoun[63] demonstrated that, in the central core of the brain stem and extending into the diencephalon, there is a structural system which, when stimulated by any afferent stimulus, brings about signs of behavior and electro-

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cortical activation of a quiescent brain, namely, the reticular activating system. Wakefulness and consciousness have both been ascribed to this system, and it has also been proposed as the locus of the action of the tranquilizing drugs. I do not believe that there is sufficient evidence to support such an extension from the experimental findings. The reticular activating system can have no more than an *ad hoc* alerting function. If there is any neural structure which is responsible for spontaneity and drive, I'm inclined to point to the globus pallidus, for the following reasons: First, it is the paleostriatum, the phylogenetically old motor system. Second, the syndrome of parkinsonism, which is attributable to disease of the globus pallidus or related structures, generally includes inertia as a prominent symptom. Third, reserpine and the phenothiazine tranquilizers which, in my opinion, decrease the supply of instinctual energy, also produce, in many instances, severe extrapyramidal movement disorders.[77] I am suggesting that the globus pallidus may be the *fons et origo* of all spontaneous activity.

I should like to suggest, too, that during sleep instinctual energy is regenerated, and, in fact, that the primary function of sleep is the regeneration of instinctual energy. In animals, we see more clearly than in humans that the rate of activity is maximal following sleep, and that it subsides progressively until the next period of sleep. The fact that the human ego has some reservoir properties obscures this simple activity cycle in the case of man. Reserpine and the phenothiazine tranquilizers sooner or later increase the amount of sleep required, I suspect, by decreasing the rate of regeneration of instinctual energy. Dement, Kleitman, and others have recently demonstrated that sleep lightens recurrently four, five, or six times a night, and that each period of sleep lightening is accompanied by dreaming. I interpret these episodes of sleep lightening as the results of upward thrusts of instinctual activity which, in turn, follow from the regenerative function of the sleep. The ego seems to be able to dissipate these premature incursions of drive impulse by dreaming, and thus the dream acts as the guardian of sleep.[25]

¶ Affects

General Biologic Considerations

With the consideration of affects we leave the area of observed behavior and must face the far more difficult problem of subjective experience. Although we cannot possibly know what, if any, subjective experience may occur in animals, some careful observers, including Darwin and Lorenz, do not doubt that affects appear in, and influence the behavior of, animals. If we follow them, we must assume the existence of some form of consciousness in animals, since affect can exist only in consciousness. Perhaps the most archaic function of consciousness is to perceive affect.[75] In the most primitive vertebrates the chief exteroceptive input to the telencephalon is olfactory. Hence it may be that the most archaic affects are those which developed as a part of the olfactory sensory system. In fact, it may be that the entire affective system developed first as a component of the olfactory sensory system, and it later became available to apperception by other sensory modalities as well.

A pleasurable experience rewards the individual for arranging for the performance of the consummatory act, and it ensures that the act will be completed.[32,60] It comes to serve as a signal which is associated with and identifies the releasing sign stimulus of the act.

Affects, that is, affective sensations, are always accompanied by autonomic changes and changes in the striated musculature. The ratio of the amount of such changes to affective intensity, and the pattern of these changes, are inconstant from individual to individual. Yet the pattern of changes apparent to others is sufficiently constant to permit members of the same species to recognize the affect which possesses the individual at the moment. These signs of affect come to serve as sign stimuli to other individuals, social releasers, which facilitate coordination and synchronization of group activities.[70] The origin of these characteristic affect patterns is uncertain. Darwin[18] suggested that some of these telltale somatic

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alterations at one time served a useful function, that others represented an attempt to undo the first type, and that still others were manifestations merely of overactivity. Lorenz[87] derives these social releasers from a ritualization of intention movements (this is similar to the explanation of Darwin's first group) and from a ritualization of displacement activities (which is similar to the explanation for Darwin's third group). Freud[88] accepted Darwin's suggestion that the expressive movements accompanying affective sensation were phylogenetic precipitates of what had served archaic progenitors as purposeful acts.

Positive Affects

Positive—that is, pleasurable—affects always accompany the performance of consummatory acts. Some positive affects may be all of what is left of a "rudimented" consummatory act, such as the pleasure of feeling sheltered and safe. Perhaps laughter and the enjoyment of music may also be rudimented consummatory acts in which the affect is the chief or only remaining component.

The anticipation of the consummatory pleasure is itself a pleasurable experience, though it is unsettling, in contrast to the consummatory pleasure which is satisfying. Performance of the appetitive acts preceding the consummatory acts are another source of pleasure. The two together, that is, performance of appetitive acts and anticipation of consummatory pleasure, in human love-making compose what Freud called "fore-pleasure," namely, the pleasure obtained from the erotic play preceding coitus, including touching and looking, and involves erotic zones other than the genitals, as well as the genitals themselves. Human behavior, as distinguished from animal behavior, stresses these two forms of preliminary pleasure rather than consummatory pleasure, which is discouraged and restricted by the rules of our society.

A different kind of pleasure is the pleasure of the satiety following the consummatory act. It is the pleasure of not striving, and is occasioned by the reduction of ego energies. Freud[20] adopted the term nirvana-principle for the finding of pleasure in the reduction of ego energies, and saw in it a manifestation of the death-instinct operating against the individual himself. This state of enervation is pleasurable only as long as the individual is permitted to rest. When the fatigued or melancholic individual is subjected to demands, whether internal or external, he feels both his state and the demands to be painful.

Negative Affects

Among humans there is, in general, a tendency to protract appetitive acts and delay consummation, but some instinctual behavior must be performed as the need arises; for example, the needs to defend oneself against attack, to obtain nourishment, and to eliminate urine and feces. In short, when instinctual behavior is required to provide for tissue needs, it cannot be long deferred.

Let us examine first the instinctual arrangement for providing for the prompt satisfaction of tissue needs. When the physiologic need appears, a sensation reminiscent of that accompanying the desired consummation appears, for example, waves of hunger or of excretory fullness. This sensation acts as a lure to motivate appetitive behavior which will lead to a proper opportunity for consummation. As time passes, this anticipatory sensation becomes painful and more urgent. In addition to the pain, a psychic distress appears which is to be attributed to the flooding of the ego with energy and which, according to Freud's view,[24] is anxiety. There are some acts which conceivably, if performed, would delay consummation in the face of mounting tissue need and subjective distress. The specific quality of pain cannot be transferred to the releasers of these delaying activities, but the anxiety can, and when it is transferred in small amounts to label the potentially harmful situation, it acts as a signal, warning against the development of definitive anxiety. To take an example from neurosis, an individual disturbed by a fear of suffocation will develop signal anxiety whenever he finds himself in a small enclosure.

Because the subjective experience of anxiety seems to resemble none of the specific pains of tissue need more than the distress of being unable to breathe, Freud[24] considered a sug-

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gestion put forward by Rank. Rank proposed that the subjective prototype of anxiety in the adult is the infant's sensation of being born, that is, of its struggle to get its first breath. We do not know whether subjective experience occurs during the birth process, or whether it can be retained.

A similar mechanism operates to avoid painful experiences. When an attack of some kind produces skin pain, an instinctual tendency to fight off the source of pain appears. When fighting is carried out and the pain is relieved, the problem is solved. When fighting cannot be performed, the accumulated and undischarged energy floods the ego and creates anxiety. The same impasse is the cause of battle neurosis, when inactivity under fire is required. If, as a result of experience, some acts come to be recognized as leading to the situation of unrelieved pain, the releasers of these undesirable acts can be labeled not by a signal pain but by a signal anxiety. The diffusion of anxiety from the ultimate experience of pain, back to all possible precursors, is dramatically demonstrated by the patient with causalgia, who develops anxiety when confronted with any possibility that his sensitive limb might be touched.

Let us consider now, not actual attack but threatened attack, or danger. Danger situations may be recognized by innate or acquired criteria. In the presence of a danger situation, the affect of fear appears. While fear is often confused with anxiety, they are not the same. Fear signals the recognition of danger. When action cannot be taken to remove the danger, the ego is flooded with energy, and anxiety appears as well. Premonitory situations which are associated with potential danger are labeled with signal anxiety. Hence the animal flees from such premonitory situations or acts to avoid them.

How does realistic anxiety, as we have described it, compare with neurotic anxiety? Common to the two is their appearance either when the ego is flooded with instinctual energy, or when it seems likely that such flooding will occur. In the case of realistic anxiety, the traumatic situation and its precursors are imposed from the outside. In the case of neurotic anxiety, the flooding or its precursor results from the escape of poorly repressed instinctual drives. Whereas, in the case of realistic anxiety, the individual is induced to flee from the disturbing element, in the case of neurotic anxiety, actual flight is precluded, and a process similar to flight, namely, repression, performs a similar function. Repression excludes from consciousness ideas and wishes which might generate anxiety and so functions like flight.[24] (In phobias, the source of the anxiety is projected into the environment, so that actual flight can supplement repression.) If I read Freud correctly, it is his view that repression may be considered a consummatory act, analogous to and perhaps a rudimented form of escape or avoidance, which is released by signal anxiety.

In summary, anxiety is a feeling of distress which appears in the ego when a consummatory act is released but cannot be carried out, or when such an emergency can be anticipated. In the former case we have definitive, and in the latter case, signal anxiety. Realistic anxiety motivates flight or avoidance and neurotic anxiety motivates repression, so that the psychic representative of the disturbing drive cannot remain in consciousness and act as a releaser.

With respect to negative, unpleasant affects, an important distinction must be made between animals and humans. In animals, almost all instinctual drives which press for discharge are legitimate and deserve consideration. Humans, on the other hand, by virtue of plasticity, neoteny, domestication, and rudimentation, come under the influence of instinctual drives, some of which are obsolete, others dangerous, others forbidden, and others which threaten the existence of the loved object. It is my impression that the system of negative affects is employed to label such unacceptable wishes after they have been scrutinized. One may say that, in a sense, the flexibility and subtlety of the human instinctual apparatus is purchased at the price of recurrent and inevitable suffering.

Let us consider specific negative affects. Horror is not generally attributed to the repertory of animal feelings. Yet animals do avoid dead or mutilated conspecifics, and Köhler[47]

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describes the fearful avoidance of toy stuffed animals by chimpanzee and dog. The archaic ego of the human, too, presumably is equipped to react with aversion to sights of mutilation, but when the aversion is clearly excessive or inappropriate, it generally appears that the disturbing neurotic fantasy is one which involves confrontation by mutilated male genitals or by female genitals which, to the archaic ego, are a mutilated version of the male genitalia. A horrified individual shudders, as an animal might, to shake some noxious agent off his body. To the archaic ego, a wound is often seen not only as a mutilation but also as a mutilating agent.

Suspiciousness may be thought of as a negative affect too. Animals normally exhibit a curiosity drive which enforces the exploration of new and unfamiliar configurations.[93] However, when the strange configurations include a mixture of new and old elements, or where there is mutilation or death, the exploration drive is slowed. As exploration does occur, the strange becomes familiar, and the need for exploration disappears.

It does not require too much imagination to see signs of disgust in animals. Dogs, for example, will often refrain from drinking water in which solid objects are floating. Lorenz and Tinbergen[62] point out that when an animal is confronted with the releasers of an act which has just been consummated, it may automatically be forced to fix the releaser, yet turn away from it in a satiated "disgust." Köhler[47] notes that if chimpanzees in captivity inadvertently soil themselves with feces, they will seem to be disgusted (though the very same animal may at another time indulge in deliberate smearing and coprophagy). In human psychology, disgust is used to reinforce the ego's efforts to repress coprophagic or cannibalistic wishes.[68]

Depression is sometimes described in dogs who lose their masters. Köhler[47] saw fury, despair, anorexia, and wailing in a chimpanzee separated from the group. Fear, however, was the dominant response when a young animal was separated. The human infant, separated from its mother, cries, presumably as a result of the anxiety which develops from the ungratified instinctual needs and the threat of failure of gratification. Spitz[91] observed that infants separated from their mothers during the second six months of life show signs of sadness, psychomotor retardation, and depressive weeping. The difference between the earlier and the later response is presumably due to the fact that when the infant is six to eight months old, the mother achieves "the full status of a libidinal object." It is when the infant is able to appreciate the mother as an independent, integrated individual rather than as a conglomerate of releasers that depression replaces anxiety as his reaction to separation.[24,68] From a clinical point of view, it is well to remember that it is the longing for the absent mother which is the prototype for subsequent depression, which may, in reality, follow a loss of love-object or of self-esteem.

The crying of the human infant may be understood as a signaling act which compels the attention of the mother. It is to be compared with the whimpering of other young mammals separated from their parents. Tearing occurs not only in humans, but also in other primates and in dogs.

The depressed individual generally acts and feels as though he were suffering a dearth of ego energy.[68] Freud notes too[27] that in both mourning and melancholia the ego seems to be impoverished. It has seemed to me as though, when a love-object must be given up, depression sets in and drains the ego of energy, lest it be flooded as a result of unrequited desire. The ego impoverishment of depression may have a defensive function.

No one, to my knowledge, has attributed a sense of shame to animals. Darwin[13] notes that shame, in man, is associated with blushing, and both he and Freud[32] believe that it arises out of concern with one's appearance. Specifically, Freud suggests that it is the reaction to the wish to exhibit, and motivates a wish to conceal oneself.

Lorenz states[59] that his dogs showed signs of guilt following behavior which they knew was disapproved. What we call guilt in the human is an unpleasant affect which appears when the behavior profile sanctioned by the super-ego is violated. The super-ego is the intrapsy-

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chic precipitate of the images of the parents. It is by means of this intrapsychic existence that the human parent can continue to supervise the behavior of his child and, in a sense, remain its indirect object. The feeling of guilt is a composite one, including at different times anxiety due to fear of punishment, depression, and longing out of fear of loss of love, and often shame which makes a guilty individual wish to hide.

Affects of pity, mercy, and sometimes sympathy generally signify an aggressive wish, which must be repressed. Suppression of hostile intention is seen in the chivalry reaction of animals described in recent years by the ethologists.[58] When an animal is beating another animal in intraspecific combat, the loser automatically performs a ritualized act which has the force of a surrender gesture and prevents the victor from killing. The young of the species and also the female submitting to copulation are immune from attack. While the vulnerability of the object tempts predatory tendencies, when the object is intraspecific an inhibition sets in which prevents or arrests the attack. It is not unreasonable to suppose that this mechanism obtains in humans too, and is manifest in affects of pity, mercy, and sympathy.

Physiologic Basis of Affects

In recent years a large number of experiments relating behavior to brain stimulation and destruction have appeared in the literature. At this point I can do no more than indicate some of my own conclusions from this material. I believe that the basic experiment relating brain structure to affect is that of Klüver and Bucy. They removed both temporal lobes of mature monkeys and observed an absence of innate wariness, an absence of negative affects such as anger and fear, and an increase in the amount and diversity of sexual behavior. Other experiments have since confirmed these observations. Moreover, the affective sensations that appear during the course of temporal-lobe seizures are generally unpleasant, for example, anxiety, depression, and unpleasant odors and tastes. I suspect, therefore, that some of the structures of the temporal lobes are responsible for the elaboration of negative affects.

At the beginning of the section on affects, I considered the possibility that the affective mechanism may have developed originally as part of the olfactory apperceptive system. The hippocampus, which, in the human, is located in the temporal lobes, is a structure which phylogenetically arose as part of the olfactory system but subsequently changed its connections and came to serve all forms of sensory function. A priori, then, it is a reasonable candidate for the source of negative affects. The amygdaloid nucleus, or group of nuclei, is functionally a part of the rhinencephalic system but structurally a part of the striatum. It may serve the function of modulating ego energy in compliance with affective demands. There is some evidence (Olds) that the septal region may be the seat of positive affects. For a fuller discussion of structural correlates of affective function, the student may consult my papers on the psychic function of the temporal lobe.[73, 75]

¶ Apperception

The Archaic Ego and the Mature Ego

I have suggested that the ideal ego of the human infant might be homologous with the archaic ego which Freud attributed to animals. It will be helpful to compare the archaic ego of animal and of human infant with the mature ego of the human adult. It seems to me that there are two essential differences. First, as the ego matures, it seems to acquire the capacity, by means of the repression mechanism and by means of the system of negative affects, to deny entry to some of the drives of the id. (The need for this inhibiting capacity and its *modus operandi* have been briefly given above.) Second, the ego of the maturing human (and possibly, to a much smaller extent, the ego of the primate and even of the other high orders of mammals) acquires a supplement. The supplement contains a systematic arrangement of the individual's store

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of memory images, so that in his thinking and planning he is not limited to currently available percepts but may draw freely upon a microcosmic representation of his world. This distinction between an ego-nucleus, which is homologous with the archaic ego of animals, and a supplementary structure, which includes memory images and is peculiarly human, is suggested in Freud's last description of the ego.[30] Whereas the perceptual surface of the archaic ego is exposed directly to environmental percepts, that of the mature ego is exposed only to the ego supplement which may transmit a percept derived from the current environment or one from its own store of memory images. By exercising a function which we call attention, the perceptual surface of the ego-nucleus can examine any of the contents of the ego supplement, as its interests may lead it, except for those that are repressed. (For some interesting physiologic data on attention, see the papers of Galambos *et al.*[36] and Hernandez-Peon *et al.*[41, 42])

If one wishes to distinguish the functions of the ego-nucleus from those of the supplement, one may turn to hypnagogic states, dreams, catatonic stupor, and the automatism of psychomotor epilepsy, in all of which, presumably, the ego supplement is inoperative. In these conditions the subject is aware only of his own feelings and has no interest in, or, indeed, knowledge of the existence of other individuals. When encountered, they are ignored or treated automatically, as if they were merely carriers of sign stimuli. This is primary psychic narcissism[28] and probably resembles the kind of subjective awareness which exists in the archaic ego of animals.[58]

We noted above, in our discussion of depression, that the infant responded to separation from his mother with depression only after he had been able to conceive of the mother as a separate and whole object. It seems that this capacity to conceive of the instinctual object as another individual and not merely as a mosaic (Lorenz' term) of sign stimuli does not exist, in general, in lower orders of mammals or in submammalian vertebrates. I believe that this capacity is provided by the ego supplement. As a result of disease, in fetishism, and in schizophrenia, a sign stimulus is treated as an object. In the former case the patient responds to a part of the object's body or clothing, and in the latter to the words or gestures of the object. The development of the ego supplement probably begins with the separate conceptualization of the mother and the self. With experience, the child elaborates it by including in it a microcosmic reproduction of its entire external world.

In a sense, the ego supplement replaces, for the nucleus of the ego, the external world. The stimuli of the latter fall first on the supplement, which may or may not present them for apperception. Moreover, the ego-nucleus is sometimes content to search for object images among those stored in the supplement without resorting to environmental percepts. Lorenz[57] makes the interesting point that what seem to be voluntary acts of animals are no more than tool reactions which build up action-specific energy rapidly and which are readily released by banal stimuli. Analogously, we may reason that what seem to be voluntary fantasies and thoughts in the human are no more than appetitive instinctual impulses presenting themselves to the ego for execution, and finding appropriate object images in the ego supplement.

The Apperceptive Process

Von Uexküll drew attention to the fact that each animal has its own *Umwelt*, its own range of sensitivities to the external world. This range is adequate to provide for the individual's contact with his instinctual objects, and with probably little to spare, for the only function of perception is the direct or indirect facilitation of instinctual gratification. For example, carnivores are equipped with binocular vision which permits accurate aiming at objects straight ahead. Herbivores, on the other hand, are equipped with eyes set at the sides of the head so that the visual fields scarcely overlap.[40]

The human has the binocular field and frontal position of the eyes, characteristic of the carnivores. He also has a central visual field for searching and watching, and a peripheral field which responds to interesting, unex-

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pected stimuli. In the tactile modality, one may also distinguish an exploratory function performed by finger tips and tongue, and the passive alertness to sensation of the rest of the body. No such distinction between a central and a peripheral field exists in hearing, but some sounds are more powerful mobilizers of alertness and interest than others.

For the archaic ego of the animal, apperception seems to be simple. Under the influence of an appetitive drive, the ego scans the perceptible environment, or searches until it finds an object which emits sign stimuli to which it is sensitive. When a match of percept and template image has been made, a positive affect appears, and the archaic ego proceeds to execute the next act in the instinctual sequence.

Whence are the template images of the releasing mechanisms derived? Some, as we have seen, are provided innately; others are acquired as a result of individual experience. The innate sensitivities include those for recognizing the perceptible aspects of the instinctual objects and those for dealing with terrain and materials. In the human the experiences which determine the ultimate collection of releasing templates are probably those which precede latency, that is, the period characterized by the repression of sensual desire, which starts at the age of five, six, or seven, and which terminates with puberty. These acquired sensitivities include those for the images of one's parents, one's name, the sounds of one's native language, one's home, and the trappings of the child's life. The ego supplement accumulates not releasing templates but images of objects. However, the instinctual relevance of these memory images is determined by their associations with, or resemblance to, the innate or acquired releasers (see Klüver[45] on equivalent stimuli); hence instinctual gratification in adult life is governed by the significant experiences of childhood. This is the basis of the repetition compulsion,[20] that is, the need to derive instinctual gratification from repeating in adult life some of the experiences of childhood.

In the mature human, then, the ego supplement intervenes in the process of apperception. I would visualize the process in this way. The percept which appears at the psychic receiving station is not permitted direct access to the releasing mechanisms of the ego-nucleus, as it would be in the archaic ego; rather, it must first find a place in the microcosm of the ego supplement. In other words, the "real meaning" of the percept must first be ascertained. As an instance of the microcosmic element which it matches, the instinctual significance of which has been ascertained from experience, the new percept is now permitted to confront the releasing mechanisms of the ego-nucleus. It is because of this detour in apperception that the mature ego comes to deal with images of real objects rather than simply with sign stimuli.

The process of repression has two aspects. First, it opposes the impetus of the prohibited id drive. Second, those images in the ego supplement which pertain to and would tempt the drive are excluded from consciousness; that is, they and their matching percepts cannot be permitted to reach the releasing mechanisms of the ego-nucleus. This second aspect, namely, exclusion from consciousness, is called denial.[26]

Consciousness occurs, in the course of the apperceptive process, when the percept and its paradigmatic image from the ego supplement encounter an appropriate releasing mechanism in the nucleus of the ego. At that point the form of the conscious experience is contributed by the percept, its real connotations by the ego supplement, and its affect by the releasing mechanisms of the ego-nucleus.

Deviations of the Apperceptive Process

This model of the apperceptive process can help us to understand some of the deviations of apperception which we encounter in clinical work. If we see neurosis as the result of a partial breach of the repression barrier, then we can visualize that in neurosis, even those percepts and ego-supplement images which were to be kept apart from the releasing mechanisms of the ego-nucleus, manage somehow to reach them, and so, in distorted form, to be brought into consciousness. In schizophrenia, the ego supplement loses its control over the apperceptive surface of the ego-nucleus which, as we have seen, regresses to the archaic responsiveness to sign stimuli rather than to

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objects, and which plucks memory images and words from the ego supplement at its convenience, with no regard to the logical and reality-testing criteria of the latter, treating these images as if they were real objects.

Dreaming may also be seen as a distortion of apperception. On p. 70 I referred to the recent observations of Dement and Kleitman and their associates, who recorded the time course of some of the physiologic correlates of sleep. I suggested that the dreams that occurred with each period of sleep lightening represented the effort of the ego to dissipate premature incursions of id energy, and thus protect itself against being awakened. Freud suggested that the ideal ego of the infant was able to achieve some gratification from hallucination and suggested that in dreaming there was a regression to hallucinatory wish-fulfillment. (The student may profitably consult Chap. VII of Freud's "Interpretation of Dreams" for a discussion of the metapsychology of dreaming.) In terms of our model, we may say that, in dreaming, the aroused ego-nucleus takes the images of the still-dormant ego supplement as external objects, as it does in schizophrenia. It deploys these images in such a way that the instinctual needs, which are thrusting upward from the id, appear to be gratified, and at the same time it appears to discharge the energy which threatens to wake it fully. Dream consciousness appears when the images of the ego supplement encounter the releasing mechanisms of the ego-nucleus. The repressive barriers lie within the ego-nucleus and manifest themselves as the dream censor.

A third situation in which the ego nucleus overrides the structural, logical, and reality-testing organization of the ego supplement is the failure of the ego supplement when it has been cut off from its usual source of sensory supply.[38, 53, 89] Subjects who are deprived of afferent experiences, whether as a result of experimental or accidental isolation or as a result of darkness or blindness, show mental confusion, delusions, and visual hallucinations resembling a toxic delirium. In fact, the phenomena of toxic delirium and of drug-induced delirium[8, 79] may be accentuated by darkness or closing the eyes. Perhaps the toxic condition or the drug operates synergistically with the afferent isolation to impair the function of the ego supplement.

Even in the absence of disease, some percepts seem to act directly upon the ego-nucleus almost with the compelling power of sign stimuli, circumventing the barriers of the ego supplement. The human voice, for example, has a cogency which is not possessed by non-vocal sounds or music. A meeting of the eyes means emotional contact. The response to the facial expressions of others is also automatic. Freud discovered that certain configurations, which were themselves not objectionable, seemed to appear with undue regularity in dreams, myths, and art. He suggested that these were used regularly as substitutes for the repressed images of objects and contact apparatus; that is, that they functioned as symbols. Olfactory sensation, the neural pathway of which is unique in that it does not pass through thalamic nuclei before going to the cortex, is not readily integrated into the ego supplement, and, in its ability to command affective response and escape intellectual examination and manipulation, it probably suggests the subjective experience of the archaic ego when confronted with sensations of all modalities.

Sensation

Schilder[84] and Klüver,[44] among others, have attempted to ascertain the ultimate nature of sensation. Subjective experience has been examined by means of eidetic imagery, tachistoscopic exposure, and alteration by drugs or disease. Perceived images consistently tend to fragmentation, displacement, changes of size and color, and multiplication. Moreover, these changes seem to occur rhythmically. Form seems to be most invariant, and form is probably the basis for the classification of images in the ego supplement.

Now these spontaneous and rhythmic changes, while they are probably the consequence of the intrinsic nature of central-nervous-system function, have value in apperception. If the perceived image fluctuates regularly, its real referent need not match the template exactly, for spontaneous fluctuations

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will tend to obviate differences. While differences in size, distance, intensity, speed, and number may, for certain instinctual purposes, be irrelevant, nevertheless, percepts that are too large, too loud, too bright, or that approach too rapidly are judged dangerous, no matter what their form. Form and, in some instances, color may be considered essential qualities of percepts, while other qualities may be considered irrelevant parameters except when they exceed certain limits in intensity or extent, in which case they are taken as signs of danger.

In the course of psychic seizures resulting from temporal-lobe irritation, there are often illusory alterations in these irrelevant parameters of perception, as well as illusions of reality or familiarity.[73] I am inclined to infer, therefore, that some structures of the temporal lobe are normally concerned with stabilizing these fluctuating images and making them conform to reality so that they can be incorporated into the ego supplement. The same mechanism could also detect the variations in the nonessential parameters and make them available to the ego supplement as well, as auxiliary data. These functions of the temporal lobe are disturbed by the hallucinogenic drugs. In fact, because the temporal lobe receives information from all of the primary sensory areas,[80] because it is the only area of the human brain from which formed hallucinatory experiences can be elicited,[78] because disorder of the temporal lobe produces sensory illusions, and because I believe there is evidence to support the idea that some structure of the temporal lobe elaborates negative affects in the process of apperception, I would suggest that the temporal lobe is the site of the apperceptive process.[75]

The Ego Supplement

In our discussions of human apperception we have had to refer to the ego supplement a number of times in order to account for differences between human and animal function. Its evolution has obviously been important in altering the mode of instinctual function which man inherited from his progenitors.

While the nucleus of the mature ego, like the archaic ego from which it is derived, is regulated by the pleasure-pain principle, that is, the need to seek pleasure and avoid pain, the ego supplement is concerned only with ascertaining what is real and what is possible so that the mature ego can substitute a reality principle for the pleasure principle. The ego supplement also must distinguish between percepts and its own images—it must test reality.

The ego supplement is probably the locus of thought processes, though the thoughts become conscious only when they are examined by the perceptual surface of the ego nucleus. We noted above (p. 67) how the abstractions with which thought deals, and perhaps even the thought processes themselves, are derived phylogenetically and ontogenetically from instinctual techniques. If these are the only sources of our conceptual and procedural models for thinking, then human thought must, in an ultimate sense, be limited—there will always be some facts about the universe that humans can never know or conceive.[76]

The loading of the ego supplement with information is the basis in humans for what we have described above as latent learning. The supplement also attempts to relate events temporally and causally, so that it will be able to make predictions. This tendency was called by Nunberg[68] the "need for causality." It is an instance of the synthetic function of the ego. By imposing a compliance with reality, logic, and true causal relations, the ego supplement tends to substitute secondary-process thinking for the primary processes of the id and of the ego-nucleus which are concerned only with the prompt achievement of instinctual gratification, ignoring the requirements of the real world.

Because the parietal lobe seems to be concerned with speech formulation, with calculation, and with space and form comprehension,[12] I am inclined to attribute to it the functions of the ego supplement, namely, the formation of images of objects, preconscious memory, thought, and the capacity to predict.

¶ Ontogenetic Considerations: Constitution

In any given person, many, if not most, of the organ systems participate in behavior de-

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termination and execution; these are chiefly the brain, spinal cord, musculature, endocrine glands, reproductive organs, and alimentary system. It is to be expected, therefore, that individual variations in these systems will each contribute an individual component to the total behavior pattern. We may assume, then, that an individual's somatic endowment provides a physical substrate which is modified by experience, and which, in its modified form, constitutes the organic basis for behavior determination. While psychoanalytic data demonstrate daily that adult behavior is given content and perhaps form by childhood, and especially infantile, experience, they also demonstrate that one cannot predict which experiences of childhood will be meaningful to any given individual, or what will be the form, intensity, and duration of a neurotic response to a traumatic situation of childhood or a frustration of adult life. Certain experiences are traumatic to some individuals and not to others. For this reason, Freud spoke of a "complemental series" of cases of neurotic illness in which constitutional predisposition and experience played combined roles in varying proportions.[23]

A priori, one cannot predict whether these variations in constitutional endowment will scatter in a random fashion, or whether they will cluster into modes. Nor is it evident that such variations will necessarily betray themselves in readily observable and measurable indicators. That such clustering into "types" will be found, and that the types will be correlated with obvious physical manifestations has been taken for granted by the earlier students of human constitution. Recently, some psychoanalysts have taken an interest in the problem and have attempted to find recordable indications of variations in endowment.*

The term "constitution," as it applies to organic nature, has been defined in a variety of ways. Bauer, a physician, refers to "the sum total of an individual's characteristics as they are potentially determined at the moment of fertilization." Hebb, a psychologist, thinks of the term as "the factor of heredity." Rees, a psychiatrist, recognizes two definitions, one defining constitution in a narrow sense as related to disease susceptibility, the other as referring to the sum total of an individual's physical, psychological, and physiological characteristics. He emphasizes hereditary determinants and, only secondarily, environmental factors. Constitution is often identified with physique or body type, especially its gross aspects. Clinically, the term is sometimes used as a general unspecified reference to some unknown factor or set of factors responsible for otherwise inexplicable conditions or behavior.

Sheldon asserts that "the adjustments of man to his environment require for their description and explanation the selection and functional analysis of *meaningful* variables at all levels of investigation from morphology to cognition." This defines the constitutionalist's task, namely, the systematic establishment of how the organism is dynamically constituted, necessarily an interdisciplinary undertaking.

Constitution, then, is the organizational pattern potential, the selective realization of which, in respect to degree and content, is modified by physical, psychological, and social environment. The constitutional approach assumes all behavior, variations as well as general tendencies, to have an economy and a significance. While concerned with factors common to all organic life and establishment of scientifically defensible generalizations, science fails to fulfill its responsibility until the single case can be accounted for by defining its characteristics, its deviations from the generalized principle, and by determining the significance of the observed variations.

Historically, stress has been placed in constitutional theory on physical and chemical types, and this trend has persisted to the present. Hippocrates was a constitutionalist five centuries before Christ. His twofold descriptive classification divided people into those who were short, muscular, and strong, that is, *habitus apoplecticus*, and those who were tall, thin, and delicate, that is, *habitus phthisicus*. In his system the temperament of an individual was determined by dominance of a par-

* The following material on typology has been kindly provided by Ashton M. Tenney, Director of the Constitution Laboratory of the Research Facility of Rockland State Hospital, Orangeburg, N.Y., and the summary of recent psychoanalytic and biochemical investigations by Sidney S. Furst, Riverdale, N.Y.

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ticular body fluid or humor, that is, phlegm—phlegmatic; blood—sanguine; yellow bile—choleric; and black bile—melancholic. The relation of variations in physique to humoral dominance was not clarified. Six centuries later, Galen, an eminent Greek physician, was concerned with the relation of quality of blood and other humors to temperament and pathology. Dryness, moistness, warmth, coldness, or a combination of these conditions accounted for differences in disease and disposition. Some belief in the temperament types of phlegmatic, sanguine, choleric, and melancholic has continued into our own century. Even Pavlov held that a dog's temperament significantly influences formation of a conditioned response.

Interest in constitutional problems, centering at varying periods in such areas as gross body type, size and shape of internal organs, physiognomy, cranial topography, disease susceptibility, embryonic layers, pigmentation, autonomic responsivity, endocrine balance, temperament, race, chemical types, and mental disorders, have been maintained. Investigations usually have led to either a two-, three-, or fourfold typology, providing a relatively crude descriptive scheme, insufficient to account for the nature and extent of human variation in structure and function or personality and behavior.

The most prominent European constitutionalist is Ernst Kretschmer, a German psychiatrist. Prior to World War II his writings received considerable attention and interest in the United States. He classified people by clinical observation and anthropometry into four body types: the pyknic, described as a compact organism with large, round head, thorax, and abdomen, soft-round, poorly muscled limbs, and a marked tendency to put on weight; the athletic, recognized by his strong skeletal and muscular endowment; the asthenic or leptosomic, a thin, fragile organism with poor bone and muscle structure; and the dysplastic, a mixed type. Kretschmer recognized that the pyknic, athletic, and asthenic components may be intermixed in a given physique.

As a psychiatrist, Kretschmer was particularly concerned with the relation of body type to mental-disease entities and believed that the manic-depressive or cycloid type of mental illness is associated with a pyknic physique and the schizophrenic or schizoid type is asthenic in body build.

Kretschmer's observations and conclusions are provocative, but his descriptive system of morphological variation is inconclusive. A recent German edition, in which he has more extensively explored the nature of biochemical, physiological, and psychological constitution as related to morphology, has added impressively to his thesis. When this is made available in English, a renewal of interest in the problem and Kretschmer's point of view can be anticipated.

In the United States William H. Sheldon, of Columbia University, has made extensive studies of human constitution, including problems of physical variation, temperament, delinquency, psychosis, disease susceptibility, child growth, and their interrelationship. His writings and viewpoint have been subjected to extensive appraisal. With respect to the problem of morphology, he defines three basic components or primary variables which may be evaluated in a given individual. These include endomorphy, characterized by predominance of roundness and softness throughout the body; mesomorphy, in which bone, muscle, and connective tissue dominate the body economy; and ectomorphy, in which there is linearity and fragility of body structure with a lack of either roundness and softness or strength of bone and muscle structure. Sheldon introduced a photographic technique which, by use of a standardized medical photograph of the nude subject, made possible the evaluation of the strength of each of the three postulated components, either by inspectional rating (anthroscopy) or measurement of the subject (anthropometry). This technique also provides a permanent record of the subject, particularly useful in longitudinal investigations. When each component is rated on a seven-point scale, a somatotype or body-type index is provided as a quantified description of the physique.

The extreme endomorph is referred to as a 711 (read: seven, one, one), which means that the subject is extremely obese, with minimal endowment or development of bone and muscle structure and is neither linear nor fragile.

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The extreme mesomorph is a 171, in which prominence of bone and muscle is manifest, without softness and roundness or delicacy of structure. The extreme ectomorph is a 117, deficient in either softness and roundness or strength of bone and muscle. A mid-range or balanced somatotype is a 444. This tripolar schema of classification makes possible a refined discrimination and description of individual differences in physique for comparative purposes. While human physiques are infinitely varied, there are reasonable descriptive limits for purposes of constitutional analyses.

The problem of temperament and its relation to personality is regarded by the constitutionalist as a primary concern of behavioral science. By temperament, the constitutionalist means the persisting disposition and mode of response of individuals to problems, conflict, and stress, essentially rooted in innate differences. In Sheldon's system the temperament is arrayed and rated in a fashion similar to the somatotype. His components of temperament are viscerotonia, characterized by extraversion of affect or uninhibited expression of feeling and emotion; somatotonia, extraversion of action or uninhibited expression of drive and energy; and cerebrotonia or inhibition of both affect and energy expression. He lists twenty traits for each of these three categories. The resulting temperament type is presumed to correlate highly with the somatotype.

In Sheldon's system of constitutional analysis, observation of exaggerated manifestations of temperament lead to the posulation of three first-order psychiatric components: the dionysian, or the pathological lack of the inhibitory or cerebrotonic component; the paranoid, or pathological absence of affect or viscerotonia; and the hebephrenic, a pathological deficiency of drive, energy, assertiveness, or somatotonia. The meaning and value of these concepts are being explored.

Whether the significant relationship between physique and temperament, as alleged by constitutionalists, is a fact or not, no biochemical or physiological typology, comparable to those describing the varieties of physique and temperament, has been formulated.

Are there biochemical and physiological correlates of physique, temperament, emotion, personality, and behavior? Innumerable explorations, speculations, and proposals have been set forth, but still no conclusive and universally acceptable theory or technique has been established.

Eppinger and Hess proposed a typology of individual differences based on relative dominance of sympathetic versus parasympathetic processes of the vegetative nervous system. Opposing states were termed "sympathicotonia" and "vagotonia." Characteristic of sympatheticotonics is high blood pressure and tachycardia, while vagotonics have low blood pressure, slow pulse, and poor peripheral circulation. It is assumed that these conditions have significance for manifest personality and adaptive behavior. More recently a number of investigators have been exploring the meaning of hormones for personality by studying the effects on blood pressure of adrenalin, noradrenalin, and mecholyl injections in groups of psychotic, neurotic, and control subjects. Differential physiological response patterns have been described; these are significant, but they are inconclusive for constitutional study.

Equally promising are the studies of Adcock, who has conducted factorial research in temperament. He proposes four factors: (1) autonomic lability, a tendency to undue emotional fluctuation; (2) autonomic balance, a bipolar factor dependent on the adrenergic-cholinergic balance of the autonomic nervous system (fear and inhibition are associated with adrenergic balance, dominance and anger with cholinergic balance); (3) drive, possibly associated with hyperthyroidism; (4) tenderness, related to maternal response, based on an appropriate hormone. Adcock analyzes these factors in relation to Sheldon's temperament types in the following manner: the factors of viscerotonia are low autonomic lability and tenderness; somatotonia is dependent on cholinergic balance and drive; and cerebrotonia is related to adrenergic balance and high lability.

Under the influence of dynamic psychiatry and modern psychoanalytic concepts, a new trend in constitutional research has recently emerged. Unlike the older work, this approach is unconcerned with classification into types but is aimed at elucidating the role which constitutional factors play in human behavior and,

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more specifically, in the true dynamic processes by which these factors influence and find expression in clinically observed behavior and personality. In essence, the method involves detailed longitudinal observation of children and infants, beginning at the prenatal stage, and extending through to adulthood, at times including findings in the psychoanalytic treatment of these older age groups.[18, 34, 104, 105] This approach, which of necessity is phenomenological, is based on the following hypotheses: (1) There are forms and patterns of behavior that are manifest at birth and shortly thereafter, which are genetic or constitutional in origin. (2) These patterns play an etiological role in the process of development, and this role can be ascertained objectively. (3) The behavior patterns delineated for study will have more or less predictive value with respect to the child's later responses and personality development. [This follows from (2).] Far from attempting to provide an answer to the old controversy of constitution versus environment, this approach assumes a situation of intimate, continuous interrelation and influence between the two, in accordance with Freud's frequent emphasis of the role played by constitutional factors in both normal and abnormal development.[19]

One research program being carried out at the Child Study Center at Yale University by Katherine Wolf and her associates[104] serves as an example of this method of approach. They conceptualize each developmental step made by the infant, even in the first days of life, as entailing an "individual solution" (which is essentially genetic or constitutional in nature). It follows that there are various ways by which developmental progress can be made. For example, individualization can be evidenced by the particular, preferred techniques with which the infant deals with situations which threaten to disturb its equilibrium—that is, which produce an increase in "tension." Thus, neonatal behavior may be considered in terms of a "tension-accumulation–tension-reduction" syndrome. Four paradigms of this syndrome that can be observed and studied in the baby at birth are: (1) hunger—food intake; (2) fatigue—sleep; (3) gastrointestinal stimulation—elimination; (4) sensory stimulation—motor discharge. These have been carefully studied in many neonates, and it has been found that the mode and frequency distribution of these tension-reduction paradigms differ so greatly from infant to infant that in each case, they yield a cohesive pattern of the inborn equipment of the child and of the way in which this pattern is expressed in the individualization of the child. Further, it appears that, despite vicissitudes due to external and other factors, these patterns can be traced into later phases of development and can serve at any point as the basis for prediction.

A brief excerpt from a clinical example will serve to illustrate the way in which these concepts are utilized:

> Nancy was born after a difficult labor, was uncomfortable to hold, showed a negative response to lifting, and was jittery, screaming, and tense most of the time. After feeding she was, if anything, more tense, cried, and was uncomfortable. However, her elimination course was regular and smooth, with marked rise in tension toward climax, and relaxation immediately following. Later, at fourteen months, she was noted to be well developed but unattractive. She rated high in performance tests. Her most striking features were her sober, unsmiling countenance, and an attitude of "stay away" both toward her mother and, even more so, toward the examiner. She showed a decided preference for playing with images of things rather than with things themselves. In this case the technique of dealing with the environment by exclusion, which was evident at birth, is shown to influence later personality development. Conversely, other observations showed that from the beginning her relaxation potential was high, but self-gratification was the goal, and this was achieved quickly and efficiently.

A similar approach was utilized by Fries and her co-workers, who studied the amount and type of motor activity which newborns show in response to certain stimuli. From these observations the concept of "congenital activity types" is evolved, and this is shown to play an etiological role in personality development. Specifically, the congenital activity type was demonstrated to exert a determining influence

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on the child's relationship with its parents, on its psychosexual and ego development, its preferred defense mechanisms, and on predisposition to pathology. Here, too, the constitutional factor was evaluated in the context of its interaction with the environment.

Mittelmann[67] studied several aspects of mobility in infants, children, and adults with respect to the manner in which they influence the development of ego-functions. He finds that a congenitally determined motor drive plays a crucial role particularly during the second year of life, which is designated as "the motor phase of ego and libido development." During this period, motor activity dominates exploratory efforts, attempts to master the environment, object-choice, and other maturational (ego) processes.

Alpert, Neubauer, and Weil[3] have described unusual variations in the libidinal and aggressive drive endowment of three children suffering from neuroses. Initial variations in the quantity, balance, and distribution of these drive energies were shown to be causally related to ego development, maturational sequences, and ego achievements. These authors assume that a similar situation prevails, in greater or lesser degree, in all children, and that it has a significant bearing on development.

Because of the widespread interest in the physical and chemical basis of brain function, recent advances in biochemical research which have relevance to the subject of constitution should be mentioned. Of these, none is more provocative than Williams' concept of "biochemical individuality." Essentially, this is a statement to the effect that the individual is possessed of a constitutionally determined biochemical endowment which differs in many respects from that of his fellows, and that observed physical, physiological, and psychological variations among humans may be better understood on this basis. Historically, this hypothesis, which was first suspected by Garrod in 1902, is supported by a mass of data from transplantation experiments, blood groups, analytical chemical studies, drug actions, allergies, endocrinological studies, and nutritional and enzyme investigations, all of which have given ample indications that such variations exist between one individual and another with regard to quantitative levels of body constituents, metabolic pathways and requirements, etc.[101] Interestingly, the work of Leo Loeb has established that, the higher the place of a given species in the evolutionary scale, the greater is the degree of intraspecific variability. In a series of recent experiments designed specifically to explore these concepts, Williams and his group have tested twelve healthy individuals with respect to forty-two items, including taste thresholds for common substances, and blood, salivary, and urinary constituents, and have found that the resultant pattern for each individual was wholly unlike the others, and bore no relation to a hypothetical norm. There was one exception—a pair of identical twins. The fact that their patterns were similar but not identical indicates that constitutional factors are responsible for the differences in the large group, and this interpretation was confirmed by similar tests on babies. Williams rather conservatively concludes that these chemical differences must have something to do with observed physical and functional variations among individuals. This principle may be assumed to apply to the brain as well—that is, the variability characteristic of psychic function may be, at least in part, accounted for on the basis of inborn biochemical differences. Direct experimental proof is not yet at hand, but evidence of a preliminary and circumstantial nature has appeared. Many amino acids, for instance, have been shown to transverse the blood-brain barrier in both directions at an extremely rapid rate.[51] In addition, the proteins of the brain were found to be in a dynamic state of constant synthesis and breakdown, and further, this "protein turnover" pattern differs markedly, both quantitatively and qualitatively, from one brain area to another, and also from one intracellular structure to another.[35]

Attempts to evaluate the biochemical basis of behavior must be undertaken with caution. Primarily, it must be shown that a given chemical reaction subserves a psychic event occurring in the brain and not a general metabolic requirement of brain tissue. In addition, it is not unlikely that the chemical reactions which

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underlie psychic function are of an extremely fleeting and subtle nature, in accordance both with the rapidity at which these processes take place and with the view that they require extremely small quantities of energy for their execution. Although these considerations may be taken to indicate that it will probably be difficult to gain direct experimental validation of the concept of a constitutionally determined biochemical basis of psychic function, they do not detract from its plausibility or potential fruitfulness.

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CHAPTER 4

PERSONALITY THEORY

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PERSONALITY IS MANY-SIDED and so, also, is the interest it elicits. In addition to the general common-sense, naïve, and amateur attention given to it, there are a number of disciplines which have distinguishable kinds of sophisticated concern with persons and their particular ways of being and doing. To mention philosophers, theologians, economists, political and social scientists, educators, personnel administrators, plastic and pictorial artists, poets, dramatists, novelists, biographers, and historians is to initiate a listing that could be extended. As with every enterprise, the motives which govern an active interest in personality are largely determinative of the methods and results of its pursuit and of their utilization. Recognition of this fact might reduce *some* of the disparities among theories. However that may be, anyone who deals with the subject should indicate his intentions.

This chapter will emphasize psychological or "academic" theories of personality, as distinguished from psychiatric or "clinical" views, which are the concern of other chapters. The distinction is practical rather than neat, however, for though the theories which come out of the universities generally strive to be theoretically precise, inclusive, systematic, and capable of universal application, many "academicians" are clinically sophisticated, some are practicing clinicians, some hold medical as well as psychological degrees, and all make use —some much, some little—of the theories and data of the psychoanalytic schools of thought and practice. Furthermore, intellectual, aesthetic, and practical motives for evolving an articulate viewpoint may combine in various proportions in any theorist. It is frequently informative to notice the nature of the research conducted by the proponent of a theory, and also the area or areas, if any, in which he applies or utilizes the theory.

Our discussion will take the following course: (1) an indication of earlier trends which are discernible in current personality theories, and the major steps by which the psychology of personality became a respectable part of general psychology; (2) representative views concerning acceptable approaches to research in personality; (3) an outline of one instance of current "academic" personality theory, which will serve, incidentally, to make more lifelike the ensuing sections; (4) a mere "pointing at" characterization of a dozen contemporary theories, which may aid the psychiatrist in choosing, among those with which he may

not be familiar, the ones he may wish to explore; and (5) an indication of major issues in personality theory, together with some of the different positions that are taken in regard to them.

¶ Some Historical Antecedents of the Present Outlook*

The purpose of this section is to give a brief historical introduction (from around 1900) to the discussion, in the succeeding sections, of current methods, theories, and issues of personality study. We shall first characterize the main currents of the period and then outline the events by which the study of the personality in its total aspects became a respectable preoccupation of general psychology in the universities.

During the earlier decades of this century, behaviorism, gestalt psychology, and psychoanalysis partly displaced and partly absorbed the trends that were dominant at the turn of the century. The introspective experimentalism, of which Wundt and Titchener were the most illustrious exemplars, held that the field of psychology was consciousness, and that the method of psychology was the analysis of states of consciousness into their constituent elements (sensations, images, feelings). The new schools, each in its own way, offered alternatives to those principles. Behaviorism and gestalt psychology were, in large degree, reactions against the unsatisfactory *status quo* in academic psychology. Psychoanalysis was outside of that context and arose in response to clinical needs.

Behaviorism

The background of the trends which came to be called behaviorism was the attitude and scientific practice of mechanistic materialism of the nineteenth century. In Russia, Pavlov and Bekhterev, working independently, established—on a quantitative and objective basis—the concept of the conditioned reflex. Pavlov noted that a laboratory dog responded to his approaching step, as to the meat which frequently accompanied his arrival, with salivation. He found that if a tuning fork were sounded when meat powder was supplied, the dog would come to respond to the former in the absence of the latter; that is, that salivary reflexes could be attached to an originally ineffective stimulus (tuning fork) on *condition* that it accompanied, a certain number of times, the application of the native stimulus (meat powder) for this response. Using a fistula (and later more elaborate means) to collect the saliva for measurement, he studied the frequency of dual stimulation that was required to elicit response by the new stimulus alone, how long the conditioned reflex would continue to operate without repetition of the dual stimulation before it became extinguished, etc. Bekhterev, working with reflexes in human subjects (for example, associating originally ineffective visual and auditory stimuli with the native retraction of a finger from an electric shock), progressively elaborated more complex experiments. Both Pavlov and Bekhterev were physiologists and scrupulously avoided the interpretation of their results in the way that analogous phenomena were explained by traditional mental associationist doctrines. They came to believe that intricate habits, including thinking, might be accounted for as combinations of wittingly or unwittingly acquired conditionings (a technical way of describing "learning by experience").

In the United States Watson attempted to make psychology objective by viewing it as the study of *behavior* without the use of mental concepts or even of consciousness (except for verbal reports by human subjects). His originally modest expectations were profoundly fertilized by his discovery of the work of the two Russians, and he and his followers soon came to believe that his conceptions might be expanded to explain all learning, including the learning involved in the establishment of the central psychological functions. In place of the traditional mental concepts—sensations, images, feelings—Watson utilized physiological concepts—receptor functions, effector functions, learning (conditioning). Unstriped-muscle responses, as well as striped-muscle and glandular

* This section relies heavily on Murphy[26] and quotations are from this work unless otherwise indicated. See also Baldwin,[8] Boring,[9] Müller-Freienfels,[23] and Williams and Bellows.[37]

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responses, and consequently the complex patterns of emotional expression and the characteristic traits of an individual, could, in principle, be objectively explained essentially on the same principles. Important for the learning of many complex responses was the physiology of language. The meaning of a word is the conditioned response to it, including the mouth and throat neuromuscular equipment involved in speech. A word thus connected with a given object or situation will elicit the response which the presence of the object would evoke. Spoken words may be replaced by silent speech (thinking) without basically altering the situation because the same innervations involved in overt speech occur, in reduced strength, in "covert speech." When these are not detectable they are presumed to be present and to constitute the mental aspects of the event.

Experimentation and theory formation based on conditioning procedures were extensively and variously developed by many enthusiastic behaviorists, so that by mid-century, as Murphy says:

> Accurately or inaccurately, "behaviorism" means to many psychologists today any of the following:
>
> 1. The biological approach to animal and human psychology, promising that psychology shall some day make itself as objective as physical science.
> 2. A mechanistic or materialistic view of psychology.
> 3. Watson's personal combination of (1) and (2).
> 4. Other behavior-centered systems, such as those of Tolman, Hull, and Skinner.
>
> In other words, the progeny of the behaviorism of a few decades ago are already very diverse in appearance and in disposition.

During the twenties, and due in large degree to behaviorist influence, United States psychologists were predominantly occupied with the learning process. Since man is a desiring organism, and since human desires are learned (that is, since all inherited tendencies are more or less modified by experience), learning theory may occupy itself with the most important aspects of personality. In fact, it can be—and has been—so employed, by some, as to constitute a virtually complete psychology of personality. Two groups of stimulus-response theories may be distinguished according to whether they chiefly emphasize contiguity (association) as the significant factor in conditioning, for example, Guthrie, or reinforcement (reward), for example, Hull.* Behaviorism and stimulus-response theories, with their austere adherence to operationism (see p. 94ff.), represent, par excellence, the nomothetic, hypothetico-deductive, laboratory-experimental, mathematical, physical-science enterprise as applied to psychology.

Gestalt Psychology

The problem of the one and the many seems to be as old as reflective thinking. Certainly, since the time of the ancient Greek philosophers, there have been thinkers who have sought the ultimate building blocks of the universe and its contents, including man. They hoped better to understand complex entities by a knowledge of the atoms or elements of which they were supposed to be composed. Another frame of mind has stated, in various ways and in various contexts, that the whole is more than the sum of its parts, and that the sum of the parts does not explain the whole —perhaps not the most important aspects of the whole. Of course, those thinkers who have defined the problem at the deepest level have wrestled with the question of the relations between wholes and their parts. Associationism —the doctrine that complex conscious states were nothing but combinations of simple stable elements which were associated with each other in various ways—was dominant during much of the eighteenth and nineteenth centuries. However, there were occasional adumbrations of the holistic attitude during that period which can be viewed in retrospect as harbingers of gestalt, or form, psychology. The viewpoint was initiated in Germany in 1912 by Wertheimer, with his experiment on the perception of movement. The following is Murphy's account of it.

* There are proponents of non-stimulus-response, or cognitive, theories of learning, such as those of Tolman, a connectionist, and Lewin, a gestalt psychologist and field theorist. These as well as the stimulus-response theories are summarized in Hilgard.[17]

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When light is thrown through a small slit placed vertically, and a moment later through a slit inclined 20° or 30° to the right, the interval separating the two presentations may be so chosen that the shaft of light appears to *fall* from one position to the other. Wertheimer proceeded to work out quantitatively those time relations which would give (1) two simultaneous illuminated slits, (2) the experience of motion from A to B, and (3) the sense of temporal succession, the first being followed by the second, but no movement being involved. The central problem was the nature of the experience of movement, the phi phenomenon.

The most likely previous view was that the perception of movement was due to a track of light made on the retina by the successive stimulation of adjacent points (as the flight of Zeno's arrow was composed of a series of its stationary positions) which were successively registered in adjacent points of the brain. Wertheimer's production of the experience of movement by two separate stimuli, the eye being stationary, destroyed that explanation, and he insisted that the perception of movement is essentially different from the perception of a series of static visual stimuli. He attributed it to a brain process which actively interrelated the two stimuli. From this beginning he proceeded to a critical study of the part-whole issue, affirming that organized wholes must be approached directly and that insight into them, the understanding of their structure, might also make possible the understanding of their components. A consequence of this view is the law of membership character, namely, that the elements (tones in a melody, colors in a picture) of a given object or event (form, gestalt, entity) are definable, if at all, in terms of their relationships within (membership in) that object or event. Furthermore, it is well known that wholes are experienced as such, even when details are distorted and when some parts are missing. From this and similar considerations, Wertheimer announced a second law, the law of *Pragnanz* ("goodness"), to the effect that gestalts (structured wholes, organized entities), as perceived, tend toward that which is orderly, comprehensive, and stable, and away from the opposites of those qualities.

Murphy says:

> These two laws, the law of membership character and the law of Pragnanz, are typical of many which rapidly evolved in Wertheimer's thinking. They are, in general representative of Gestalt laws as a whole, laws in which one works not with an infinite number of tiny particles arranging themselves more or less independently, but with a limited finite number of possible modes of stable organization, which because of their orderly, rationally intelligible form are capable of being discovered, and their dynamics understood.
>
> The first task of the perceiver, then, is not to create, but to apprehend the order and meaning which is there objectively in the world. This is, so far, essentially like Platonism. There are, however, many forms or structures to be found, not all of which are of equal relevance to the perceiver. Just as perception moves from the incomplete toward that which is more nearly complete, so there is continuous dynamic selection and integration of forms. We have thus a direct transition from the psychology of perception to the psychology of thought, without involving the need of any essentially different principles. We need to grasp, first of all, the order lying in nature and waiting for our apprehension; and second, that internal order which the thinker manifests as he passes from one to another orderly form, creating new order in the succession and in the integration.

Consistent with his view of perception and of thinking is Wertheimer's view of all the psychological functions. Thinking is primarily recentering—the reorganization of experience into a more accurate and inclusive perspective on the object of the thinking. Affective and conative phenomena are not segmental part functions, except secondarily, but involve the gestalt quality of the total organism.

The work of Wertheimer and his two younger colleagues, Wolfgang Köhler and Kurt Koffka, began to be available in this country in English in the early twenties, and very soon thereafter the younger members of the trio accepted invitations to many American universities to expound their outlook. Their verve, which equaled that of the behaviorists, together with the extensive body of experimental material that had been amassed, won wide

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attention and acceptance among United States psychologists. By the mid-thirties the method had been applied to all the major issues in psychology, and gestalt psychology had become an established school of thought. Though there were few complete converts, the movement strongly impressed upon all psychologists the importance—and the experimental possibility—of serious consideration of the molar structure and functions of personality.

Psychoanalysis

Psychoanalysis is presented in other chapters of this handbook and so needs only brief mention in the present context. Though its origin antedated behaviorism and gestalt psychology by several decades, its influence on psychology in this country was roughly concomitant with that of the other two schools. It broke in from outside the historic stream of academic psychology; it was strange, unexpected, repellent, and intriguing. Its lack of experimentation and of sharply defined constructs did not commend it to psychologists, who had come to consider these qualifications as essential to scientific psychology. Perceptive and eclectic minds gave it serious consideration from the beginning (see Murphy[28]). Others vigorously rejected it for being "unscientific." To Boring,[9] a historian of psychology, it was worth attentive consideration but was labeled "pre-scientific." For a time textbooks on mental hygiene, adjustment, etc., absorbed certain of its ideas, such as the defense mechanisms, and simultaneously flouted its theories and loose methodology. Today it is widely pervasive in academic psychology, especially where the molar aspects of personality are concerned.* All theories of personality are influenced by it, in greater or lesser degree. Some theorists will not include it in surveys of psychological progress, except indirectly in the form of empirical definitions of the issues it has dealt with by its "unsatisfactory" methodology; not a few stimulus-response theorists, such as Miller and Dollard, include it discriminatingly but importantly in their systems; some, such as Murray, who has announced the value to himself of his personal encounter with it through Jung, make extensive use of it in their systems, though not without considerable selectivity and modification. The chief general contributions of psychoanalysis to psychology are perhaps the following ideas: clinical methods of research (as well as of therapy) of unprecedented penetration; the systematic study of the total personality in its actual life situation; the fact, nature, and extent of unconscious mental processes; the pervasive purposiveness of behavior; the inclusiveness of psychic determinism; the profound influence of childhood experience on the adult personality; and the importance of the interrelations of biological, psychological, and social factors (id, ego, and super-ego) to the understanding of "character" (personality).

Our characterization of twentieth-century psychology in terms of three dominant viewpoints, or rather, three groups of basically similar viewpoints, is grossly oversimplified. The emphases of these schools of thought, together with many other ideas, are held in varying ways and in varying combinations by many psychologists. It seems true, however, that, in general, United States psychologists believe—on the basis of a wealth of experimental and clinical material—that both consciousness and behavior, and also both part functions and whole functions, need to be approached directly in psychological research.

The Rise of the Psychology of Personality

It has been said that, in its struggle for emancipation from theology and philosophy and for acceptance among the natural sciences, psychology lost first its soul, then its self, and finally (with behaviorism), lost consciousness. Certainly, the more the study of psychological phenomena was restricted to the available scientific methodology, the less was it possible to deal with personality as a whole. The investigation of molar issues had to wait on the cumulative development of general psychological methods, theories, and facts; on the construction of adequate molar-problem instruments; and on the more probing clinical procedures of psychoanalysis. The following is

* See Murphy[25] for a differential estimate of the influence of Freud on each of the various areas of United States psychology.

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a sketchy indication of how these preconditions of formal personality study were fulfilled.

Although there was some mutual borrowing and combining among the three chief schools, cross-fertilization was limited by the fact that each school was a movement, if not a crusade, and by academic adherence to the classical principle that parts of a system are distorted if wrenched from their proper context and "stuck" onto another system. The child-guidance clinics and the social-work agencies, however, performed the function of a melting pot. These increasingly numerous enterprises were less squeamish about eclecticism because of the practical urgencies they faced and because of the paucity of their scientific resources. In these institutions psychiatrists, social workers, and psychologists, increasing numbers of whom were psychoanalyzed, welcomed ideas from behaviorism, gestalt, and psychoanalysis. Their case histories, which involved the whole person in his real life situation and were replete with facts but limited in meaning, became progressively more structured in terms of personality dynamics. This confluence of events was a main source of the modern conception of personality study.

Concomitant with these primarily organismic approaches, "environmentalists" were making significant discoveries. To take but one illustration, Margaret Mead's publications in the twenties and thirties,—especially, perhaps, her account in 1935, of sex and temperament in three primitive societies in which "masculine" and "feminine" traits and occupations differed strikingly from those of our own culture—demonstrated the profound influence of cultural factors in the structuring of personality. The professional journals had for some time carried hundreds of articles which dealt with the biological and social aspects of personality, but these were generally subsumed under "physiological psychology" and "social psychology," respectively. In the thirties, however, three books on the psychology of personality (Stagner, *Psychology of Personality*, 1936; G. Allport, *Personality: A Psychological Interpretation*, 1937; Murray, *Explorations in Personality*, 1938) dealt inclusively and creatively with the diverse contributions and "pointed the way to an experimental science of personality study. The psychology of personality was being recognized as a subdivision of general human psychology. . . ."

The development of new probing devices for diagnosing personality marked a crucial step. From the turn of the century, attention had been given to individual differences, and it was recognized that the individual *projects himself* into his receptive and assertive relations with the world. Intelligence testing offered an opportunity to introduce scientific method into the matter of individual differences, and, later, psychiatric need for diagnostic aids stimulated the development of tests of other components of personality. Rorschach's ink-blot test, progress toward the standardization of graphology, the interpretation of spontaneous drawing and painting and of children's play with "dolls" representative of important relationships, and, finally, Murray's thematic apperception test in which the subject reveals inner attitudes by "making up a story" from the stimulus of an ambiguous picture—these and many more similar procedures have proved remarkably effective in penetrating into the hidden substructure of personality. "The development of projective testing has done more than any other single thing to give formal personality study a place in psychology, enabling personality research to stand on its own feet as a legitimate inquiry relatively independent of problems of diagnosis and therapy."[28] The limitations of projective techniques—the fact that most of them are cross-sectional only—are slowly being met by systematic longitudinal studies of individuals through many years of development.

A further augmentation of personality study as a science comes from the activities of psychologists in applied fields. For several decades psychologists who were so disposed found opportunities for the application of their science in schools and colleges, industry, clinics, and courts. Although psychotherapeutic application was limited prior to World War II, the war provided unprecedented opportunity and stimulus for that activity, and at the present time psychotherapy is an important integral aspect of psychology. The therapeutic activity of psychologists has significantly invigorated the scientific psychology of the universities by

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infusing fresh data and problems into the courses and by extending the field of services for which university curriculums are an important part of the training.

Now, at mid-century, *Psychological Abstracts* and *The Annual Review of Psychology* both have sections labeled "personality," and there are journals which are devoted largely or entirely to personality. There are many books on personality theory—academic as well as psychoanalytic—and, increasingly, books which draw impartially on both those historic currents. Books are beginning to appear which present, evaluate, and compare sizable groups of individual theories. There is widespread, if not universal, recognition that part functions are functions of a unified personality which is highly determinative of their nature. In fact, it is now necessary to define what the difference *is* between general psychology and the psychology of personality. Murphy states that, should a psychologist emphasize the more complex functions and expressly desire to see all interrelations within the organism at once, as well as the hierarchy of laws governing those interrelations, he would be occupied with the psychology of personality. "The psychology of personality would then be that particular kind of general psychology which emphasizes the totality and the organic systematic relations which obtain within it."[27] G. Allport, who has always stressed the uniqueness of the individual, goes further: "The day may come when psychological formulations will be regarded as invalid unless they are written to accommodate personal patterns of functioning, personal attitudes, and personal projects. A good general psychology will then be a theory of personality."[3]

¶ The Question of Method in Personality Research

We shall present the views of a few representative psychologists regarding ways of studying personality. (No attempt will be made to deal specifically with the imposing array of ingenious and elaborate experimental and mathematical means and instruments currently used by psychologists in research.) The viewpoints chosen for this purpose, because of their explicitness and their variety, are those of Hall and Lindzey, Murphy, G. Allport, Rogers, and Munroe. After their views are stated, the methodological conceptions of several psychiatrists—Freud, Sullivan, and Arieti—will be indicated, and some generalizations will be attempted.

Hall and Lindzey

Hall and Lindzey[16] hold that theories of personality can, and should, constantly strive to conform to the positivistic logic and rigorous experimental methods developed by the physical and biological sciences. They admit the fertility of some theories which do not meet their standards, however, and are lenient toward existing theories because they represent the present elementary stage of personality research. The following is a summary of their position, chiefly in their own words.

A theory is a set of conventions (terms, concepts, definitions), a creative, imaginative organization by the theorist of his observation. It is an artistic, arbitrary product. It is not and can never become either true or false, though its implications may be either. A theory is, rather, useful or not useful—useful if it can generate predictions or propositions regarding relevant events which turn out to be verified (true). Ideally, a theory is a cluster of assumptions systematically related to each other and to a set of empirical definitions. The assumptions, which generally represent the distinctive quality of the theory, should be pertinent to empirical events. They may be general or specific, according to the extent of the area the theorist wishes to embrace. They may be mathematically precise or relatively inexact. Assumptions must be clearly stated and explicitly related to each other and to the other elements in the theory. This is the "syntax" of the theory, and, unless it is clear, derivations cannot be made from it.

The empirical definitions (or coordinating definitions) permit the more or less precise interaction of certain terms or concepts within the theory with empirical data. In this way the theory comes, at certain prescribed places, into definite contact with reality or observa-

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tional data. Empirical definitions are frequently called operational definitions, because they specify the operation by means of which the relevant variables or concepts can be measured. The investigative purpose of the theory is thus indicated. The empirical (coordinating, operational) definitions may be more or less exact and may be quantitative or qualitative. Precision is preferable in principle but should be relaxed if, in given circumstances, it restricts the theorist to insignificant matters.

Turning from the structure to the function of a theory, the authors indicate three things a theory does. First, it leads to the collection or observation of relevant empirical relations not yet observed. The core of any science lies in the discovery of stable empirical relations between events and variables. The function of a theory is to further this in a systematic manner; it is a proposition mill. Only those derivations or propositions or ideas derived from the theory are open to empirical test. The theory is assumed, and its viability is determined by its utility, not by its truth or falsity. Utility, in this connection, means the verifiability of the propositions derived from it, and its comprehensiveness, scope, or completeness. A theory may be verifiable but insignificant. Ideally, it should make predictions of inclusive scope.

Some theories, which do not observe the principle of constructing empirical definitions and therefore cannot generate research systematically, nevertheless have a heuristic value due to other characteristics, and produce much research. The theories of Darwin and Freud illustrate this.

A second function of a theory is to incorporate known empirical findings in a logically consistent and relatively simple framework. It is a means of organizing and integrating all that is known regarding a related set of events. (Because theories are guided in their inception by what is known, they are in that sense "inductive.") But this organizing of the known is a minor function of theories; their major function is to point out new and unobserved relations.

The third function of a theory is to prevent the observer from being dazzled by the full-blown complexity of natural or concrete events. It is a set of blinders directing his gaze so that he can abstract what is pertinent to his purpose, on the basis of explicit assumptions. A useful theory will give rather explicit instructions as to the kind of data to be collected. This is why a given empirical event may be studied from many different theoretical positions with diverse results.

So much for the structure and functions of scientific theory in general. Applied to personality theory, it means that "a theory of personality must be a set of assumptions relevant to human behavior together with the necessary empirical definitions!" Hall and Lindzey add, "it must be relatively comprehensive . . . should be prepared to deal with any behavioral phenomenon which can be shown to possess significance for the individual."

Viewing their conception of what personality theory should be like in the light of the existing theories (both psychoanalytic and academic) which they expound in their book, they comment as follows: "Our discussion [that is, their theory of theory and of research methodology] is of value in identifying the qualities toward which all theorists aspire and it also gives some idea of what, eventually, personality theories should look like. It is clear, nevertheless, that at the present time they do not look like this." Existing theories, they say, lack explicitness, their assumptions are hard to get at, they are confused regarding what is assumed and what is stated empirically as open to test; that is, the distinction between the theory and its implications or derivations is poorly maintained. Since in the light of this scientific ideal the theories are so seriously lacking, would it not be better, the authors ask, to give up the effort for the present and focus on empirical tools and specific findings? Their answer is, "Not at all!" For since nothing can be done without theory (implicit if not explicit), the abandonment of theory is to give oneself up to implicit or unconscious theory, which is not to know very clearly what one is doing. But, say the authors, poor as they are, the available theories of personality are far from useless: They direct investigation, they provide specific dimensions which are considered important in studying the problems they are addressed to, and their heuristic value is great, since it has led to large

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quantities of research and a healthy flourishing of investigation.

Murphy

Murphy has a fine appreciation of classical literary and philosophical psychology, but the general scientific revolution of modern times, which became effective in psychology in the late nineteenth century, receives his most energetic devotion. He believes that we cannot know how far the experimental method can be extended but that where and when it is applicable to psychological problems it wields the final authority. However, he recognizes that most of the crucial issues in personality study are currently amenable to the strictest methods to only a limited degree, and that these issues —to the borderland of psychology and philosophy—should be attacked with whatever methods are available. He recognizes as major research tools "(1) the genetic methods (the cross-sectional comparison of groups at different developmental levels, and the longitudinal-biographical study of individuals); (2) the comparative methods (the phylogentic and the anthropological-sociological); and (3) the experimental method." Statistics may be thought of as a fourth method or as an adjunct of each of the others. The sections of his major contribution to the theory of personality,[27] with his chief sources of information for each, are: (1) organic foundations—the heredity-environment origin and substructure of personality (genetics, embryology, physiology, and comparative psychology); (2) learning—growth, the acquisition of a behavior system, conditioning, complex integrations, conflict (genetic and experimental psychology); (3) the personal outlook—sense perception, imagery, feeling, imagination, and thought (partly experimental psychology, but largely the observations and inferences of the clinic and life histories); (4) the self—the ego, ego defenses, unconscious processes (genetic observations, experiments, interrogations and, in particular, the psychoanalytic methods); (5) wholeness—the interrelations of traits and the organization and functions of the totality (experimental psychology); and (6) individual and group—the implications of the communal nature of personality, situationism, personality and culture, field theory (the social sciences).

Allport

The term "personality" has two meanings—it is a name for a general characteristic of human beings, and it is the name for the uniqueness of each human being. Allport considers uniqueness the most basic characteristic of personality and has repeatedly defended the concept of the person, all of whose manifestations have membership character in his essence, against all forms of scientific reductionism. To one who said that "psychology, as a science, deals with universals, not particulars," he replied that "as long as psychology deals only with universals and not with particulars it won't deal with much—least of all human personality."[2] In one article he discusses the question whether personality is a problem for science or for art, and concludes that both are necessary to do justice to it. Referring to "the four basic provinces of research and learning: the natural sciences, the biological sciences, the social sciences, and the humanities," he says, "Have you ever thought before that it is in the territory of psychology and *only there*, that all these four intellectual winds collide and run a tempestuous course? I suppose it is natural enough that they should do so, for only by the aid of all the inventions and all the resources of the mind can the creative mind itself be adequately explored."[4]

Another of his beliefs is that there are two contrasting outlooks on personality, each rooted in a deep-lying philosophical predilection.[5]

> There is a basic difference in philosophical assumptions regarding the nature of mental life, the Lockean tradition being dominant in England and America; the Leibnitzian and Kantian on the Continent. . . . The Lockean tradition, in brief, holds that man's mind by nature is a *tabula rasa* (environmentalistic leaning); mind does what it is made to do (a leaning toward reactivity and behavioristics); its components are basically discrete (simple ideas), and its organization therefore a matter of cementing bonds (associationism). While not all these doctrines are fully developed by Locke himself, his particular brand of em-

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piricism paved the way directly for Hume, Hamilton, Mill, and later for objectivism. Darwin gave the tradition a functional turn, and borrowing from Freud gave it depth. But the tradition remains clearly traceable. By contrast, the Leibnitzian and Kantian positions have been dominant and, in my opinion, are still dominant on the Continent. They are clearly reflected in present-day characterology. To Leibnitz, as to Kant, the intellect was perpetually self-active (not merely reactive). When Locke said *nihil est in intellectu quod non fuerit in sensu,* Leibnitz gave his famous retort . . . *excipe: nisi ipse intellectus.** To him, the inner and spontaneous workings of the mind were at least as important as its content or productions. His concept of the self-active monad easily became the person who with his entelechtive strivings pursued a unique destiny (cf. Stern's personalism).

These two contrasting *weltanschauungen* "are still reflected . . . in all basic psychological thought." His general conclusions regarding method are as follows:[3, pp. 19, 21]

> The scientific ideal which we all share—though we may define it variously—has one serious charge against it. It has produced practically none of the substance for current theories of personality. . . . Excessive methodological purity, as advocated by some Anglo-Americans, can result in bigotry and sterility. On the other hand, if fresh insights, phenomenological deliverances, and hunches are freely allowed, disciplined method can at the proper stage help sift the wheat from the chaff.

Rogers

Rogers' method of deriving his theory of personality is unique among academic psychologists. He created a strikingly original psychotherapeutic procedure, which he and his associates practiced for some years, and finally he formulated a theory based, apparently, entirely on observations of therapeutic phenomena.† He initiates the construction of personality theory by induction based on observation (supplemented by listening to electronic recordings) of his psychotherapeutic interviews with clients. From assumptions generated in this way, he deduces operational hypotheses which he tests by objective measures. The experimental means used by him and his associates in their major research effort[31] at Chicago University included various methods for quantifying psychological variables (Q-sorts, and specially designed rating scales), statistical procedures, and projective techniques (the thematic apperception test, the Stein sentence-completion test, and tachistoscopically given Rorschachs). The molar units of the research were twenty-eight completed, verbatim-recorded cases of client-centered therapy. To these must be added the control cases and the attrition cases (those who did not continue in the therapy). The therapy was conducted for therapeutic *and* research purposes. This school of therapy has certain characteristics which make research of this kind more encompassable by it than by most of the others. (Even so, the time and labor required were enormous.) Clients are generally seen once a week. The length of the therapy, which is determined by the client, is relatively short; one of the subjects in this research completed her therapy in four weeks; the three longest cases continued, respectively, 137, 91, and 78 weeks.

Rogers has reported, in a much-discussed article,[31] how he resolved the conflict between his imaginative flights and his experimental duties. In summary he says:

> Science is a way of preventing me from deceiving myself in regard to my creatively formed subjective hunches which have developed out of the relationship between me and my material. It is in this context, and perhaps only in this context, that the vast structure of operationism, logical positivism, research design, tests of significance, etc., have their place. They exist, not for themselves, but as servants in the attempt to check the subjective feeling or hunch or hypothesis of a person with the objective fact.

Munroe

Munroe's viewpoint roots in her practice of clinical psychology and her close study of the

* There is nothing in the mind which was not [first] in the senses. . . . Nothing except the mind itself.

† It is in keeping with this that his theory of personality should occupy a few pages at the end of a large book devoted to procedure and clinical findings.[30]

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psychoanalytic schools of thought. She believes that some aspects of the life sciences are amenable to physical-science methodology, but, because organisms are crucially different from inanimate objects, and particularly because the human organism is crucially different from all other objects and organisms, the important aspects of personality can be studied more accurately by relatively "loose" methods. These methods should not be borrowed from other sciences but developed from empirical relations with this unique material, while means for the reduction of error are evolved in the same manner. She writes:[24]

Too often this [theoretical] perspective (should I call it *operationalism?*) has led to efforts at careful definition and measurement in psychological science analogous to the methods of physics. Many of these methods seem to me inappropriate to our essential task. The systems we deal with in psychology are of a different order, and must be studied in different ways. Almost by definition, the exact sciences deal with systems which are repeatable and measurable for the purpose of the investigation (the hypothesis). I shall refer to such systems as "tight."

Fairly tight systems are not unknown in the life sciences, but most of our significant problems are subject to scientific ordering only through recognition of *processes*. Our useful systematizations *should* be thought of as relatively "loose", —as *not* definable and measurable with anything like the precision of physics. Any organism has a *history* peculiar to itself which makes it intrinsically different from every other organism, unlike the atoms which resemble each other so closely that the physicist or chemist can cheerfully ignore variation up to the highest reaches of the quantum theory. By virtue of its especially great flexibility in learning, the human organism is especially variable as a unit that is observed. Its past experience is of crucial importance. Furthermore, it adapts itself creatively moment by moment to the current situation—not as a neatly definable entity, *homo sapiens*, but as an organized personality.

Psychological science *must*, I think, work with processes and trends, with "loose" systems. Exact definition and measurement are helpful tools for many aspects of our problem. For the most part, however, better understanding of a trend (a system) is more feasible and more useful and more *correct* than a finicking precision.

She recognizes that certain pitfalls are indigenous to the traditional method, for example, *reductionism*, the tendency to overgeneralize a useful formulation; and *reification*, the tendency to make a causal entity of a useful dimension or description of dynamic relationships. But she believes that these temptations should be handled by awareness of their existence and by creative vigilance rather than by abandoning the whole approach and replacing it by an alien one borrowed from the physical sciences.

Freud

The source of Freud's theory of personality was clinical—the intensive idiographic study of a relatively small number of cases. The essential methods of the strict scientists—clearly formulated assumptions, operational definitions, and objective or experimental testing—were not employed. Members of the psychoanalytic schools have generally followed, and follow today, Freud's clinical method, though some of them have interrelated theory formation and clinical observation more closely. Freud considered psychoanalysis to be a part of psychology, and explicitly stated his views on method.[15] Hall and Lindzey[16] after quoting him, summarize with admirable accuracy and succinctness his position, which is in sharp contrast to their own.

By choice, then, Freud preferred the more open, informal type of inductive theory-building which stays reasonably close to the empirical supports upon which it rests to the more formal deductive type of theory which starts with sharply defined concepts and carefully phrased postulates and corollaries from which testable hypotheses are derived and subsequently tested. Moreover, as this quotation shows, Freud was fully aware of the importance of the "prepared mind" of the scientist in enabling him to make maximum use of his empirical data.

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Sullivan

Sullivan has declared himself as follows:

> Clinical research in psychotherapy is participant observation addressed to the problem of improving the living of the patient but done well enough and reported well enough to make it possible for others to approximately repeat it—the procedure—when they find themselves in significantly similar inter-personal situations.[36]

Though this quotation does not indicate it, Sullivan made extensive contributions to theory, but, for him, theory and therapeutic procedure and the observed phenomena (of which the therapist was an integral part) constituted an almost indivisible syndrome. It is as though understanding and skill were to be acquired in the richness and imprecision of the practical effort where two whole persons constituted a unified "field," and as though what was learned was to be conveyed (operationally, but not in the usual sense of the term) to one's fellow students who might test it in the same kind of practical activities out of which (with the aid of Sullivan's "prepared mind") it had come.

Arieti

Arieti[7] solves the basic methodological issue with a forthrightness reminiscent of Alexander cutting the Gordian knot. He sees the solution of this problem in recognizing two distinct methodologies which are not to be integrated with each other logically but both of which are to be used, at appropriate points, in personality study:

> The scientific or nomothetic approach studies phenomena in order to abstract the laws which rule these phenomena. The knowledge of these laws is considered necessary to enable the student to interpret, to predict, and eventually to alter the course of the phenomena. . . . This approach is more concerned with quantities than qualities, more with categories than with the individual. The idiographic or historical approach deals more with qualities than quantities, with specific entities and with the sequence of events more than with laws and classes. . . . The pursuit of [the scientific] method in psychiatry has, as a whole, been extremely unsatisfactory. . . . [Furthermore, some psychologists have attempted to utilize this method but] not with great success. . . . Freud . . . revolutionized the methodology in psychiatry and psychology. . . . What Freud and the Neofreudians did was to apply the historical method to psychology and call it psychodynamic. . . . [In general] the psychoanalytic profession has accepted the historical-idiographic method. The longitudinal character of the study, the temporal sequence, the detail, the motivation, the global outlook, the emphasis on the uniqueness, on the autonomy of the individual, are all characteristics which pertain to the psychoanalytic procedure.

A roughly graded series of outlooks on method may be generalized from the foregoing examples.

1. Those who believe that psychology is scientific only to the extent of its use of physical and biological science methods. (If Hall and Lindzey's principles were applied more narrowly and strictly than those authors require, they would speak for this category of theorists.) They are, procedurally when not philosophically, mechanistic and materialistic; they maximize the continuities and minimize the discontinuities between man and the subhuman species.

2. Those who believe that strict methods are, in principle, applicable to personality study, though at present the realization of that ideal is limited (for example, Hall and Lindzey).

3. Those who, while highly valuing the idiographic methods, believe that the experimental methods can and should conquer more and more territory, but that it is for the future to determine how far they can go (for example, Murphy).

4. Those who, while they believe, like most students, in the use of both "tight" and "loose" methods, believe also that "loose" methods are, and will continue to be, the most adequate means of understanding the superior aspects of personality. They emphasize the discontinuities and de-emphasize the continuities between the human species and other species. They also emphasize the uniqueness of individual personality (for example, Allport, Munroe).

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5. Those who believe in clinical means as the deepest sources of insight into personality, but who believe (a) that scientific psychology affords assimilable and useful contributions (for example, Arieti) and (b) that the checking of clinically derived theories should be done by objective methods (for example, Rogers).

6. Those who rely on clinical methods and have little confidence, or show no interest, in exact-science methods in personality study. Probably only nonacademic clinicians would fall in this category (for example, Freud and Sullivan).

It is clear that there is considerable congeniality between the clinicians and the "right" wing of the academicians. There are differences, however, which are probably due to the distinguishable difference in their occupational aims. The latter are professionally concerned with the systematic advancement of knowledge, whereas the former are professionally concerned with the alleviation of the suffering of individuals.

There is a "method" of understanding personality which is seldom mentioned in academic discussions of method but which is highly valued by many psychologists and psychiatrists. This is the method of understanding personality through self-transformation through growth in self-insight, whether achieved by psychotherapeutic experience or some "natural" equivalent of it. Personality is the one object in the universe which the investigator can study from the inside as well as from the outside. It is the one field of research in which the researcher himself is an instance of the object of his research. Furthermore, self-understanding is never merely the understanding of one's unique, idiosyncratic self; experience seems to indicate that the deeper one enters into his own individuality the more understanding he has of that which is universally human. It seems inevitable, also, that the more truly one experiences personality, in himself and in his relationships, the more truly will he understand objectively acquired psychological knowledge. (The reverse does not seem to be necessarily true—perhaps because objective psychological knowledge may remain a restrictedly cognitive or "intellectual" acquisition.) For these reasons many clinicians and many right-wing academic psychologists consider self-understanding to be the basic psychological, as well as psychotherapeutic, "methodology."

¶ Murray's Personology: an Example of Contemporary Personality Theory

Personality is the continuity of functional forms and forces manifested through sequences of organized regnant processes and overt behaviors from birth to death. The functions of personality are: to allow for the periodic regeneration of energies by sleep; to exercise its processes; to express its feelings and valuations; to reduce successive need-tensions; to design serial programs for the attainment of distant goals; to reduce conflicts between needs by following schedules which result in an harmonious way of life; to rid itself of certain persisting tensions by restricting the number and lowering the levels of goals to be attained; and finally, to reduce conflicts between personal dispositions and social sanctions, between the vagaries of antisocial impulses and the dictates of the super-ego by successive compromise formations, the trend of which is towards a wholehearted emotional identification with both the conserving and creative forces of society.[29]*

The psychologist's objects of concern are individual human organisms, or persons. (Groups are the sociologist's objects of concern.) But a person is an emergent entity *of* and exists *in* a certain physical, social, and cultural milieu and cannot be properly represented in isolation from it. The superordinate governing institution of the human organism is the personality, or mind. The brain is not

* This quotation is the summary at the end of the fifty-page exposition of his conception of personality by Murray, with the collaboration of his anthropological associate, Kluckhohn. It indicates the major themes but will be more meaningful in the light of the epitome which follows here, and very much more meaningful still if one reads the complete original exposition. In the epitome the phrases of the authors will be used as much as possible, but space-saving curtailment will eliminate most of the examples, logical development of the ideas, and excellent style and wit. The greatest violence to the text will be the omission of the authors' qualifications of many of their assertions: for instance, ". . . it seems best to think of the id as consisting of . . ." will become ". . . the id consists of . . . ," etc.

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the personality, but it is its anatomical center and main constitutional determinant. Because so little is known of the psychophysical correlates, we will forget the brain and restrict ourselves to the psychical-behavioral level of analysis and formulation.

The establishments (a person's knowledge, value system, vocational goal, etc.) and the processes (his transient perceptions, emotions, intentions, etc.) which constitute a personality are out of sight and must be inferred from the facts of his behavior and his reports of his mental content. Hence, in actual practice, the personality is an abstract formulation composed by the psychologist.

"Regnant" refers to momentarily governing processes at the superordinate (regnant) level of integration in the brain field. It may be perception, apperception, intellection, expectation, etc., and it may be conscious or unconscious.

Personality is always in process: the history of the personality *is* the personality. For convenience the waking hours of a person's life may be divided into a sequence of temporal segments or proceedings of personality, some of which are mostly internal and some mostly external. An external proceeding, an instance of a person coping with some aspect of his immediate physical or social environment, is the psychologist's simplest real entity. It is the thing he should observe, analyze, try to reconstruct, and represent, if possible, with a model, and thus explain; it is the thing he attempts to predict, and against which he tests the adequacy of his formulations and hypotheses.

A person's behavior cannot be adequately characterized by a list of adjectives, because the situation he is in at a given time is a determinant of his behavior. Thus the environmental situation which is an integral part of every external proceeding (real entity) must be, in its more relevant portions, described or symbolically represented.

In an interpersonal (dyadic) proceeding—the psychologist's most significant type of real entity, or transaction—the other person constitutes the ever-changing situation of the subject, and vice versa. Consequently, both sides of the equation must be given equal analytic consideration.

The result of a proceeding can be roughly indicated by representing the structure of the field (the instantaneous total situation) at the beginning and at the end of the transaction. For a more exact understanding it is necessary to conceive of a proceeding as a succession of instantaneous fields, each of which determines the action that ensues at the moment. The behavior of a person is in terms of the external situation (the other person) as he sees it. This is the beta situation, as distinguished from the external situation as it really is (the alpha situation), which should be ascertained, whenever possible, by direct inquiry.

Every proceeding leaves some trace of its occurrence, so that gradually (sometimes suddenly) a person changes. As a rule the psychologist looks for uniformities among events, but he should not overlook exceptional occasions, which may be fateful.

Many actions, though temporally discrete, are resumptions of similar previous actions and anticipate future resumptions of them (for example, skill learning, enduring relationships). Such a functionally connected but temporally disconnected series of proceedings is a serial. Various actions, especially serials since they often express inner initiative, may be called proactions, in contrast to reactions, such as are denoted by the old stimulus-response formula. Generally, proaction is not merely homeostatic (serving to restore a normal psychological homeostasis) but superstatic (aimed at growth, development, creation). Serials are important because of their interrelations with the ego system and with means-end learning, skill learning, value learning, and emotional development.

Certain specific objects or kinds of objects which become more or less enduringly attractive or repellent to a person are, respectively, objects of positive cathexis (positive value) and of negative cathexis (negative value). When the object is both liked and disliked, it is ambivalent. A positively cathected object is said to have final or intrinsic value when it is enjoyed for its own sake, instrumental or extrinsic value if it is merely a means to an intrinsic value. Parental and other family figures are important cathected objects, because the interactive patterns or themas established

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with them influence later relationships. A cathection which is too binding, which should be outgrown in order to permit a more appropriate cathection, is a fixation.

Personality is both the ground and product of activity. Its particular perceptions and apperceptions determine its view of the world, and hence, through numerous trials, failures, and successes, the personality evolves and changes. Generally this is gradual, but sometimes (probably not without latent incubation) it is sudden. Different kinds of serials are dominant at different periods of life, others merely holding their own, some possibly regressing during a given period. Since the establishments of personality change with time, the description of them must distinguish different long periods in the life course—infancy, childhood, etc. Any one of these should be studied by means of closely observed representative short periods.

There are three major types of activity: (1) ungoverned, or process, activity and (2) governed activity, of which latter there are two forms: (a) modal, or formal, activity and (b) directional, or instrumental, activity. Process activity is both effortless and aimless. During the early dependent and irresponsible period, the infant's needs are satisfied by the mother, to the mere cue of a cry. The mind is left free for random processes, which consist in the transformation of percepts into images and also, later, into words (symbols) and fantasies.

Modal activity, like process activity, is of intrinsic value but is more organized. It involves the achievement of excellence or form. The most obvious illustrations of it are participation, expressively or receptively, in storytelling, and in dramatic and musical performances.

Most dynamic psychologists have neglected process and modal activity and have assumed that the most important thing to observe in a person's career is its major directionality of activity. Since directional activities vary in respect to their intensity and duration, their degree of coordination, and their definiteness of aim, it is customary to conceptionalize a directing superordinate "force" in the brain region. It has been variously named—tendency, drive, need, propensity, instinct, urge, impulse, desire, wish, purpose, motive, conation, resolution, intention, etc. We use the term "need" or "need disposition" to refer to the roughly measurable "force" in the personality which is coordinating activities in the direction of a roughly definable goal; and we use the term "aim" to refer to this need's specific goal (to be achieved perhaps in association with a specific object in a specific place at a specific time). Thus, "directionality" means the trend of the activity, and this can be defined only in terms of its aim, or goal, or intended effect. Since Freud, the aim may be conscious or unconscious. The habit of American psychologists to take the hunger and sex drives as basic illustrations is not adequate for the study of "higher-order" human motives.

The infant's mind is not acting most of the time as the instrument of some urgent animal drive (as many psychologists assume) but is preoccupied with gratifying itself. Among these purely mental gratifications of early life is the need to dramatize everything, to invent another world that is more exciting and hence more "real" than the reality of sheer perception. This inner world of childhood provides the basic stuff out of which are shaped forms of play, myths and religious rituals, songs and dances, folk tales and poetry, and even, at a later date, philosophies, scientific theories, and technical inventions. The child—and the adult—not only enjoys imaginative activity but enjoys also the imaginative products of others. The human mind is inherently a transforming, creating, and representing organ; its function is to make symbols for things, to combine and recombine these symbols incessantly, and to communicate the most interesting of these combinations in a variety of languages, discursive (referential, scientific) and expressive (emotive, artistic). In short, the mind lives in two worlds—the world of imagination (religion, art, and science) and the world of perception and practical action. In some areas the two may coalesce; in other areas they may be poles apart. It is the former which is peculiarly human, as distinguished from the predominantly practical lower organisms. In insanity a person does not go "out of his mind," but wholely "in his mind" (Santayana) and out of the external world. Creative mental needs

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have no clearly envisaged goal; step by step, they realize something that never existed before.

A need is not a discernible fact but an intervening variable, hidden in the head, which must be inferred from certain criteria. Hence needs must be diagnosed. They are sometimes obvious and sometimes extremely obscure.

Happiness, though emphasized by most great thinkers of the past, is generally neglected by psychologists. Actually, satisfaction is an affective state which is likely to manifest itself objectively as well as subjectively. It is no more difficult to diagnose than anxiety or anger. We propose a variable, *H* (hedone), which is rooted in the brain (possibly the thalamus) and which varies along a continuum, the hedonic scale. At the lowest end of the scale, *H* manifests itself subjectively as a feeling of extreme dissatisfaction (dejection, depression) and objectively by readily distinguishable postures, etc.; at the highest end, by extreme satisfaction (elation, joy), combined with its objective signs. Indifference is represented by the center of the scale. Every occurrence which moves *H* down the scale is hedonically negative; up the scale, hedonically positive. The aim of all needs is hedonically positive (in the imagination). The person may, however, be in error in his expectation, which means that goals (values) are something that must be learned. This conception is not psychological hedonism, for people never deal with pain, or pleasure, in general. Rather, what is required is the elimination of a certain kind of dissatisfaction or the achievement of a certain kind of satisfaction. Need, then, is the fundamental variable, and the degree of satisfaction (hedone) the best indicator of its state or progress.

The concept of "role" is strategic to the integration of two levels of theoretical analysis, psychological and sociological. Every self-and-body must perform certain individual roles (functions)—biological, psychological, and interpersonal. Every group (social system) must perform a number of social roles to maintain, govern, defend, reproduce itself, etc. By extending the conception of role (social role) to personal roles, a psychological action system and a social action system can be represented as roughly homologous, at least in certain respects. All social roles require one or more kinds of actions (the habitual production of one or more kinds of effects), and these effects (goals) can be classified in the same manner in which needs are classified. At times the individual need-aim and the social role-aim may exactly correspond, namely, when the individual wants to do what his group wants him to do. The extent of this happy harmony is limited by the necessity for concerted action, the requirement that the action be performed at a fixed time. In view of the role action needs of the personality, most individuals try to conform to the group's schedule of role functions.

A need is a general disposition which commonly becomes associated (through "focalization," or "canalization," as Murphy would say) with a number of specific entities (for example, a certain doll, or dog, or person, or group, or town, or theory, or work of art, or religion, etc.) and, through "generalization," with a number of kinds of (semispecific) entities (for example, French wines, or horses, or women, or music, or novels, or philosophies, etc.). As life proceeds, some attachments are outgrown and some new ones are acquired. Certain permanent attachments (for example, mother-fixation) are problematic. So also is the inability to remain loyal to anybody or anything. In addition to provisional maturational or age-level needs, there are diffuse (free-floating) needs and focal (enduring) needs. The distribution in any personality of different kinds of cathections (evaluations, sentiments, attitudes) are correlated with the three vectoral dispositions (Horney): moving toward people (positive goal objects), moving against people (negative goal objects), and moving away from people (noal objects). Positively cathected goals and goal objects (kinds of values) are of two classes: (1) goals which have been experienced rather regularly and (2) goals which attract but have not been attained. By "learning" American psychologists almost always mean means-end learning. More important are goal and goal-object learning, that is, the acquisition through experience of valued goals and goal objects.

Social psychologists, concluding that much human thought and behavior is value-oriented, took "attitude" as their key concept (Allport).

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They view personality as a relatively integrated system of attitudes, each of which is a relatively permanent disposition to evaluate some entity negatively or positively. The general or specific entity (object of the attitude) is a value, positive or negative, or has value (power to attract or repel). Incidentally, "attitude" and "sentiment" are synonymous. "Value" is synonymous, in one sense, with "cathexis" and "valence" and, in the other sense, with "cathected entity" and "object with valence." There is always a representation (image) of the valued or cathected entity *in* the personality. Most social psychologists see a gap between attitudes (vaguely defined dynamical forces) and needs (or drives): the former are "higher" and the latter "lower" and "segmental"; the former are "pulls from in front," the latter "pushes from the rear." Actually, the concept of attitudes must be broadened to include all affect-invoking entities from feces to the Fallen Angel. Also, they must be connected with directional activity (the concept of need), so that it may be known how strongly and in what ways a given interest is pursued. As for needs (for example, aggression), not only must the object of the need (for example, brother) be specified, but also the value (for example, one's freedom) in the service of which the need has operated. This means that both action tendencies and valued entities must be classified. Following Levin and Erikson, we call action trends vectors, each of which is a physical or psychological direction of activity, such as (1) rejection, (2) reception, (3) acquisition, (4) construction, (5) conservation, (6) expression, (7) transmission, (8) elimination, (9) destruction, (10) defendance, (11) avoidance. Valued entities (more difficult to classify) might be: (A) body (physical well-being), (B) property (useful objects, wealth), (C) authority (decision-making power), (D) affiliation (interpersonal affection), (E) knowledge (facts and theories, science, history), (F) aesthetic form (beauty, art), (G) ideology (system of values, philosophy, religion). (These are the six components which form the basis of Spranger's typology, with the addition of "body.") Note that each value vector is a need. Such a scheme permits a high degree of concreteness. It can also be used to distinguish the action trend (*need-aim*) in the subject and the action trend (*press-aim*) in the object. In sequence they constitute the thema of a proceeding. For instance, the proaction of the subject (s) could be that of *expressing* (6) an *idea* (E) and the reaction of the object (o) might be that of *rejecting* (1) the *idea* (E): Thema: sE6—oE1. For a more complete statement of the thema, other variables (cathexis, status, conformity to role) must be added to each side of the formula. (The authors state that this scheme is still in process of construction and not yet ready to be applied to the topics which follow.)

Before Janet and Freud, the mind was equated with consciousness. But with the recognition of unconscious establishments and processes, in all people, the conception of mind was greatly expanded. The id is not merely the repository of unacceptable dispositions, in conflict with the "rational" ego; rather, it consists of all the basic energies, emotions, and needs (value vectors) of the personality, some of which are wholly acceptable when expressed in a culturally approved form, toward a culturally approved object, in a culturally approved place, at a culturally approved time. Thus the function of the ego is less to suppress than to govern instinctual needs. Criteria of ego-structure (ego-strength) are in terms of certain specified capacities of three ego-functions. For instance, one of three criteria of A, perception and apperception, is *external objectivity*—the ability to perceive human actions and events without distortion, to analyze and interpret them realistically, to predict the behavior of others. One of three criteria of B, intellection, is *concentration, directionality*—the ability to apply one's mind to an assigned or selected topic, to direct one's thoughts along a chosen path, to persist when bored, to inhibit daydreaming. One of nine criteria of C, conation, is *conjunctivity of action*—the ability to schedule and organize one's activities, to make a plan and follow it, to live an ordered life. The power of the ego, relative to other ego systems, requires some knowledge of the strength of the id. Some "egos are astride a docile pony, others astride a wild broncho." The chief criteria of id

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strength are: (1) intense energy, zest, spontaneity, and enthusiasm; (2) intense needs and appetites; (3) intense emotions; and (4) abundant, vivid imaginations.

Freud's oversimplified account of the super-ego must be radically revised. The super-ego develops by stages, stratum upon stratum. In its most primitive form it consists of no more than projections of the child's own oral, acquisitive, and aggressive tendencies, represented, say, by a vampire, werewolf, or gigantic biting animal, such as Moby Dick himself, or, possibly, by a child-devouring witch or deity such as Kronos. In the child's imagination "totem" animal figures are gradually replaced, as they were in the evolution of religions, by human figures, first, perhaps, by an affrighting God-father image, and then usually by a more kindly symbol of moral authority. Here we are speaking largely of the lower layers of super-ego formation, marked by archaic, semihuman, and mostly punishing images. As socialization proceeds in Western cultures, these strata, overlaid by others, become unconscious, and in later life are manifested only in dreams, artistic productions, and insane delusions. Contemporaneous with the development of these imaginative, figurative, mythological, or religious aspects of the super-ego, one finds the gradual structuration of behavior according to certain abstract moral imperatives which are transmitted by parental example, suggestion, persuasion, promises, rewards, threats, or punishments. According to the given parent, these may consist of arbitrary and inconsistent pressures, or a fairly rational ordering of ethical principles. In either case, conflict is bound to occur with the rise of the second major source of super-ego constitutents, the reciprocative and cooperative interactions among members of the individual's peer group. An additional class of super-ego determinates is literature, which exposes the youth to a great variety of contrasting moral judgments. Most mortals cannot make order out of such diversity, and, as there is no central authority among most Western religious groups, wide agreement on basic assumptions and their rationalized derivatives is found only among members of totalitarian systems, such as Communist, Fascist, etc. As a result of these several factors, there is, in contemporary America, more and more adjusting of behavior to the evaluations of one's peers, while the inward Puritan conscience has lost its "charm." The deterioration of the religious and ethical super-ego is made clear by comparison with the intellectual or scientific super-ego, which is increasingly self-exacting. In childhood the chief conflicts are between id tendencies and parental restraints. Later, if socialization advances, many conflicts are between id and super-ego (internal standards). During these years the ego is hardly more than a battleground, or puppet, dominated alternately by the id and super-ego. Eventually, however, under favorable circumstances the ego may become strong enough to arbitrate to some extent between id impulses and super-ego imperatives. Ideally, the super-ego is an inviting conception of an ideal, or at least better, future world; the ego-ideal an inviting conception of an ideal, or better, future self. If integrated with the super-ego, the ego-ideal will portray an individual who is promoting in some small or large way the development of a better world. If not so integrated, the ego-ideal may consist of images of the "master criminal" or of any other wholly egotistical "successful" person.

Following their discussion of the major structures and functions (establishments and processes) of personality the authors continue with two sections which we will merely note. Under "Formulations of Personality" they describe how their scheme is to be used in the actual practice of assessing a personality. Under "Major Functions of Personality" they justify their choice of functions and describe in detail those listed in the "Summary" which we quoted at the beginning.

Murray's "Personology" is among the most broadly based of personality theories. It draws on biology, academic and clinical psychology, psychoanalysis, and a wide humanistic culture. The inclusiveness, discrimination, and operational definition of the various facets of personality are apparent even in our bare outline. The schedule of needs and of press which Murray has painstakingly elaborated, and other items omitted here, may be found in *Explorations of Personality* and other writings listed in the bibliography.

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With this single but illustrative example of a theory of personality in mind, we have a concrete basis for considering the various items which should be dealt with, in some manner or other, by any theory which intends to be inclusive. Before passing to issues in personality theory, however, we will take brief note of a few other current theories.

Notice of Some Important Current Theories

Lewin

The structure of Lewin's widely influential field theory[20] stems, ultimately, from the nineteenth-century electrogenetic field theory of physics and Einstein's theory of relativity, and, proximately, from gestalt psychology. His view is that the context in which behavior occurs is an inherent determinant of the behavior, and that understanding proceeds from the inclusive field to its constituent parts, including the individual. He strove to establish concepts which would make possible the mathematical description of a given individual in a given situation.

Allport

The manner of Allport's psychological theorizing[1, 5] illustrates a central tenet of his outlook, namely, the ultimately unclassifiable uniqueness of the individual, which he believes science can never fully absorb. Yet this "self" theorist's conception of the self is complex and "loose" in order to include in it both the continuities and the discontinuities between child and adult and between normal and abnormal. He has given much attention to the traditional question of traits but in a very untraditional manner. He is less formally precise than empirically rich, and the membership character each contribution has in his total work is more organic than systematic.

Maslow

A number of the great minds of ancient and modern philosophy have contributed to the organismic or holistic conception which has been an organizing factor for a number of scientists, psychologists, and psychiatrists, such as Goldstein (see Chap. 65) and Meyer (see Chap. 64). Maslow and Lecky and Angyal all emphasize holistic principles; in true gestalt fashion they see the meaning of parts as being largely determined by their relation to the whole. Maslow[21] terms his organismic outlook a holistic-dynamic point of view. He laments the fact that psychology has neglected half its rightful province, that it has analyzed the morbid and the miserable aspects of man and neglected the healthy and the happy aspects. Man's inborn nature is essentially good, and if it becomes neurotic or bad it is because of social ignorance or pathology. He has studied effective persons intensively and found certain characteristics common to all of them.

Lecky

With Lecky,[19] as with Adler who originally inspired him, the individual personality is seen in sovereign terms, and all psychological manifestations are in harmony with it because they are manifestations of it. His key concept is self-consistency.

Angyal

Angyal,[6] like Lewin, extended holistic principles beyond the organism to include the organism-in-environment whole. He originated concepts to describe the elaborately differentiated structures and functions of organic existence that would do justice, simultaneously, to their separateness from and relatedness to the whole. The whole which he envisages transcends, includes, and integrates biological, psychological, and sociological phenomena.

Sheldon

Sheldon[34, 35] has taken as his province an area, constitutional psychology, which has been relatively neglected, in its molar aspects, by American psychologists. By means of an original and elaborate methodology of anthro-

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pometrics, he has distinguished three components of physique—endomorphy, mesomorphy, and ectomorphy—and three corresponding components of temperament—viscerotonia, somatotonia, and cerebrotonia. The former, in various combinations, yield eighty-eight empirical types.

Eysenck

From the psychometric study of individual differences and the factor analysis of Spearman, originally emphasizing intellectual factors but later expanded to include other dimensions of personality, finally emerged a number of theories of personality. Among these, Hall and Lindzey[16] select for exposition Eysenck and Cattell, because of the "explicitness and extensity of application" of factor analysis in the development of their respective theories of personality. Eysenck,[14] in his "seventy journal articles and five books," has dealt with various topics, but in his personality theory proper he has depended chiefly on the unusual combination of two concerns, namely, psychometrics and psychiatric phenomena. By means of factor analysis, a highly sophisticated mathematical technique intended to discover the significant underlying variables which determine empirical (observable) variables, he has distinguished and described three dimensions of personality structure—introversion, neuroticism, and psychoticism—which provide a basis for the typing of individuals.

Cattell

Cattell's comprehensive factor analysis study of personality[11] exemplifies the growing tendency of researchers who prefer scientific rigor —quantification and mathematical treatment of data—to tackle the molar psychological problems. His approach is in terms of traits, but, unlike Allport, he works chiefly with common traits; unlike Eysenck, he strives to establish a score of traits rather than only a few; and unlike Murray, he emphasizes experimental more than clinical methods. His theory is elaborate, and the relations between constructs and data are close-knit.

Dollard and Miller

In the thirties the question of how learning takes place became a major preoccupation of psychologists in this country. Stimulus-response theories (as distinguished from "cognitive" theories) of learning may emphasize conditioning by association (contiguity) or by reinforcement (reward, law of effect). Hull[18] represents the latter, and Dollard and Miller[13] have elaborated and applied Hull's theories to the most complex issues of personality, including psychotherapy. Psychoanalytic, social, and anthropological theories and data also inform their theory and experimentation.

Sears

Sears, who is outstanding in his interest in the experimental testing of psychoanalytic concepts,[32] is a stimulus-response theorist who has become critical of the study of the individual in isolation and advocates dyadic units —the individual in relation with another, or others—as the unit of study.[33]

Mowrer

Mowrer,[22] also a stimulus-response, reinforcement, learning theorist, has overcome a limitation that is very widely characteristic of nonpsychoanalytic theories by recognizing that anxiety, as well as primary drives, may constitute a form of reinforcement. He has also occupied himself with problems of language and of psychotherapy.

Rogers

Unlike most nonpsychoanalytic personality theorists, and as much as any analytic theorist, Rogers[30] focused originally and still focuses closely on the psychotherapeutic process. In client-centered therapy (originally nondirective therapy) the main function of the therapist is to communicate his continuous imaginative empathy with the vicissitudes of the client's feelings. Rogers' explicit systematic theory of personality appeared after extensive clinical

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experience, and since that time the development of theory and of therapy have been kept intimately interrelated. The viewpoint is a phenomenological, organismic, self-theory, and the chief concepts are the organism (the total individual), the phenomenal field (the totality of experience), and the self (a differentiated part of the phenomenological field which consists of the individual's picture of and evaluation of himself).

Murphy

Murphy has made extensive contributions to general, historical, and social psychology. His wide sympathies and encyclopedic knowledge are manifest in the creative eclecticism of his theory of personality[27] which, as Hall and Lindzey say, "includes most, if not all, of the common and familiar concepts, principles, and postulates of modern psychology." At the opposite extreme from purely psychological theories (for example, Lewin), his "biosocial approach" not only makes extensive use of biological, social, and anthropological findings but, as far as possible, interrelates them with the psychological phenomena, topic by topic. Methodologically, he prefers rigorous experimental methods where they are available or applicable, but he encompasses the most inclusive issues with whatever less rigorous means are available.

Buchler

Buchler[10] is technically a philosopher rather than a psychologist. He is listed here because his philosophy is, among other things, an elaborate theory of personality. Furthermore, it has a "field" emphasis which makes it congenial to many psychological theories of personality. His "proception" and Allport's "propriate functions" both emphasize the dynamic-process aspects of what other theorists call the "self," as distinguished from its static structural aspects. Both are attempts to account for the integrative functions of the personality without resorting to reification, without the positing of a homunculus. Buchler's "proceptive domain" and Angyal's "biosphere" are similarly homologous; both are conceptual means of representing the psychological world of the individual and thus taking account of the inextricable wholeness of organism-environment.

¶ Some Major Issues in Personality Theory

Scope

Theories of personality vary widely in scope. Theorists who strive to be thoroughly comprehensive and systematic (for example, Murphy, Murray) deal explicitly with the score or more of major issues which have emerged in the history of personality study, and interrelate the positions they take regarding them in a coherent fashion. Others concentrate on the issues they consider most important and subordinate or neglect the others, or fill the gaps with borrowings from other theories. Early psychiatric and psychoanalytic theories were theories of various mental conditions—they did not pretend to be theories even of the *abnormal* personality. Psychoanalysis, however, developed into a theory of personality. Because it sees neuroticism as ubiquitous, it considers its principles applicable to both abnormal and normal personalities. Psychoanalysts have been accused of too readily applying their "abnormal psychology" to normal persons. The socially oriented analysts (for example, Fromm, Horney), who believe with L. K. Frank that "society is the patient," consider that statistical normality in our pathogenic society is, from a transcultural point of view, abnormal. Rank, and many others since, considered the neurotic to be humanly superior to the "normal average" individual on the grounds that the latter has accepted the truncation of his personality in the interest of adjustment whereas the former was still struggling for fuller selfhood, though unsuccessfully. Some academic theories of personality apply chiefly to normal personalities; others attempt to explain both normal and abnormal personalities by the same set of principles (for example, Murphy); still others (for example, Allport) are based on the

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assumption that the differences between the abnormal and the normal are great enough to require a high degree of differential consideration.

The Definition of Personality

A definition offered by a theory of personality is a summary of the theory, and the whole theory is an attempt at a more complete definition. Allport[5] was able to collect fifty significantly different definitions, which he grouped into classes and analyzed. For general purposes it would be useful to have a definition on which all would agree, but this is impossible to achieve. For instance, Stagner ("Personality" in the *Encyclopaedia Britannica*) proposes the following: "Personality is the characteristic way of thinking and acting which identifies each person as a unique individual." At first blush this definition would seem innocent enough to secure universal acceptance. Yet many would say that it deals with only one of the two different but indispensable references of the term; that it embraces the particular but not the general aspect of personality. Furthermore, many believe that only the general aspects of personality are amenable to scientific study. Then, extreme behaviorists might consider that "thinking" is superfluous since "acting" (behavior) is all-inclusive, or misleading because behavior alone can be approached by rigorous methods.

Although it is generally accepted that no definition of personality is generally accepted, the fact is variously explained. There are those who believe that it is due to the immaturity of personality science; others believe it to be a permanent state of affairs due to the nature of personality or to the irreducible differences in philosophical outlook (Allport) or basic psychological structure (Jung) on the part of personality theorists.

It may be that one definition of personality is more useful than another for a given kind of preoccupation with personality. Certainly one definition is preferable to another for epitomizing a given theory. Thus, a definition of personality is less a source of knowledge of the truth about personality—even the most general and essential truth—than an indicator of the outlook and ability of its author.

Structure and Function

These two aspects of living organisms are recognized by all theories, but some emphasize the one, some the other. The structural emphasis tends to go with a cross-sectional interest in the interrelation of traits at a given moment or period of life; the functional emphasis tends to correlate with an interest in developmental stages that distinguish one age level from another. A complete theory will deal fully with both and will integrate them closely.

Unconscious Processes

Biologically minded theorists tend to think of unconscious processes as physiological rather than psychological activity. Those with a cultural, interpersonal, or psychological emphasis consider them psychological in the sense of their being more usefully describable in terms of conscious mental processes, the essential difference being the fact that they are not in awareness. There are differences also regarding the extent and importance of unconscious processes as compared with the activity of consciousness, some theorists emphasizing one and some the other. Then, there are those who believe that unconscious processes are extensive in neurotic but not in normal personalities. The content of unconscious processes may be thought to include various combinations of the following: (1) native instinctual tendencies which are enduring, while it is their expression which is modified by experience; (2) relatively plastic tissue tensions which are basically modified by experience; (3) unsymbolized notions which took form before the advent of speech and so cannot be cognitively recalled; (4) bad impulses, or (5) good impulses, or (6) both, which are repressed or dissociated.

Organism-Environment

Differences exist according to whether personality is conceived of as being structured

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primarily by biological or by environmental influences, but all theorists recognize both factors as influential. In practice, one or the other sometimes does not get explicit consideration. The way the interrelation of the personality and its environment (including, especially, other personalities) is represented by a theorist is a large and important part of the theory.

Learning Theory

For several decades, learning theory has probably attracted more sustained and ingenious attention from psychologists in the United States than any other aspect of personality. Varieties and subvarieties of learning theories are numerous, and experimentation is voluminous.[17] The lack of attention to the learning process among psychoanalytic theorists and sometimes among the more clinical-minded academic theorists is more apparent than actual. The fact seems to be that academic theorists (other than the clinically minded ones) deal microscopically and experimentally with learning, while clinicians deal with it macroscopically and clinically. The latter are occupied with learning—whether the term is employed or not—when they trace the molar sort of learning of attitudes and traits to various sorts of familial attitudes and atmospheres that are experienced during the formative years. (This emphasis on molar aspects of personality, as distinguished from molecular aspects, characterizes this group rather generally, for example, the theory of developmental stages. Compare Sullivan and Erikson with Gesell.)

The Identification of Motives

We will mention only two issues involved in the all-important matter of motivation—the basis of motivation and the question of the number of motives posited. A fundamental source of various secondary divergences between different theories is the issue (often not explicitly formulated or dealt with) of how profoundly and permanently the organic inheritance is modified by postnatal experience. On the one hand there is the assumption that the instinctive equipment is "tough" and persistent in its structure and that a psychological layer of personality is grafted on to it, by experience. The alternate view is that the inherited "preferences" of the tissues are "tender" and highly malleable, though within limits. The former put more emphasis on the constitutional determination of personality and the latter on the social. The latter, consequently, view the psychological level of existence as a genuine emergent, though not necessarily, nor often, in the sense of historic vitalism (cf. Ref. 27, p. 35).

In the past, motives were considered to be rooted in a limited number of instincts which were modified by experience. Social psychologists, particularly, felt the need of lists of sentiments (McDougall) or basic wishes (Thomas and Znaniecki) to explain, by their combinations and modifications, the varieties of human activity. Today only a few psychologists attempt to specify a definite list of motives, and when they do, they usually classify environmental need-satisfiers as well (cf. Murray). Many theorists assume one need—the vital need of the organism to maintain and enhance itself, or an unspecifiably great number of highly individual needs that are structured by the interplay of the particular organism with its particular environment. This situation is the result of the general contemporary realization that the inner sources of motivation are numerous; that they are, for the most part, impossible to locate anatomically; that they have many permeable boundaries between them, so that they are partly separate and partly convergent; and that their relation to each other may change momentarily or with time. But this is not all; the matter is further complicated by the fact that motives are organism-environment integrations. A motive is the integration of an inner impulse with a specific environmental object or class of objects, or qualities; it is learned, and it may be temporary or permanent.

The Psychological Environment

There are as many psychological environments as there are individuals because the psychological environment of a particular individual is the world as perceived by him. This

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is the world he acts upon and to which he reacts. All theorists take account of this, but some give it much more attention than do others. In the relatively healthy personality the psychological environment and the objective environment are relatively congruent, and the mentally healthy person can progressively correct errors in his psychological environment by experiencing the frustrations which are caused by his misperceptions. In the neurotic or psychotic individual the disparity between the world as it is and the world as perceived is great, and since it is great because the individual has an urgent need for his psychological world to be as it is, clinicians emphasize the need of self-correction by psychological means rather than by logical confrontation with the real world. This is probably a reason why some clinical theorists have a strong phenomenological outlook and give little explicit attention to the objective world. Psychiatrists and psychoanalysts seldom use the term "psychological environment," but the concept is inherent in their concepts of projection, transference, parataxic distortion, etc. In fact, the psychoanalytic emphasis on such phenomena, together with the success of projective diagnostic tests, is a major reason why the psychological environment is recognized as important in most theories of personality.

The Self

The concept of the self was abandoned (as well as the soul and other synonymous terms) by experimental psychologists during the early decades of scientific psychology because of its association with theology and philosophy and because of its unamenability to experimental studies. It was left to philosophers and to European—and some other—psychologists who made no sharp break with philosophy. Its prominent place in United States psychology today is a testimony to the emergence of the psychology of personality as a field of scientific endeavor. Some theorists use the term "ego" as others use the term "self," some use both terms, and some use both terms in a manner directly opposite to their use by others. The concept (or concepts) under consideration refers in all cases to central, integrating structures and functions of the personality, and the problem is to define it so that it will perform that service without the reification of a more or less integrated group of functions—that is, without positing (whether explicitly or not) a homunculus, and without making it impossible to explain segmental and part functions and, particularly, molar conflicts and multiple personalities.

Field Theory

Psychological field theory was borrowed from the field theory of physics. Its characteristic feature—the representation of phenomena as a field of forces, constantly changing, according to laws of process—renders it capable of vividly and economically representing, simultaneously, the intra-organismic field, the extra-organismic field, and the processes which take place between them in the field which includes both. Several factors—the extreme complexity of personality as currently viewed, its constant change in minor structure and continual though more gradual change in major structure, and the constant, intricate interaction of organism and environment (including other organisms)—have led many psychologists to utilize field theory to conceptualize psychological processes. Some, however, make more use of it than do others, or are more explicit in the use of it.

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The following list includes the titles of several books each of which surveys a number of theories of personality, including the theories of the psychoanalytic schools. Since this handbook contains separate chapters on the major psychoanalytic schools of thought, books restricted to the exposition of a particular psychoanalytic school are not included here. Consequently, the list consists chiefly of volumes each of which presents a single influential "academic" or nonpsychoanalytic theory current in the United States today. The list is highly selective, consisting generally of only one or a few volumes on each theory. The principle of selection was comprehensiveness and recency.

As for the surveys, Munroe[24] presents excellent empathic expositions and critiques of Freud, the major "Freudians," Adler, Horney, Fromm, Sulli-

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van, Jung, and Rank. Hall and Lindzey[16] present excellent expositions of Freud and the other psychoanalytic schools mentioned above, except Rank, and most of the nonpsychoanalytic theories represented in the following bibliography. They give a biographical sketch of the author of each theory, indications of the major research inspired by each theory, the chief criticisms directed against it, and finally a summary of general trends in personality theory today. In *Perspectives in Personality Theory*, edited by David and von Bracken, twenty-two leading authorities survey various psychological topics and methodologies as well as summaries of personality theory in Germany, Switzerland, Britain, Italy, and France. Gardner Murphy's *Personality* presents his individual contribution to personality theory, but it should be mentioned along with the surveys because, in accordance with his principle of creative eclecticism, he draws widely and explicitly on all the schools, including the psychoanalytic (up to 1947). The *Annual Review of Psychology*, published since 1950, has a 20- to 25-page section on personality. The authors of this section (listed below) are, in chronological order, 1950–1956: Sears, McKinnon, Eysenck, Bronfenbrenner, Child, Nuttin, and McClelland. The monthly, *Psychological Abstracts*, which epitomizes psychological books and journal articles on a comprehensive and international basis, has a section on "Complex Processes and Organizations" which includes a subsection on "Personality."

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CHAPTER 5

THE FAMILY OF THE PSYCHIATRIC PATIENT

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IN A VERY REAL SENSE it may be said that the study of the family as a significant system in its own right has no history, no body of commonly accepted concepts, and no established findings. This is especially true in regard to the topic of the family of the psychiatric patient. This does not derive from any lack of concern or activity. Social workers, psychoanalysts, psychiatrists, psychologists, marriage counselors, educators, sociologists, and anthropologists have all taken an interest in the family of the patient, but, despite the strong interest, the family as a unit has consistently failed to come into focus. Isolated aspects of the total picture—selected traits of the relationship of parent and child, or of siblings, selected situational or psychodynamic factors —have been extensively investigated, but such subrelationships are almost always dealt with out of context, as if the family-as-a-whole did not exist. Thus this topic cannot in any sense be described as an organized field of research, of practice, or of conceptualization.

¶ Introduction

We feel that it is important to view this paradox of the lack of identity of the patient's family as a *field of inquiry* coexisting with the topic's widespread appeal to various disciplines in the perspective of American society and its culture. The United States has always been a nation that was youth-centered and, in a romantic way, family-minded. In the last century these interests were embodied in a quasi-scientific form under the guidance of G. Stanley Hall.[86] "Genetic psychology" did not last as a movement among the enlightened public, but the underlying values remained, reappearing as a concern with the child and his family by various family-service societies,

and more recently the child-guidance movement.

The themes of service and welfare have also been important. These sprang from the idea that it was the charitable duty of the wealthy upper classes to help immigrant and impoverished families by teaching them the values of thrift, hard work, and independence. It sprang, too, from the idea, largely implicit, that people can be changed by changing their environment. This environmentalist point of view is expressed not so much in explicit formulation and theory as in active attack, usually through organizational effort, on whatever aspect of the social milieu is presumed to be the cause of unhappiness or disability. This active amelioration tended to be in conflict with the organismic viewpoint, also held, that human distress can be alleviated only through the modification of the physical and psychological processes within the isolated individual.

General Historical Background

The history of the development of this still uncrystallized field reveals these divergent themes. A brief review of this history will give a better understanding of the current situation. In the first decade of this century, Adolf Meyer, protesting against the organic and nosological rigidity of nineteenth-century psychiatry, advanced the revolutionary idea that mental illness was a failure in the adjustment of the person to his situation. In a broad but vague way he called for more attention to the patient's family in the diagnostic work-up,[140] in treatment,[141] and in post-hospital settlement.[139] His "common-sense approach," however, never was formulated as a specific theory of psychopathology and its treatment. With no conceptual guides to link the person with his situation, individual psychiatrists were left to center their attention on the disturbance in the one or the other. This was the beginning of a characteristic polarity in American psychiatry. For example, the work of William Healy initially concentrated upon the individual delinquent or disturbed child. Later, as information about the causes of delinquency accumulated, there was a swing in attention to the home, the family, the neighborhood, and the school.[89]

During the second decade of this century, social work carried the burden of interest in the family. Psychiatrists, occupied with individual patients in private practice or in mental hospitals, were able to ignore the patient's family, but social workers were early forced to recognize the impact of the family when they tried to help clients adjust to their environment. But even in the practice of social work, the significance of the family was less than fully established, and integration at the level of theory was lacking. Mary Richmond,[178] in her well-known monograph *Social Diagnosis* (1917), scolded her colleagues for paying insufficient attention to the family-as-a-whole. Much earlier, in 1890, Zilpha D. Smith had enunciated the idea of the family's significance, saying "Most of you [referring to the general run of social workers at the time] deal with poor persons or defective persons as *individuals*, removed from family relationships. We deal with the *family* as a whole, usually working to keep it together, but sometimes helping to break it up into units, and to place them in your care"[178] (p. 95). Despite these practical principles, social workers, too, tended to lose track of the family unit as interests swung from the environment to the individual and back. When, in the early 1920's, psychoanalysis was introduced into the curriculum of schools of social work, social workers underwent another, and very significant, reorientation in their thinking and techniques with respect to the family. This reorientation brought the family case worker closer to the interests and methods of the psychiatrist.

The child-guidance movement, born in the early 1920's, reflected these swings of interest. In the early stages social workers, the most sophisticated members of the therapeutic "teams," played an important role in giving a dynamic focus to emotional problems and in having the empirical techniques for investigating the environment. The approach at that time was for the guidance clinic to make a diagnosis and then work out a plan with the family and community agencies, through

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which the problem was to be relieved.[215] Only later, when this approach proved inadequate, was direct psychotherapy with the child attempted. By this time the psychiatrist had emerged as the member of the team with the most authority and responsibility. As the movement progressed, a compromise between the environmentalistic and the organismic poles developed; this was the principle of working with the parent. In practice this meant that some relationship with the mother was established. The father was seen infrequently, if at all.[165] Once again partial and arbitrarily selected subrelationships within the family were dealt with, while the family-as-a-whole was neglected.

The reasons why the family was continually being recognized as significant but was always eluding the grasp of theoreticians and practitioners alike are very complicated. The problems of the forced and inhibiting compromise between attending to the individual and attending to the family at the procedural level, and the lack of adequate conceptualization of the interrelations between the family and the individual at the theoretical level, are undoubtedly part of the picture. There seems, however, also to be some resistance among investigators which makes it difficult to maintain the focus on the family unit. This resistance is illustrated in the first round-table discussion of the American Orthopsychiatric Association. A psychiatrist, a social worker, and a clinical psychologist spoke, in this panel discussion, about treatment of behavior and personality problems in children. Alone among the three discussants, the social worker, Charlotte Towle, dealt with the problems and the family in a dynamic fashion. She was articulate and direct concerning the family, saying in part, "Treatment cannot be given to any member of the family without affecting the entire group. In some cases the entire family must be drawn into treatment. Approach to this or that member, or centering treatment on a certain individual, cannot be a random thing"[225] (p. 582). The prolonged discussion that followed dwelt largely on whether notes should be made in front of the patient. No reference to Towle's ideas was made at all. The whole issue of the dynamic formulation and handling of family relationships simply dropped out of sight.

By 1930 the main features of the variety of approaches to the family of the patient which have come to characterize the literature were already in evidence. There were two significant areas—psychoanalytic theory and sociological theory—whose interaction has had a profound influence on the present state of the field.

The Influence of Psychoanalytic Theory

The continually growing interest in psychoanalytic theory has had a definite but very complicated and ambiguous influence on professional attitudes toward the family of the psychiatric patient. The complexities are in part due to the ambiguities within the theory itself, in part to the various ways in which professional groups have responded to psychoanalytic theory, and in part to the general American cultural tendency, already described, to become concerned with the possibility of environmental reform through organized action.

It is always difficult to discuss psychoanalytic theory briefly because of the great variation it has shown in the course of its own growth and development. Considering only the notions of Freud himself on the origins of psychopathology, ambiguities and discrepancies are detectable in his writings on theory, his case histories, and his writings on applied psychoanalysis.

Freud called attention in several ways to the impact of the family upon the potential for healthy or pathological development of the child. The theory of psychic trauma held that intense feelings of rage, love, or fear—precipitated in the course of interfamilial events—could become the focus of neurotic symptom-formation. In the theory of psychosexual development, the actual responses of parents, siblings, and other family members to the behavior of the child in each phase could, presumably, influence the ability of the child to resolve the pressures of conflicting internal forces. A third formulation was the concept

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of the Oedipus complex which, according to Freud, was the nucleus of every neurosis. Finally, the concept of identification stated that the development of the super-ego and, in part, of the ego took place through a process of internalization of the parents and other family members as objects of libidinal or hostile cathexis.

These four concepts would suggest that the actual configuration of the family and the behavior of its members would have an overwhelming effect upon the development of the child. In his theoretical writings, however, Freud took the opposite viewpoint. The seeming paradox was resolved by the importance given by Freud to the effect of the conscious, and more so the unconscious, fantasies of the child. The mind of the child could not accurately reflect the reality of the family environment, he felt. Rather, it reflected a highly elaborated and inaccurate version of that reality, distorted by the wishes generated by the unconscious instinctual forces which proved so difficult to control. Thus, while the influence of the actual reality of the family constellation was not ruled out entirely, it assumed only a secondary and contingent importance in Freud's formulations. The final effect of "accidental" or situational factors was always regarded as contingent upon their influence on the unconscious fantasy life of the child. Even the process of identification was, according to Freud, not the result of the internalization of a true and objective version of the parent but of a version of the parent created in fantasy.

While Freud, in his theoretical writings, tended to tip the balance in favor of the unconscious fantasy life of the child as the primary etiological factor, his case histories give a quite different impression. In one case[73] the details of the adolescent Dora's family setting included a mother with a "housewife's psychosis," an intermittently depressed philandering father, a hypochondriacal aunt, and a husband of her father's mistress who made sexual advances to her. It is difficult not to wonder how Dora would have turned out had she lived in a less complicated family milieu.

Similarly, in his more speculative and philosophical writings in the area of applied psychoanalysis, Freud[72, 74] frequently gave the impression that the disposition to neurosis could be laid at the door of the environment—whether pictured in terms of the family, the community, or the culture. Here, Freud tried to be impartial in assessing the part played by man's instinctual endowment and that played by the environment, but his ambiguity, indeed ambivalence, shows through. The finger of blame lingers longer on the external environment, and mysterious hints are dropped about the possibility of improving the hostile social milieu.

It was then perhaps inevitable that, with these ambiguities in the theory, psychoanalysis should have had an inconsistent and confused impact upon various professional groups in this country—especially in the area of their thinking and techniques with respect to the family. Psychoanalysts with adult patients found that the theory validated what they were already inclined to do—ignore the families of their patients. The psychiatric social workers in child-guidance clinics saw in it the confirmation of their views regarding the significance of the parental environment of the child. It explained the difficulties they were experiencing in persuading parents to adopt the recommendations made by the clinic after the diagnostic work-up of the child. It sanctioned their inclination to concentrate upon the mother as the person whose emotional problems were chiefly responsible for the social worker's difficulties. For those interested in mental hygiene, it justified the organizational energies which they wanted to expend on the public. Finally, it had a mild but definite impact upon those social scientists who were becoming concerned with the status of the family as a dynamic group. It is with this professional group that we must now concern ourselves.

The Influence of Sociological Theory

The family has long been a topic of great interest to sociologists and other social scientists. As early as 1909 the *American Journal of Sociology* devoted two full issues to papers on the institutional forms and social problems of the family. The interest in institutional

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forms—their origin and evolutionary development—was the traditional concern of family sociologists in the nineteenth and early twentieth centuries. Some facets of this social Darwinist interest struck responsive chords in American sociologists who were concerned with social problems and reform. In approaching the problems of low wages, urbanization, factory labor, women working, freer divorce laws, etc., sociologists were strongly and clearly committed to the environment as the explanatory factor and the area for active ameliorative attack.

At the time, families were seldom studied directly. Since no dynamic theory of personality was then available, there was little concern with the impact of the environment upon individual personalities or the intimate inner life of the family. Even if sociologists had been more interested in processes within the family than in its institutional forms, and if they had had the skills to carry out investigations in this area, the sentiment that the privacy of the family was inviolable, that "a man's home is his castle," would have deterred them. However, some concern with the fate of the individual and with the quality of family life was emerging.

During the first two decades of this century, social psychologists were grappling with the problem of how to explain the order and dynamics of social behavior. Lacking any sophisticated psychology, and oriented to the environmental rather than the organic pole, they developed the equivalent of instinct concepts in social instinct and imitation theories. Early in the century a philosophical and scientific interest in social explanations of personality-formation and behavior emerged.[42, 138] The culmination of these interests came in Thomas' formulation of the "definition of the situation."[220] These definitions of the situation, in the formation of which the family played a crucial part, were seen as the principle immediate determinants of behavior.

These developments, more social-psychological than sociological, were crystallized in an influential paper, "The Family as a Unity of Interacting Personalities."[31] Though Burgess was a sociologist, he formulated the "essential characteristics" of the family as "sentiments," "conceptions of itself," "social images," "super-personality"—all social-psychological qualities. This paper was widely read and established the chief themes in family sociology for the next twenty-five years. Burgess' paper appeared in a social casework journal, and it was eagerly taken up by social workers, who found it easy to fit into the psychoanalytic framework which they were developing. Academic social psychologists and sociologists were led more in the direction of the empirical study of selected narrow aspects—one might almost say traits—of the family through the medium of the questionnaire.

At the same time, American sociologists were becoming familiar with psychoanalytic theory.* The rather naïve, oversimplified version they assimilated seemed to fill a gap in sociological theories concerning the motivating forces of social behavior and social groups. Psychoanalytic theory seemed to contribute much to the understanding of the social problems in which sociology was deeply interested, such as delinquency and crime, labor unrest, and prostitution. This coincidence of interests was extended, and a new branch of sociology, labeled "social psychiatry," was developed.[190]

A few of the sociologists who became interested in psychoanalytic theory applied it to conceptions of the family.[69, 84] As with social workers, the tendency was to interpret psychoanalysis as contributing to an environmentalist position. Thus there was common interest between psychoanalytically oriented sociologists and social-psychologically oriented sociologists, and psychoanalytic conceptions became part of the language and tools of family sociologists. Psychoanalytic notions were added in an eclectic fashion and used as needed. No integrated theory was forthcoming, however. American sociology has had a strong antitheoretical bias, putting more value on sensitive empirical accounts than on systematic studies and theory building.

The economic depression of the 1930's threw into bold relief what had been seen throughout the 1920's—the problem of the adjustment of families to the social order.[150] In the case of

* Eliot[57] gives a comprehensive historical review of the early interests.

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the depression, however, the fault lay more clearly with the social order. Studies of adjustment were focused primarily on the concrete external problems of unemployment, poverty, poor housing, etc.[11, 15, 36, 115] This interest in adjustment to stress, shorn of its evolutionary implications, was dominant up to World War II and continued through the war.[96, 116]

During the same period in the 1930's, social psychological interests and methods remained strong, particularly in the field of marital adjustment.[32, 218] In pursuit of the practical goals of counseling married or engaged couples, questionnaires were widely used. These questionnaires consisted essentially of lists of traits that had been found to be statistically discriminating. Any theoretical grounding was absent.

In the postwar period some concern began to be shown over the fact that the study of the family had been tied so intimately to the problems of the day that no general conceptions and knowledge were being developed.[47] By this time the anthropological approach to cultural forms, functions, and values, and a range of comparative materials were widely familiar to sociologists. More sophisticated versions of psychoanalytic theory were also known. It became clear, then, that knowledge of many aspects of the family could be advanced only by the collaboration of psychologists, psychiatrists, sociologists, and related specialists.[80] For the sociologist the social-psychological bias is still strong, but these established conceptions and methodologies are being challenged.[29, 59] Some sociologists have become concerned that the sociological aspects of the family are being neglected.[95] Accordingly, more interest has recently been devoted to the family as a small group with determinate structures and processes common to all small groups. Attempts have been made to analyze the family in such a fashion and systematically to relate it to psychic processes, personality development, and broader social groupings.[159]

In many ways, sociological interests in the family have been analogous to the interests of psychiatrists and related professionals. The demands of doing something about specific problems have overridden the need for developing theory to organize observations and guide action. There has long been an awareness that the family is a group with a unity and a reality of its own, but this awareness has not been systematized. Despite its social-psychological bias, the stressing of the environment and the interest in marriage have provided a useful counterpoint to the psychiatric stressing of the organic pole and its focus on personality development. Throughout their recent histories, both disciplines have had a strong interest in the causes of mental disorder. Recently, as interest in the social context of illness and of medical organizations has developed, sociology has been in a position to make contributions more specifically pertinent to psychiatry.

The Family as the Etiological Agent in Mental Illness

As a result of these cultural and historical processes, the general impression was gained in this country that the family was in some way responsible for the disposition toward mental illness. The interaction between the typically American tendency to blame the environment for the production of personal unhappiness, the culturally conditioned response to psychoanalytic theory, the family-welfare societies, the growth of the mental-hygiene and child-guidance movements, and the influence of the theory and applied procedures of the social scientists produced an intense convergence of interest on the family as the agent of mental illness. As a result, from the 1920's to the present, there has accumulated an extensive literature seeking to assess the nature of the etiological relationships within the family. This literature has been found very difficult to appraise[173] because of the lack of consistency in its methods of procedure, its conceptualizations, and its findings. After an extensive review of the literature, we have reached the conclusion that its subject matter falls naturally into three groups: (1) the characteristics of parent-child relationships presumed to be productive of mental illness; (2) the structural aspects of the family, such as birth order and number and sex of siblings, presumed to

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be correlated with psychopathology; and (3) the influence of genetic or constitutional factors within the child, and the family's response to it. Each of these groupings will be discussed in order.

The Influence of Parent-Child Relationships on the Adjustment of the Child

Of the three groups mentioned above, this has received the most extensive investigation. We have reviewed and abstracted 85 articles in this area. This does not constitute an exhaustive coverage, but we believe that it is representative. It would be meaningless as well as impossible in the space available to discuss all these articles. We shall therefore limit ourselves to citing references illustrative of general trends and concentrate mainly on the problems inherent in the area.

There has been a tendency among the investigators to regard the psychopathology in the child as produced by, or correlated with, certain pathogenic characteristics in the parents. Whereas this has been the general point of view, the studies have varied along a number of dimensions. In approximately half of the articles reviewed, the investigators have attributed the difficulty of the child to one or more traits in the parent, which are seen as unchanging, permanent aspects of the mother's or father's personality and behavior. These traits are usually described by an adjective

TABLE 1. **Partial List of Pathogenic Parental Traits Identified in 85 Parent-Child Studies Published since 1930**

Abusive	Overprotective
Cold	Overtly rejecting
Controlling	Passive
Covertly rejecting	Poor self-adjustment
Dependent	Poor social adjustment
Domineering	Punitive
Emotionally unstable	Sadistic
Fearful	Successful
Hypochondriacal	Submissive
Inadequate	Uncritical
Masochistic	Underachieving
Narcissistic	Unhappy
Neurotic	Wavering
Overachieving	

TABLE 2. **85 Parent-Child Studies Published since 1930: Number of Studies with Selected Characteristics**

	DIFFUSE	SPECIFIC	TOTAL
Trait studies			
1930–40	*5 (71%)*	*2 (29%)*	*7 (100%)*
1940–50	*19 (86%)*	*3 (14%)*	*22 (100%)*
1950–57	*9 (64%)*	*5 (36%)*	*14 (100%)*
Subtotal	*33 (77%)*	*10 (23%)*	*43 (100%)*
Process studies			
1930–40	*6 (86%)*	*1 (14%)*	*7 (100%)*
1940–50	*10 (77%)*	*3 (23%)*	*13 (100%)*
1950–57	*14 (64%)*	*8 (36%)*	*22 (100%)*
Subtotal	*30 (71%)*	*12 (29%)*	*42 (100%)*
Total	*63 (74%)*	*22 (26%)*	*85 (100%)*

labeling the undesirable or pathogenic element in the parent. As can be seen from Table 1, the partial trait list culled from our sampling of the literature is long and varies in accordance with the specificity or diffuseness of the behavior presumed to be etiological. This table does not show, however, that most traits have been found by someone or other to be associated with every type of disturbance.

In the other half of our sample, the investigators have viewed the pathogenesis of the child's disturbance as the result of a process of on-going events between parents and child, and, in a few instances, of the dynamics of the interrelations throughout the family. For example, schizophrenia in a child is described as the product of a symbiotic process set up between mother and child, in which the mother regards the child as an extension of her own body or personality. As a result, the child is not able to regard himself as a separate, independent person, with his own identity, and is thus fixated in an oral stage of psychosexual development. These studies also vary, as in the previous group, in relation to the generality or specificity with which the pathogenic process is described. An interesting, though not unexpected, finding is a change in the distribution of these studies over the past three decades. Although the figures in Table 2 are only suggestive, because of the unknown relation of our sample to the total body of writing, they indicate that, whereas between

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1930 and 1940 the number of trait studies was about equal to the number of process studies, between 1940 and 1950 the trait type of study gained ascendence, only to have this relationship reversed in the current decade. They further appear to indicate a slight trend toward greater specification of the behavior of the parent in recent years, but the vagueness with which both traits and processes are identified remains one of the most prominent problems encountered throughout these studies.

Another factor contributing to the inconsistency of findings is the variation in research methods used in the investigations. The variation is so great and the methods in general are so questionable that it is difficult to know how to interpret the findings. We have distinguished three dimensions of variation in the articles we reviewed: (1) the use of large numbers of cases (30 or more) versus the study of the single case or at best a very small number of cases; (2) the use of subjective impressions derived from clinical case studies versus the use of objective or test measures; (3) the use of selected control groups versus studies in which no control group was reported. Unfortunately, we were unable to make these dichotomous discriminations with respect to all the articles reviewed, since some authors say nothing about the numbers of cases involved, while others say little or nothing about their methods. For this reason, the raw figures in Table 3 give only the most sketchy and inadequate view of the methods used. Nevertheless, they suggest that certain trends characterize the entire sample, while others differentiate the trait studies from the process studies. For example, in the whole sample, clinical studies far outnumber objective methods of study, and the studies lacking a control group are much more numerous than those in which a control group is used. On the other hand, trait studies use large numbers of cases more frequently than do process studies, and objective methods are, apparently, not used at all in process studies. In the trait studies, as the behavior characteristics in the parents become more specifically defined, the proportion of large to small number of cases rises, as does the proportion of objective to clinical methods of study. Most of these trends seem to be exactly what one would have expected from the nature of the research materials; the only surprise has been the finding that the process studies are equal in number to the trait studies and are apparently on the increase.

TABLE 3. 85 Parent-Child Studies Published since 1930, by Methodological Characteristics*

A. Number of studies by sample size

	LARGE SAMPLE	SMALL SAMPLE†	TOTAL
Trait studies	20	18	38
Process studies	6	24	30
Total	26	42	68

B. Number of studies by nature of data

	OBJECTIVE	CLINICAL	TOTAL
Trait studies	13	30	43
Process studies	0	40	40
Total	13	70	83

C. Number of studies by use of control group

	CONTROL GROUP	NO CONTROL GROUP	TOTAL
Trait studies	15	28	43
Process studies	2	40	42
Total	17	68	85

* Total numbers vary because of indeterminateness of characteristics of some studies.
† Small is defined as less than 30.

To report the actual findings of the studies of parent-child relationships and to evaluate them is, as we have said, extremely difficult because of the lack of systemization in the literature. Where trait studies are concerned, it would appear that the investigators have engaged in two lines of inquiry, each failing to interact with the other. Some investigators have attempted to identify the pathogenic traits in the parents of patients belonging to a particular symptom group. The parents of patients with schizophrenia, or with a neurosis, have been studied to determine what traits they possessed. A much smaller number of investigators have studied groups of parents exhibiting the traits so specified. There is little evidence in any of the studies of awareness of the nature of the over-all research problems being created by these procedures. Each investigator, with few exceptions, seems to have

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been content to start off on a line of inquiry which was provoked by his own clinical observations or which had been stimulated by a previous publication. In view of this almost random development of the literature, the most systematic plan of reporting the findings appears to be that of describing first the investigations connected with inquiry into the various symptom groups, as the dependent variable, and then describing the findings of the investigations of parental traits as the independent variable. Because the traits do not work out consistently for any symptom group, this will introduce much overlapping, but it seems the most orderly procedure. The symptom groups to be considered are psychosis, neurosis, delinquency and acting-out disorders, and psychosomatic illness.

Many different behavior traits have been ascribed to the parents of schizophrenic patients. Kasanin, Knight, and Sage[109] found parental overprotection and rejection to characterize 60 per cent of the parents of a group of 45 schizophrenic patients. Maternal depression, repeated traumas of separation, and inability of the mother to gratify the emotional needs of the child were found in a single case studied by intensive clinical methods.[172] In a study of 25 mothers of schizophrenic patients the mothers were found to be insecure, superficial, rigid, and domineering.[228] The fathers in this study were described as good providers but passive, and though aware of the mother-child problem, unable to do anything about it. Reichard and Tillman,[175] reporting 66 cases from the literature plus 13 of their own, found that parents fell into three categories:

1. Schizophrenogenic mother—overtly rejecting type.

2. Schizophrenogenic mother—covertly rejecting type. In this group the mothers dominate the child through overprotection, which occurs as a defense against the underlying hostile, rejecting attitude toward the child.

3. Schizophrenogenic father. This group of fathers is characterized by domineering, sadistic attitudes toward the child. Such attitudes represent both a defense against underlying weakness and a gratification of passive, dependent attitudes toward the wife and of rivalrous attitudes toward the child. The wife in such cases is overtly passive and dependent and ineffectual in handling the husband and child.

In none of the studies so far reported was a control group used. Interestingly enough, in two studies making use of control groups, the findings were opposite in direction. Prout and White[170] studied mothers of 25 male, hospitalized, schizophrenic patients and contrasted them with the mothers of 25 normal male subjects. They found very little difference between the mothers in the two groups. They were not able to find any difference with respect to overprotectiveness or oversolicitousness, but found that mothers of the normal controls showed a more frankly critical attitude toward their child, and a more gregarious and outgoing attitude toward life. In the other study[136] the mothers of 100 hospitalized, male, schizophrenics were compared with the mothers of 100 male medical cases. The mothers of the schizophrenic group showed a more restrictive, controlling attitude toward their sons, and tended to exhibit either cool detachment or excessive devotion.

Many of the above-mentioned traits appear in studies of parents of neurotic patients. In a study of the mothers of 25 children with conduct disorders and neurotic traits,[94] it was found that these mothers had experienced an unhappy childhood, exhibited neurotic, infantile traits, were generally inadequate as parents, had poor marital adjustment, and rejected their children without compensatory overprotection. In another study 142 neurotic patients were compared with a normal control group.[22] The parents of the patient group were rejecting in that they were unable to show love or affection toward the child or to receive it from the child. In addition, there was more conflict between parent and child and between parents in the patient group. In an investigation of the parents of 50 children manifesting stuttering and other articulatory defects, which made use of objective methods, it was found that the mothers were neurotic, submissive, and self-conscious, while the fathers did not differ from the fathers of normal controls.[237] A study of 12 children with school phobias found the

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family life to be characterized by emotional instability and conflict. The mothers were neurotic and fearful and the fathers were passive and dependent.[229]

In the area of delinquency and acting-out disorders, fewer studies of parental traits have been carried out. However, the results vary but little from the above groups. In an article entitled "Parents as the Makers of Social Deviates,"[23] Bonney states that rejecting parents cause various forms of deviance in the child. The parents of delinquents discriminate against them in favor of another sibling, while alcoholics have stern fathers and overprotecting mothers. A statistical study of 500 cases carried out at the Michigan Child Guidance Institute[94] correlated three behavior patterns in the child with the behavior of the parents:

1. Unsocialized aggression, in which the child showed violence, cruelty, malicious mischief and open defiance of authority, was correlated with parental rejection.

2. Socialized delinquent behavior, in which the child was on good terms with a delinquent gang but opposed the norms of adult society, correlated with parental negligence and exposure to delinquency patterns.

3. Overinhibited behavior, characterized by seclusiveness, shyness, and apathy, correlated with repressive overcontrol in the parents.

In contrast to the finding in Group 2 of the Michigan study, an investigation of the parental behavior of 21 adolescent socialized delinquents, using a questionnaire approach and a matched control group of normal adolescents, found that the mothers of the delinquents showed excessive control but little awareness of the child's feelings.[35] A study at the Bellevue Psychiatric Hospital of 65 children with head injuries due to accident proneness found the fathers of this group to be domineering and abusive while the mothers were overprotective, hypochondriacal, and masochistic.[61]

The familiar trait categories turn up again in the study of psychosomatic conditions. A study of 25 Jewish children with various eating difficulties found the families to be characterized by discord, the mothers being immature, domineering, punitive, and devaluating of the father. For their part, the fathers played ineffectual, undependable roles, some being submissive and others erratic and self-indulgent.[127] The parents of children specifically suffering from obesity also showed overprotection and domineering in the mothers and subordination in the fathers.[29] In a study of 63 children with allergic manifestation of all kinds, compared with 37 nonallergic children, 98 per cent of the allergic children had experienced maternal rejection, while only 57 per cent of the nonallergic children had had this experience. Similarly, 57 per cent of the allergic children but only 10 per cent of the nonallergic children had encountered maternal overprotection.[143] A new trait category appears in a well-controlled study of goal-setting (in a very specific context) in asthmatic children, which showed that these children set higher goals for themselves than do nonasthmatics, and that the mothers of asthmatic children set higher goals for themselves and for their children than do mothers of nonasthmatics.[124]

The investigations in which the trait behavior of the parents is treated as the independent variable are much less frequent than the sort just reported, and it is one of the weaknesses of the literature that such studies have not been more vigorously pursued. Some of the studies of parent groups appear to disprove the whole thesis of the significance of pathogenic parental attitudes. For example, an investigation of the social adjustment of the children of 19 neurotic mothers showed that these 58 children differed in no significant way from other groups of children. The author suggests that one reason for this unexpected finding may be that the fathers showed constructive attitudes toward the children.[129] In another study of children born in a mental hospital to psychotic mothers, Gardner found no neurotic or psychotic outcomes in the later adjustment of these children.[76] On the other hand, some studies, focusing intensively on a particular parental trait, have succeeded in demonstrating, within limits, a certain outcome. The best of these is Levy's[119] study of maternal overprotection. This study is a methodological classic. The author distinguished

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five types of overprotection: (1) "pure," that is, unmixed with rejection; (2) guilt overprotection, in which the behavior is compensatory to a desire to reject; (3) mixed cases; (4) mild overprotection, frequently indistinguishable from culturally conditioned attitudes; and (5) nonmaternal overprotection. For methodological reasons he discarded from his research sample all except the first type. Criteria for inclusion in the "pure" group were (1) a "wanted" child, and (2) directly observable and reportable acts of the mother indicative of overprotection. The sample of 20 cases remaining was then found to fall into two types —the dominating overprotective and the indulgent overprotective. In general, the overprotective attitude was found to be correlated with severe deprivation of parental love in the mother's own childhood, the child being used to satisfy the "affect hunger" which the mother had developed as a result of her own deprivation. The indulged overprotected children were disobedient and tyrannical at home, showing temper tantrums and uncontrollable behavior, but on the whole were well behaved in school and did well in classwork. They showed some sexual precocity but no severe problems in the sexual area. The dominated overprotected were submissive at home but had difficulty making friends, needing either to dominate or withdraw. Over half of the group had eating difficulties, but none had problems with sleeping or toilet training. The author reported in great detail the nature of the treatment problem with the child and mother, and concluded with a follow-up study of the subsequent adjustment of each child.

What Levy's study shows is that, when the criteria for the presumably pathogenic trait within the parent can be made sufficiently narrow and specific, and when it can be linked to factually observable behavior (in contrast to inferences about the parent's behavior and personality), a correlation with a specific type of pathological outcome in the child can be established. Even so, the outcome which can be predicted is not a strict one but constitutes, rather, a range of possible behaviors. On the whole, the review of the trait studies produces the impression that none of the parental traits held up for investigation can be correlated with a distinct and predictable pathological outcome, and that, while they may constitute a necessary condition, they certainly do not constitute a sufficient condition for the appearance of a specific form of psychological disorder in the child.

As a corollary to this statement, there emerges the distinct need for studies which inquire into the pattern of relations within the family over a period of time. In Levy's study, for example, the husbands of the overprotective mothers, both dominant and indulgent, were passive and unable or unwilling to intervene in the mother-child relations. This would seem to indicate that more activity on the part of the father—a less condoning attitude, for example—would protect the child from the pathogenic effect of the mother's behavior. But since Levy was interested primarily in the mother's behavior, this possibility was not subjected to investigation.

Interestingly enough, it seems quite likely that the process studies have been motivated by just this point of view on the part of the investigator. The aims of such investigations have been directed at elucidating the nature of the reciprocal responses of the various family members to each other in order to discover what patterns established over a length of time may be correlated with what pathological outcomes for the child. Through intensive study of a few cases, each investigator has attempted to discern such a pattern in the background of a particular child's emotional problems. Most of these studies are based on the psychoanalytic model of personality development and make considerable use of the interaction between conscious and unconscious mechanisms and their communication through implicit behavior. As a result, the possible number of patterns of behavior is very great, and the intricacy of each pattern described is so highly involved as to make comparison between patterns exceedingly difficult. In our review, we have found it impossible to codify the various constellations which have been described and to correlate them with particular symptomatic outcomes. Furthermore, as is evident from Table 3, the process studies make

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practically no use of control groups, so that it is impossible to know whether a particular pattern may occur in some families without being correlated with pathology in a child.

Space considerations preclude our giving examples of the various patterned processes which have been presumed to correlate with the different symptomatic groups. However, we would like to discuss a phenomenon which appears in the process studies and which parallels a similar characteristic noted in the trait studies. Just as with the latter, where the same parental trait, such as maternal rejection, is described for a variety of different symptomatic states in the child, so in the process studies, the same process appears in a variety of contexts. One which is repeatedly emphasized is separation anxiety. It has been described as constituting the core of the pathological interpersonal process in cases of school phobia,[103] stuttering,[70] psychosis,[211] psychopathy,[205] and asthma.[43] Although there is great variation in the network of processes established around this core, the anxiety of the mother with respect to her incomplete separation from and dependence on her own mother is held to be reactivated in her relations with her child. As a result, normal emotional development and maturation of the child are inhibited, overdependence and reactive hostility are stimulated, and reality testing is severely limited. In the context of this general process, the details of the mother's unconscious wishes are then related to the specific symptom developed in the child.

This brief comment cannot do justice to the extensive number and variety of hypotheses concerning the etiology of the pathological development of the child which were raised by the process studies. The cumulative evidence fails to correlate, in a convincing manner, any clear-cut, patterned process with a particular symptomatic outcome in the child. Nevertheless, the weight of the evidence, in spite of the lack of control groups, points to *some* relationship between the unconscious motivation and overt behavior of the parents and the emotional difficulties of the child.

One may well ask what needs to be done in order to clear up the vagueness and confusion about the precise nature of this relationship which presently characterizes the literature. At the very least, it would seem apparent that the confusion will persist as long as investigators attend only to partial relationships within the family. Lacking a stable perception of the family as a structural and functional unit, investigators vary greatly in what aspect of intrafamily relations they choose to study. Some will select the mother-child relation, others the father-child, a third, the husband-wife, and still others the mother's relation with her own mother. Since the family is actually an enduring system of interdependent relationships, none of these partial interrelations can tell the whole story. Because of the usually arbitrary way in which the partial relations selected for study have been chosen, there is no way of knowing whether the most significant set of relations within the family have been included or accidentally excluded from the investigation. This methodological problem is acute, and little hope of greater clarity and consistency of empirical findings can be expected until a large number of investigators become oriented to the family as a unit of inquiry and adopt a more orderly approach to the collection and interpretation of data. We shall comment further on these aspects of the methodological problem after discussing the studies devoted to structural, situational, and constitutional factors within the family.

Structural Aspects of the Family as Genetic Factors

A large body of literature, both psychiatric and sociological, deals with the incidence of various structural or situational characteristics in the families of patients. In general, these are statistical studies which seek to establish whether or not a particular structural or situational feature is correlated with a certain type of disease. With a few exceptions these studies attempt merely to establish a correlation between selected variables. Causal significance is then imputed to the independent variable. The causal nexus is left unexplored, in contrast to the process studies discussed above, in which the causal links are the main object of study.

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There are other differences set by the strategy of correlation. Correlational studies more often are made on large populations. If pathology is being studied, some identifiable patient population, such as all patients in a given hospital, all first admissions to a given facility, or all known cases in a given area, must be available. Since hospital populations are the easiest on which to secure standardized data, studies on the relationship of structural or situational factors and psychoses are most numerous.

The family characteristics that have received the most attention are those that can be readily determined. Primary among these have been birth rank, age, intactness of home, marital status, sex, and family size. It is difficult not to believe that such characteristics are important. There are deeply imbedded popular notions about their significance. The concrete findings, however, are not always encouraging, for contradictions abound, and, when consistency exists, it is found that the characteristic in question is related to many types of disease and thus has no differentiating power.

PSYCHOSIS

The correlations of family characteristics and psychoses have been widely studied for almost three decades. Hospitalized populations are usually considered. Sometimes no distinction is made between different kinds of psychoses. Other studies find differences in the correlations of family characteristics and schizophrenia (and even for different types of schizophrenia) and manic-depressive psychoses. In general, however, both types are related to the same structural features.

It is clear that married persons are less frequently psychotic than single persons, divorced persons, or widowed persons.[10, 50, 63, 77, 135, 156, 157, 182] This advantage for the married may, however, be explained in several different ways; it may be, as Durkheim[55] suggested, that, in general, the state of marriage exerts a controlling force on the married persons. Alternatively, it may be that psychotics or psychotic-prone persons are less likely to marry at all.[185] The selection hypothesis is strongly advocated at the present time.[156, 157, 162] It is difficult, however, to account for the great disadvantage to the divorced and widowed, who were once married, within the terms of the selection hypothesis.

This pattern of advantage for the married over those in other marital statuses is not constant. It varies with sex, age, and diagnostic category. Males generally have less advantage than females; they are more likely to be single if psychotic[135] and more likely to be schizophrenic if single.[63] At the same time, sex is related to type of psychosis, women being more prone than men to manic-depressive psychoses.[41, 89] Nor is the influence of marital status independent of age. Rates of hospitalization generally increase with age, and the pattern of relative advantage for different marital statuses shifts. Females evidently lose some of their advantage in connection with proneness to schizophrenia.[133] Thus the picture is complicated. Age and sex and marital status are to some extent related, so that part of the relationship that is found between marital status and disease proneness may be due to age and sex differences.

Many studies have tested the relationship of birth order and psychosis. There is no definitive evidence that birth order is related to psychosis.[50, 51, 84, 232] At the same time, there is evidence that sibling position is an important factor,[191, 195] though Patterson and Zeigler[160] contradict this. Since birth rank and sibling position are related (for instance, one cannot be the eldest of three children without also being the first-born), these findings are not readily reconciled. Roberts and Myers[179] have recently suggested that the effects of ordinal position vary by social class. A similarly contradictory picture is found regarding family size and psychosis. Wahl[232] found the families of schizophrenics consistently larger, but Dayton[51] found that family size of patients' mothers was smaller than normal.

By far the most effort seems to have gone into the investigation of the relationship of the broken home to psychosis. Oltman, McGarry, and Friedman,[158] who had a control group of sorts, were unable to find the differences that others claim, and conclude ". . . the incidence of dementia praecox is unrelated to known external stresses or deprivations"

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(p. 693). On the contrary side there is a great deal of evidence, which Wahl[232] has reviewed. Wahl's study is exceptional in that he attempts to develop a consistent theory of the dynamics of identification in the face of the loss of love-objects at various stages of maturity. Such a theory might predict the effects of loss of one parent or the other by different means (death, divorce, insanity) at different ages. He notes, however, that many other disease types are related to broken homes, so that the broken home is not a very discriminating variable.

There is, finally, a study of the influence of spatial mobility of families and mental disorders. Tietze, Lemkau, and Cooper[222] found that mobile populations had a disproportionately high incidence of psychosis, but they are unable to say whether the mobility is due to the disorder or the disorder is due to the mobility. Similar arguments rage in sociology about the effect of isolation (compare broken homes) in the development of schizophrenia. It has long been noted that the incidence of schizophrenia is highest in the areas of large cities in which the highest proportion of familyless persons live, and a "social" isolation theory of schizophrenia was developed.[62] This theory, though many studies have supported it, has been challenged by Kohn and Clausen.[114]

Neurosis

Though the most studies have been made of psychoses in relation to family structure, neurosis has come in for its share of consideration. In studies of neurosis the populations investigated are more usually children. We shall consider in this section not only studies in which a psychiatric diagnosis of neurosis has been made but also those which judge neurosis on the basis of various psychological tests and those which deal with clinic populations without specifying the disorders further than saying that they are "problem behavior" or "behavior disorders."

Since adult populations are less frequently studied, there are few reports on the relationship between marital status and neurosis. The only study dealing specifically with this relationship was that of Downes and Simon,[53] who found a high proportion of single persons among a group of neurotics.

The evidence regarding birth order is mixed. Some have found the oldest child less neurotic.[1, 120, 184] Norton,[153] however, found that higher birth orders are more neurotic, and Sewall[193] and Wile and Jones[236] concluded that birth order is not important. The effects of birth order may well be related to family size, another aspect of sibling position. Fisher and Hayes[66] found that if there are three children or more the oldest and the youngest are most maladjusted, and Hayes[88] reported that the more siblings a child had, as long as she had one, the more neurotic she was. Levy,[120] on the other hand, found that the distribution of problems is independent of family size.

Data on birth order may also (usually) be ordered in terms of sibling position, and many studies talk not about the effects of being first, second, etc., but about the effects of being youngest or oldest. Adler's "spoiled, only child" turns out to be no more neurotic than other children.[1,100] Holman[98] concluded that only children are neurotic, but mainly because of the higher incidence of broken homes. The conclusions about children with siblings range widely. Fisher and Hayes[66] and Wile and Jones[236] found that the oldest and youngest in the family of three or more children are more neurotic. Rosenow and Whyte,[184] however, found the second child in the three-child family more often treated in clinics than the third, and Sewall[193] found that this middle child is more often jealous and that the age difference between siblings makes a difference in jealousy and rivalry.

A similarly confused picture exists concerning the effects of broken homes. Friedlander[75] has maintained that broken homes are infrequent for neurotics. Oltman *et al.*[158] found that neurotics have more often suffered broken homes and parental deprivation than have those with other disorders, and Holman[98] has suggested that broken homes are important. Madow and Hardy[131] reviewed the literature and concur, but Norton[153] disagrees. Tietze *et al.*[222] concluded that frequent moving is related to neurosis.

It is consistently found that boys appear

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more often in guidance clinics than girls,[120] but Wile and Jones[236] did not find differences between the sexes in the incidence of maladjustment.

Delinquency and Acting-Out Disorders

The acting-out disorders that have been studied and correlated with family characteristics are principally delinquency, in the case of children, and alcoholism, in the case of adults. Since delinquency, as officially recognized, is largely a lower-class phenomenon,[84, 126] the findings may be generalized only with caution. Alcoholism, too, may be subject to similar types of bias in reporting. Birth and sibling position have been investigated much more than other factors. Higher birth ranks have been found to characterize alcoholics more often than would be expected by chance.[14] Mowrer[151] found that alcoholism clusters in the oldest and "socially" next-to-youngest (that is, though in fact the youngest, another sibling is treated as the youngest) sibling positions.

As with other disorders, alcoholism is correlated with marital status. Married males have a consistently lower rate.[13, 167] Amongst those ever married, those still married have a lower rate than the divorced, separated, or widowed.[12] Women have a much lower rate of alcoholism than men.[12] One early study[167] found, however, that married women were overrepresented relative to the total population. Marital status, then, has different effects upon alcoholism rates, depending on sex.

Being an only child disposes one to delinquency according to Levy[120] and Ward.[234] Sletto[201] reviewed the considerable body of literature that existed even in 1934 and showed that the findings were very mixed. His own research revealed no overrepresentation of only children in a group of delinquents. The Gluecks[80] found that fewer delinquents were only children. They also found that delinquents were less often first-born or youngest children than would be expected. According to Sletto,[202] the effects of sibling structure are complex. He has identified 30 different combinations of sex and birth rank and found that different constellations had different effects on delinquency. For instance, delinquency is high when the individual has younger siblings of both sexes, but low when there are older siblings of both sexes. It is higher if the older sibling is of the same sex and the younger sibling is of the opposite sex than if the reverse is true.

There is, according to several studies,[80, 126] a relationship between family size and delinquency, with delinquents coming from larger-than-normal families. Since there have been class differences in family size, and delinquency rates vary by social classes, the relationship may be due to class rather than family size.

The idea that broken homes cause delinquency is strong in the lay mind. There is much evidence to support this view, dating from 1912[26] to the present.[146] The findings, however, are highly variable, owing at least in part to methodological problems of selection. Shulman[197] reviewed the literature and concluded that the broken-home hypothesis may be a good one but that it is so broadly conceived as to be of little use. Toby[224] has recently examined Shaw and McKay's[194] data, often interpreted as disproving the broken-home hypothesis, to show that the data actually support the hypothesis in the case of adolescents but do not hold for preadolescent males or females. Toby has adduced further current data to show that there is thus a differentiated impact of broken homes on males and females and on different age groups.

Psychosomatic Illness

We have located only two studies of psychosomatic disorders, as related to the structural characteristics of the family, that have large enough samples to be considered. Kingsley and Reynolds[110] found that patterns of illness, some of which might be considered psychosomatic, differ by ordinal position. Only children have many gastrointestinal upsets, skin disorders, feeding disturbances, constipation, asthma, and allergies. First children are high on constipation and feeding disorders.

Second children are high on respiratory and ear infections, tonsillitis, diarrhea, accidents, and enuresis. These authors were not specifically investigating psychosomatic disorders, but there is suggestive evidence that ordinal position is important.

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Vincent[230] has studied the loss of parents in a population with diagnosed psychosomatic disorders. He found that 68.5 per cent had lost one or both parents. No control population was used, but undoubtedly this is a higher incidence than could be expected by chance.

General Appraisal

When presented with such diverse, sometimes contradictory findings, it is easy to dismiss this approach as unhelpful. The study of situational and structural factors as they relate to mental disorders is, in essence, a trait approach. As in the study of traits of the parents or their personalities, correlational studies do not lead to conclusions in which we can have much confidence and which have much power to discriminate between various disorders.

Still, on several grounds it is difficult completely to reject the approach. Correlations do appear, and some with a moderate degree of consistency. The possibility exists that, with more rigorous methodological techniques, some more stable conclusions could be arrived at. It is difficult, on the grounds of personality theory, too, to conclude that loss of a parent or other love-object, age, sex, sibling position, marital status, and such characteristics would have no effect upon an individual's development, pathological as well as healthy. Psychoanalytic personality theory, however, premises its conclusions not on the basis of some objective characteristics in itself but rather upon the subjective feelings that are associated with the characteristic. It may be that not the formal but the affectional structure is the significant area which requires investigation. It would be expected that these two types of structure would be related, but perhaps they are not closely enough related that the formal structure can be used as a reliable index of the affectional structure. In clinical case studies, any disparity can be recognized and taken into account. In the larger scale correlational studies, the same sort of corrections cannot be made. The investigation of affectional structures is, of course, a more complex and difficult procedure than the identification of formal characteristics, but some progress in this area has been made.[90]

In the present state of affairs, it can only be said that such formal characteristics *may* be conducive to a particular disorder of some sort. The crucial question of how and under what conditions such characteristics do or do not have specific effects cannot yet be answered, but must await more comprehensive studies of greater methodological and theoretical sophistication.

Methodological Comments

It might seem that correlational studies, measuring the incidence of two identified characteristics, should be straightforward and produce clear-cut results. However, as we have seen, there is a distressingly wide variance among different studies. Much of this variance can be accounted for in terms of the methodological characteristics of the studies. Since space limitations did not allow detailed comments on the methods of each study, some general remarks on methodological issues are appended here.

Measures. Different studies of the same phenomenon may use different types of measures, with the result that the studies are not strictly comparable. One study of the incidence of a given disease may measure the proportion of a total hospital population with a given disorder; other studies may use the proportion of first admissions with that disorder, or the rate relative to the total population, say of a city, or the rate relative to the part of the population with given characteristics, or the distribution of cases over time, by age, or by sex. Each such measure is legitimate and proper for specific purposes, but if different studies are to be comparable and our knowledge is to be additive, there must be greater standardization of measures employed.

Populations and Samples. Some studies deal with total populations, for instance of a hospital, but without indicating what, other than availability, characterizes the population; others deal with some section or sample of a population without indicating what relation this sample has to what larger population. Any conclusions made should be stated only in terms of the group studied and should be extended only if that group is shown to be representative of some broader population. We find, however, that the restrictions in

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applicability of conclusions are almost never stated. Findings on some group of patients tell us nothing about all patients, unless we know that the group studied is a representative sample of all the patients. Similarly, the study of a group of patients does not allow us to make any conclusions about nonpatients, unless, again, the patients are shown to be representative of nonpatients in some ways. Sampling and the size of group needed to allow reliable results are technical matters on which a statistician's advice is desirable.

Control Groups. By using control groups it can be demonstrated that the variable studied makes a crucial difference in outcome. Many studies use no control groups at all; others select control groups on unknown or irrelevant grounds. Frequently, there is no conception of what is being controlled when a control group is used. A finding that 20 per cent of a group of disturbed children come from broken homes helps little if 20 per cent of all normal children with the same age, sex, class, and ethnic background also come from broken homes. Similarly, we prove nothing if some factor is found to characterize a group of psychotic patients and is not characteristic of hospital employees, unless it is shown that the two groups differ in no other way which could explain the finding. Again, the selection of control group and of variables to be controlled is a technical matter.

Interrelatedness of Variables. Most studies deal with one variable at a time, disregarding the context of the variable. This failure to hold constant other significant variables can lead to spurious findings. Haldane and Smith[85] have shown, for instance, that some things explained by birth rank are really accounted for by maternal age, which, of course, increases as birth rank increases. Similarly, most of the findings about birth rank or sibling position are cast in doubt because age and sex were not held constant. Sletto[202] distinguishes 30 different sibling positions and arrives at quite different conclusions about delinquency for different positions. It may not be the fact of being first born or the oldest of three that is important, but the pattern of being a male oldest child in a family with three girls. The consideration of several variables simultaneously greatly complicates an investigation, but it is necessary if conclusions are to be valid and precise.

Theories and Hypotheses. It is clear that it is easier to establish correlations than to interpret them. Generally speaking, it is scientifically more efficient to have theories from which testable hypotheses can be deduced. If, on some logical grounds, it is predicted that some relationship should be found and it is found, then we have grounds for concluding that the relationship is real. If the explaining theory is sought after the finding is made, the likelihood that some explanation can be found is high. When theories of personality and pathogenesis are as well developed as they are, it is surprising that correlational studies so often seek findings and so infrequently test hypotheses. The theory that Wahl[232] attempts to specify about the relation of broken homes and pathology approaches the model of adequate science.

Some of these methodological comments, it will be noted, coincide with the comments made about trait and process studies of parent behavior. Many of us are not sufficiently aware of the relationship of conclusions to such technical issues. The cost in terms of vagueness and uncertainty is great.

The Family and Constitutional Endowment

Among the several functions of the family, one of the most important is the transmission of a particular genetic heritage. In an earlier era, genetic inheritance was seen as the decisive factor in mental illness, and the family, as the carrier of "bad genes," was the *bête noire*; famous studies of infamous families[54, 81] were made to support the theories of genetic determinism. Currently, such studies are regarded as dubious, but the old, false dichotomy of genetic versus environmental factors lingers on. The sort of evidence that leads some investigators to genetic conclusions[99, 105, 106] leads others[97, 168] to opposite conclusions.

A more fruitful, and theoretically more sound, approach would seem to be to regard

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constitutional and environmental factors as interdependent[128] and to pose the problem as one of tracing this interdependence. Every individual has constitutional qualities which are reacted to by significant persons in the environment. Several recent studies[61, 71, 82, 221, 285] do, indeed, take this approach and demonstrate the value of a genuinely integrated theory. They suggest, too, the complexity and subtlety of the interaction, concerning which much conceptual, theoretical, and research work remains to be done.

¶ The Impact of Mental Illness upon the Family

Most investigations of the interrelation between the psychiatric patient and his family have focused on the events antecedent to and associated with the development of the illness in the patient. Following the onset of the psychiatric disorder, and the casting of the disturbed person in the role of the patient, the family has tended to recede into the background. From this point on, clinical practice has been prone to consider the family only in so far as its cooperation is necessary in carrying on treatment procedures with the patient or in executing therapeutic recommendations. Frequently, the family is viewed by the psychiatrist in practice principally as an irritating obstacle to success in these areas. In a sporadic fashion, clinical investigations have, at times, treated the responses of family members to the patient's illness as topics for research in the technique and methods of therapy. It is only recently, however, that the responses reverberating throughout the family, as a result of the patient's falling ill, have been studied in their own right.

It is not unexpected that sociology should have taken the lead in this type of investigation. As we have stated, sociologists have for many years been interested in the effects on the family of various types of crises. In general, studies in this area have focused on crises whose origin was originally external to the family, such as the effects of war and economic depression. A few studies have, however, been devoted to the investigation of crises emanating from within the family, and, of these, some have dealt with mental illness in a family member as the specific point of origin.

The Impact of the Development of Illness and of Hospitalization

This area is just beginning to be opened up for investigation, but enough work has been done to indicate the complexities of the process through which the family members become aware that one of them has developed a psychiatric illness and how they deal with this event. The process can be studied in many different ways and from many points of view. Its complexities can best be ordered in terms of the time scale governing the sequence of events, and we have, accordingly, summarized current knowledge with reference to the following stages:

Prerecognition Stage

When behavior occurs which deviates from the normal or the expected, it is not automatically recognized as pathological. Instead, attempts are made to see the behavior within the framework of normality. This may involve considerable effort and struggle for the marriage partner and other family members,[39] and may produce feelings of threat and insecurity in them which require compensatory changes.[102]

Recognition of Pathology

At some point the deviant person can no longer be seen as normal, and a "break" occurs in the perception of and behavior toward the deviant.[19] At this point a whole range of feelings, attitudes, and interactions must, to some extent, be reordered, with consequent strain.[39] The family now contains a "sick" member whom it is difficult to treat normally and who may be unable to fulfill his normal duties. Such a failure in normal living may lead to a demoralized state, and nearly all family routines may suffer.[226] Attempts to reorganize the family with different roles for the sick member, a new authority structure, and new alliances, may take place.[102] When one mem-

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ber becomes identified as sick, the emotional problems of others may be repressed.[163]

Rupture

If the sick member's behavior or its secondary effects are serious enough, some rupture in the family relationships may be required. The sick member then becomes a patient, hospitalized or not. This act is usually felt by patient and family to be a rejection, which produces in the family guilt and consequent defenses of various forms.[39]

The fact of rupture may itself accentuate official and public recognition of illness. The family may then feel disgraced and withdraw from social contacts. At the same time, the strength of the rejection of the patient, at least in the case of children, treated as outpatients, may increase.[48] Problems may be created too—problems of economic support and living arrangements for the family.[102]

Reorganization of Part of the Family

Once the patient is rejected, whether he is physically absent or not, there is some tendency for the remaining family members to reorganize themselves and establish new patterns of relationships. Clausen, Yarrow, *et al.*[39] have investigated this phase extensively and show that the amount and content of communication within the family, with relatives, and with others, alters considerably, the extent and nature of alteration depending upon the many factors which characterize a specific family.

The organization established during this period may be so "efficient" that the family's ability to cope with problems is quite high. The efficiency may be so great that subsequent problems will arise when the patient tries to re-enter these closed ranks. It might be stated that the more the reorganization is built upon the rejection of the patient, the greater will be the likelihood that the self-sufficient organization will develop. A tendency to justify the rejection and displace responsibility to others outside the family is strong.[39] The fact that action has been taken, even if it is not ultimately beneficial, can be a source of comfort and give the family members a sense of worth.[102] In so far as this feeling is shared, it may give strength to the new patterns that emerge.

Discharge

Decisions about discharge and the disposition of patients after discharge can involve family members in conflicts and present further problems. Just as perceptions of the wife and the psychiatrist differ in accordance with their roles and their involvement with the patient in the precommitment and immediate postcommitment periods, they differ too in their evaluations of the patient's improvement.[192] Presumably, this can lead to conflict about readiness for discharge and to problems of adjusting attitudes and perceptions in family members. Considerable disagreement regarding release has been found in a group of cases studied intensively at time of release.[199] The conflict among doctor, patient, and patient's family frequently results in coalitions of pairs against the remaining member.

Even after discharge has been settled, there are problems about where the patient should go. Simmons, Davis, and Spencer[199] found a significant tendency for patients to go, on release, to a setting different from the one from which they came. It has been established for some cases, and may be true for many, that if the patient re-enters the family, he and the family are faced with a difficult situation; the ranks that have been closed do not open easily.[102]

Postdischarge

The postdischarge period, perhaps crucial in the life of both the patient and his family, has been largely neglected. The one study which considers this period[102] suggests that the postreunion period may be beset with problems—such as when the previously alcoholic husband becomes so active in Alcoholics Anonymous that his wife feels neglected.

Even this condensed review of the impact on the family of the development of illness and of hospitalization reveals that the accent is upon the negative, disorganizing effects. A few studies suggest that the complete picture is more complex. Fisher and Mendell[65] suggest that the sick member is in some sense an

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emissary sent out by the family to get help, manifestly for his own problems but implicitly for the whole family's problems. Perry, Silber, and Bloch[163] found that once a sick role was taken by someone in the family, there was not the "dynamic space" for anyone else in that role. It could be inferred that such a situation controls the deviant tendencies of other members of the family, at least in the short run. Closer examination may reveal that, at all phases in the development and recognition of illness, there are gratifications as well as deprivations.

The Impact of Other Crises

There is a large group of studies, mainly sociological, which do not deal with the impact of mental illness on the family but do deal with impact of other crises or problems. These generically related studies generally confirm the course of effects sketched above. Eliot[58] has described the process of reaction to bereavement. He shows that, just as with the family experiencing mental illness in one member, the bereaved person undergoes a reaction process which includes adjustment or readjustment of cognitive and emotional structures, changing patterns of interaction, communication, etc. Koos[116] and Hill[86] find a similar but more simplified process of reaction to stressful events. Bakke[15] early gave a systematic account of the stages of disorganization and reorganization following unemployment.

Many of the specific responses found in reaction to mental illness have been observed in families faced with other problems. Hill,[86] studying wartime separations and reunions, observed the phenomenon of the closed ranks which reopen only with great difficulty to admit the homecomer. Several studies of families in the depression show that unemployment can be demoralizing to fathers, and this has ramifying effects on many areas of the functioning of the fathers and their roles in the family.[35, 36, 115]

Some of these studies supply elaborations of particular points that might well hold for mental illness. For instance, Geiger[78] found that if the disturbing force was perceived as coming from inside the family, the solidarity of the family decreased, but if the "fault" lay outside, the family solidarity was increased. Similarly, Koos[116] found that when lower-class families experienced "troubles"—delinquency, illegitimate pregnancy, job loss, etc.—if the father was perceived to be responsible, his authority position was weakened. The mother's authority was less likely to be weakened, and a child's position was affected relatively little. Duvall[56] studied the problems of the serviceman's wife and found that adjustment to separation was best when the wife had a high rate of social participation. When a child is hospitalized and subsequently returns home, it has been found[171] that the parents' anxieties could affect their handling of the siblings. In turn, the changed handling of children can enhance sibling rivalry and other problems.

The Impact of Treatment

Many other studies deal not with the impact of mental illness on the family but with the impact of the treatment upon the mental illness. A few psychoanalysts have been interested in the effects of treatment,[27, 154, 155] but mainly as technical problems in the therapy. That treatment can have side effects which are not always beneficial has been recognized for some time, mainly by social workers. They have noted how treatment can shift the balance of family forces so that conflict increases, some other member of the family shows greater disturbance, or the child's therapy is hindered.[20, 33, 213, 233] Psychiatrists have recently begun to explore this area in some detail.[24, 144, 183, 187] Chance, a psychologist, has reported a major research project on the topic.[37, 38] At least two unpublished studies[18, 48] also deal with the effects on the family of the treatment of a child.

The involvement of relatives in treatment, through group therapy, hospital work, discussion groups, and joint treatment, has been attempted in the last decade. Rather impressionistic and usually brief accounts have been given of the amelioration of attitudes toward the hospital, the staff, and the patient by such means.[46, 142, 185, 186, 214] Detailed studies of the further effects, if any, are needed.

In summary, it can be asserted that mental

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illness and its treatment influence not only the patient but the groups of which he is a member. In the case of the family, these effects may be far-reaching and of great magnitude. The authors feel that such influences cannot afford to be neglected from either a practical or a scientific point of view.

¶ The Family and Treatment Procedures

Practice may or may not follow theory faithfully. The dynamic theories of psychopathology and the findings derived through their use have been largely individual-centered. Moreover, these theories have been constructed in such a way that the individual is conceived as a self-contained system, becoming relatively "closed" early in life. Even the social and cultural variants of these theories share this assumption. We do not find evidence that treatment procedures vary significantly from what one would expect on the basis of theory. In the context of the habitual lip service paid to the family-as-a-whole, isolated groups or individuals have attempted to maintain a focus on the family unit in diagnostic formulations and treatment procedures, but attempts to bring the family to the forefront have not become established.

Diagnosis

Since theory has not sensitized research workers or therapists to group variables, and no appropriate interdisciplinary language has been made available, it is not surprising that diagnoses are phrased in terms of the individual. Even those who are strongly convinced of the significance of the family and the necessity of dealing with the family as a unit (for example, Towle[225]) have had to formulate diagnoses in terms of the interaction and interdependency of individual psychodynamic characteristics and processes. This has remained true through the various phases of thinking about pathogenesis and treatment. It is not until the 1940's that we find a departure from this tradition and an attempt to formulate diagnoses in terms of group characteristics.[177]

As might be expected, there has been more innovation in the child-guidance field than elsewhere. As attention has turned to the mother-child interaction, diagnostic formulations have included aspects of the mother-child relationship. Nevertheless, a disturbed "mother-child relationship" has frequently turned out to be a disturbance in the mother with consequent implications for the child. In recent work on atypical children,[132] the focus has been shifted somewhat to the relationship itself. A fundamental feature of this disorder is that the mother-child relationship is undifferentiated, a characteristic of the relationship itself rather than of either party to the relationship. However, such formulations have not been extended to family-group characteristics, and ultimately the structure of the relationship has been reduced again to individual pathology.

Several authors have attempted to solve this difficulty through conceptual reformulation. Sullivan,[217] in his interpersonal theory of psychiatry, attempted to develop a language descriptive of the relations between persons, but actually he seemed to deal more with the interpersonal mechanisms within individuals than with the interpersonal relationships of pairs or groups of individuals. Bateson,[17] with his concept of the "double bind," and Wynne,[238] with the concept of "pseudo-mutuality," deal more specifically with properties of relationships.

Social scientists have long had an interest in disorganized social relationships. It is rather surprising that they have not brought their thinking to bear more directly on developing a conceptual framework for the diagnosis of pathological group relations on the small-group level. Many writers have diagnosed the "ills of society" on a very general and diffuse level. Kardiner[107, 108] has attempted to formulate the connections between broad cultural conditions and modal personality types, but detailed specification of the structures and processes through which this very general relationship operates is still lacking. In recent years, social scientists have applied themselves with spirit to the problem of diagnostic formulations in the child-guidance field.[165, 166] Pollak has been able to recast some concepts and introduce others, so that he has developed a language which is

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more consonant with the processes of interaction within the family. Nevertheless, there has been little shift of focus away from the individual and, in spite of the improved vocabulary, diagnostic formulations are still made largely in terms of the "fit" of the unconscious needs and defenses of different individuals. A more recent article departs from this feature, to talk in terms of the properties of relationships.[164]

Another aspect of diagnosis, the strategy of arriving at a diagnostic formulation, is pertinent to the implication of the family in the patient's problem. Most diagnosis is done by interacting verbally with the patient and by observing his responses to the therapist and to test materials, or, in the case of children, through the use of play materials, symbolic situations, etc. Observation of the patient in a natural group has seldom been used. Redl[174] has used groups in diagnosing children, Van Amerongen[228] has interviewed family groups, and Herriott[93] has used psychodrama in diagnosing mental patients. Sigel *et al.*[198] have observed families indirectly in their attempts to diagnose "influence techniques." In our opinion, observation of the patient within his family and in other natural settings should be investigated for its diagnostic utility.

Individual Treatment

The theories on which most psychotherapeutic efforts are based also prescribe many features of treatment technique. Psychotherapeutic treatment by its nature implies a close personal relationship. It is widely assumed that the optimal therapeutic situation is a one-to-one relationship of therapist and patient. Even within the framework of this traditional model of treatment, different things may be focused upon, the form itself not necessarily determining the content. It is the opinion of the authors, however, that in the one-to-one relationship the individual tends to be seen sharply, the family obscured. It can be said with some justice that there is a strong bias against including families in psychotherapeutic procedures. Grieg[83] takes Anna Freud to task for her antagonism to parents as evidenced in her procedures.

The principal ground for the rejection of treatment of more than one person at a time by one therapist has been the reputed difficulty in handling the transference.[117] This view has been advanced strongly, despite the fact that some analysts have successfully treated siblings,[155] spouses,[145, 154] and even families.[144] Recently, the dangers of collaborative or simultaneous treatment of family members has been viewed less seriously. The advantages of such techniques are now being stressed.[21, 137, 144, 212, 219] Ventures into joint treatment have also been reported and are probably not so rare as the published literature would suggest. Pechcy[161] has reported a technique of observation of mother-child interaction prior to each interview with the mother. The joint treatment of parents has been carried out for some time in Buffalo.[87]

Collaborative and joint treatment have far to go before their techniques are adapted to the treatment of the family as a unit, but, out of such attempts to widen the therapeutic range, there may someday emerge a method of therapy more suited than any current one to deal with the family's involvement in the illness of one of its members.

Group Therapy

Group therapy is a method of treating individuals in an artificially created group, that is, treating a number of individuals *as individuals*, at the same time and in the same place. Some leading exponents of group therapy deny that the group can be considered as an entity in therapy and treated as a focus in itself.[200] Most group therapists do not use natural groups in the therapy, particularly natural groups that sustain intimate extratherapeutic relationships, such as the family. Again, the problems of managing the transference when several family members are treated in the same group are stated to be great.

It is rather striking that, at the same time that group therapists have concluded that groups cannot be made the focus of treatment and family members cannot be treated in groups, individual therapists—especially in the child-guidance field—are coming to believe that the family must be treated as a group,[118] and

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in practice more joint or collaborative treatment is found (see above).

Group therapy has another source—one not so much in the main stream of psychoanalytic theory. This is the psychodrama movement of Moreno.[147] When orthodox therapists were denying the possibility of joint treatment, Moreno was experimenting with the joint treatment of marital problems by means of his role-playing techniques.[148, 149] Others see these techniques as capable of application to and in the family.[44, 128, 227] Still, despite many promising leads, the psychodrama movement has not attracted a wide following and has failed to produce a body of systematic research findings.

There is no dearth of titles suggesting the treatment of families in groups. Corsini and Putzey[45] list 52 items concerning families in group therapy. The great majority of these, as Abrahams and Varon[2] point out in their review of the literature, do not deal with families at all but with groups of unrelated mothers, fathers, or children. There are some exceptions. Abrahams and Varon[2] did treat mother-daughter pairs in a group setting. Parents have been treated as couples in groups,[196] and recently whole families have been studied and treated on an inpatient basis.[24, 238] In each case where such innovations in treatment procedures have been made, success has been reported. Not only does it seem possible to carry out the treatment of families as groups, but the method has advantages. Some of the patterns of interaction that produce and maintain pathology in the affected person are subtle and not easily comprehended except by direct observation of the interaction.

Marriage and Family Counseling

Giving counsel on marriage and family problems is a service that is ancient but a profession that is very young. As a separate profession with some unity and identity, marriage counseling began around 1930.[27] The separating out as a professional activity of what had before been handled by educators, ministers, physicians, etc. was the culmination of an interest in the woman's place in society and concern about the sexual adjustment of women.[152] The several large-scale studies of sex life—many under the auspices of The Association for Social Hygiene—of the late 1920's gave the immediate stimulus to provide advice on marriage and the family.

From the beginning, marriage counseling drew from a variety of sources for theory and operating knowledge. Psychologists, sociologists, and biologists, as well as physicians and social workers were involved in early clinics. To a greater extent than with other therapeutic services related to the family, marriage counseling has maintained contact with this variety of disciplines. At the same time, however, marriage counseling has assimilated a great deal of the social case-work approach and technique,[52] which, in turn, derives in large part from psychoanalytic theory. At the present time, it is difficult to see just what technical method is unique to marriage counseling. Social workers, and even psychiatrists dealing with marital problems, are assumed to be doing "marriage counseling." It would seem that marriage counseling has developed no stable core of functions, techniques, or theories it can call its own.

Eclecticism is characteristic of the aims and methods as well as the sources of influence. Enlightenment through education is a strong element in marriage-counseling practice. For example, marriage counselors teach numerous so-called "functional" college courses, given in preparation for marriage and family life, as part of their effort.[52]

The authors have only a superficial acquaintance with the field of marriage counseling and its literature, but it is our impression that it has not made any radical departure from the other types of therapy in the direction of awareness of the family as a unit, or in attempts to deal with the group rather than with a collection of individuals. Marriage counselors are naturally oriented to the marital relationship, but published case illustrations reveal little attempt to formulate observations systematically in terms of the relationship. Although simultaneous treatment and even joint interviewing may take place, the model of treatment employed is that of individual ther-

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apy (for example, Mudd[58]). The method of counseling, in particular of Rogerian nondirective counseling,[180] is based on theoretical notions which emphasize the inner desires and capacities of the individual to the exclusion of any external influences. It is characteristic of this field that such a school of counseling should have produced an extensive literature of careful research[181] without adding to our understanding of familial or sociocultural influences upon the individual.

The Relations of Families to Treatment Facilities

The topic of family care is germane to this section on the family and treatment procedures. It is, however, dealt with extensively elsewhere in this volume and need not be taken up here. One comment may be in order, since we feel that there is one aspect of family care that is very revealing of the prevailing attitudes toward the family of the psychiatric patient. "Family care is a program providing paid foster care in a home other than the patient's own. . . ."[16] (p. 643). The term thus seems to be a misnomer. We raise for speculation the question of the sources of this misnaming. Is it felt that the patient within his own family is not cared for? Do only paid, unrelated families care?

There is evidence to show, just as Towle stated nearly thirty years ago, that treatment affects and involves every member of the family, not just the individual patient. The practice, particularly of inpatient treatment, strongly suggests, nevertheless, that patients do not have families. Recently, there has been a great deal of interest in the effects of the total social organization, or milieu, within which treatment takes place.[104, 210] The planning and manipulation of the hospital environment are coming to be considered an important aspect of therapy, but there are few examples of the systematic consideration of the family as part of the environment which is affected by and affects treatment. Some Meyerian therapists are interested in families, but this interest is still without any extensive framework.[130] Brodey and Hayden[28] have noted that the relationships of the members of the therapeutic team may resound to family conflicts. Midelfort[142] has written of his original but limited work in involving families at all phases of the treatment of even seriously disturbed persons. Still, as Fleck *et al.*[87] point out, there have been few systematic studies of the relations of families and hospitals, and the interaction of hospital personnel and families is largely neglected. Interest in this area does seem to be growing, and it may be anticipated that more substantial knowledge will become available about the family's role in rehabilitation.

¶ New Approaches to the Family and Its Pathology

Family-Centered Approaches

During the past ten years there has been emerging, in some quarters, a new approach to the relationship of the individual and the family in the genesis, diagnosis, and treatment of mental illness. These changes have taken place largely within the framework of psychoanalytic theory, but they attempt to avoid those aspects of the theory and practice which have proved to be unsatisfactory and inhibiting. In these approaches the attempt is made to avoid the rigid polarity between organism and environment, to find a broader focus including both the individual and his family. Changes in this direction are relatively young, and since they involve departures—sometimes great—from conventional modes of thought, accepted terminology, and well-established ways of proceeding, it is to be expected that many of these approaches are still in the stage of being worked and tested. Many are still in the stages of refinement and have been reported only in fragmentary form.[23, 40, 70, 91, 92, 101, 121, 238]

Ackerman[3, 4, 5, 6, 7, 8, 9] is a leading exponent of these new approaches and may be considered briefly in order to illustrate family-centered approaches. Ackerman, like others, feels that the conventional orientation sees the individual isolated from the continuously operating network of interpersonal forces and

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reduces the environment to a vague background of human behavior. As Ackerman himself says:

But it is essential to view these dominant modes of behavior in the growing child as shaped by the total psycho-social configuration of the family, rather than by the parent-child relationship in isolation[6] (p. 177). In psychoanalytically oriented formulations, certain patterns of interaction are suggested between the child's unconscious needs and particular elements of parental behavior, or between the overt actions of the child and the unconscious wishes of the parent. Clearly, such correlations are partial in nature; they hypothesize a relation between a piece of the child and a piece of the parent. This piece of the parent—usually a set of conflicting unconscious needs—is not defined in its proper relation to the whole child, nor is the whole child seen in an accurate perspective with regard to the whole parent, or the full breadth of the relationship between the parents, or to the psychosocial configuration of the family as a whole[6] (p. 182).*

If we are to move toward this goal of handling the psychosocial configuration of the family as a whole, Ackerman maintains[5] that psychoanalytic concepts appropriate to the personality development of the child cannot simply be extended to the family and community. Freudian concepts and formulations are not rejected, but their limitations must be recognized. They must be supplemented by and articulated with conceptions of the structure of the environment and of interpersonal relations.[3] The primary bridging concept Ackerman advocates is that of "social role," or the operation of the integrational aspect of the total personality (the social self). This social self, which may or may not reinforce the "inner self," is what is expressed in social action and is responsive to group organization, thus giving a dynamic link between society and the individual. Goals and values, which have a dual orientation, toward the self and toward others, give the configuration to the social role a person may take.

In his more concrete formulations, Ackerman[7] develops a typology of types of marital interaction based upon what role is dominant, and a typology of family groups in terms of their internal and external integration. The diagnosis of pathology, then, involves the assessment of the internal organization of the family, the external adaptation of the family, parental roles and child-rearing practices, and how they are integrated at each stage of the child's development (Ref. 6, pp. 194–196). The child's pathology, stated in the conventional terms of his psychic processes, is only a part of the broad field that must be viewed.

Such conceptual reformulations radically alter the nature of diagnostic and treatment procedures. No longer is it adequate to study a part of the family and phrase the diagnosis in terms of the child's inner processes, or the mother-child relationship. No longer is it adequate to treat the individual as if he existed independent of the family, as if the therapy were the only force operating on him, and as if therapy altered only the one or two individuals seen. Failure to do so can only result in a partial and artificial view of problems and often in failures in treatment.[8]

Ackerman and other family-oriented investigators have taken a long step away from the approach which has prevailed for more than a generation. The shift in focus is a basic one, greatly complicating both the theoretical formulations and the procedures of observation. Because of the many problems raised by this approach, and also because of the recency of the endeavor, most of its aims are not yet fully attained. Neither a wholly coherent theory nor a consistent, adequate set of observations has yet been advanced, nor has much progress been made toward the long-hoped-for and elusive goal of developing categories of pathogenic family patterns.[10] Even so, however sympathetic one may be with respect to the difficulties and present failures of a youthful and

* In the discussion of this paper, Bender nicely states the traditional point of view that internal processes are of greater significance than environmental forces. "I am repeatedly impressed with how much all children are alike, and how overwhelming is the tendency of the inborn developmental pattern to assert itself in all human young. . . . Race, mixtures of race, language, family patterns, complete abandonment by parents—all these are finally less significant than what the child himself can demonstrate and what the physician, educator, and parental figures have to offer the child in terms of his specific problems"[6] (p. 202).

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novel approach, one may question whether its concepts and procedures are adequate for its purposes. If it is artificial to isolate the individual from the family network, is it not equally artificial to isolate the family from its cultural and community (including extended-family) setting? Ackerman recognizes the significance of cultural values, but he has no classification of them and gives them a minor place in his framework. Similarly, the external environment is a collapsed and nebulous factor for Ackerman, and extended-family systems seem to have no part whatsoever.

Such gaps are not easy to fill, but they need not be neglected. Erikson,[60] though not working specifically in the area of family research, has raised the question and pioneered in breaking a path leading from the individual to his family and on to the cultural network. Lindemann[122] has been another pioneer in stating and investigating the reciprocal relationships of individual family and community. Fisher and Mendell[65] have recently demonstrated the curiously enmeshed continuity of cultural and pathological themes extending through the family from generation to generation. The point brought out, though rather indirectly, by such studies is that the base adopted by Ackerman, broad as it may be, is yet too narrow to encompass the forces associated with the pathogenic process in the family. The constriction is both theoretical and procedural. From the point of view of theory, insufficient effort has been made to bring psychoanalytic formulations into line with sociological and anthropological theory. Procedurally, the observations are much too confined to the nuclear family, neglecting the horizontally extended network of relatives and the heritage of generations, as well as the impact of the community and its value system.

The Transactional Approach

A more comprehensive and systematic approach, currently being employed in the study of the relations between the family and mental health or illness, is perhaps not so open to these objections. This is the "transactional" approach first proposed, at a general philosophical level, by Dewey and Bentley,[52] and used by Spiegel,[205, 206] and Spiegel and Kluckhohn[208] in family research. Essentially a field approach, the transactional point of view postulates that the events involving the sick individual with his family occur within a total system of interdependent subsystems, any one of which—for example the individual, the family, the community, the value system—may become, temporarily, a focus of observation. The "world" being observed must include the observer and his act of observing.[188, 189] Within the field encompassing the interconnected subsystems, a component system, such as the individual, can be isolated and studied as an entity, but this is a heuristic device which always involves some distortion and sacrifice of precision or predictive ability.

If this philosophical position is accepted, then the individual and the family are seen as subsystems which are intimately and complexly interrelated. Neither has any greater "reality" than the other,* and no characteristic of one or both has any necessary priority. A somewhat similar philosophical stance has been adopted by others under the name of "general system theory."[231] No matter what it is called, this point of view alters the concept of causality. Viewing one entity or process as causing another, or as dependent upon another is possible only if their interrelations can be isolated from total contexts. Putting variables within a total context shifts the question from "What in the family 'causes' pathology in the individual?" to "What processes occurring between the individual and the family are associated with the behaviors which are called 'pathology'?" As used by Spiegel and Kluckhohn,[113, 204, 207, 208] the transactional approach attempts to articulate the structure and process of events in the individual with the structure and process of events in the family and culture. This involves developing and articulating theories

* The same argument applies, of course, to the relationship between family and community, society, culture, and soma,[205] but it is difficult to keep all subsystems under observation for the purposes of a particular study. For example, the individual and the family may be studied without including the community, society, culture, etc. in the field of observation. Some distortion will inevitably occur under these circumstances, but to a lesser extent than if the two subsystems are treated as separate entities while the remaining subsystems are treated as if nonexistent.

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of group and cultural behavior comparable to the relatively well-worked-out theory of individual behavior provided by psychoanalysis.[208]

The method currently being used in the Spiegel-Kluckhohn approach to transactional analysis is the attempt to specify the chief sources of strain in the culture, the family, and the individual, and to relate each of these kinds of strain to each other, conceptually and procedurally. The procedure consists of comparing families along two dimensions. The first dimension is cultural and involves the comparison of Irish-American, Italian-American, and "old" American families, all at the working-class level. The second dimension is psychodynamic, and involves the comparison of families from these subcultural groups who have an emotionally disturbed child with a similar group of families matched on sociocultural background factors, differing in that no family member is clinically disturbed. The first group, the so-called "sick" families, are studied through the weekly psychotherapy of the mother, father, child, and other family members, and through participant observation of the family interaction in the home, at work, and at play—such as family celebrations. The second group, called "well" families, are observed only through weekly participant observation in a variety of contexts. Contact with all families is maintained for a 1- to 3-year period and is carried on by a multidisciplinary team consisting of psychiatrists, anthropologists, sociologists, clinical psychologists, and psychiatric social workers.

The method of locating the strain in the family employs three levels of systematic concept formation, for each of the three levels of observation. At the cultural level the theory of variation in cultural-value orientations[111, 112, 113] is used. For locating the strain in the interpersonal relations in the family, the concept of social role and role-conflict resolution[204, 207] is employed. At the intrapsychic level of individual process, the theory of psychodynamics derived from psychoanalysis is used. These theoretical concepts interlock with each other. It is considered that the cultural-value orientations influence the way each family member takes his social role as mother, father, or child, and thus in the way he perceives and responds to "reality." Conflicts in cultural values, either conscious or unconscious, are therefore associated with interpersonal conflicts in the way roles are to be adopted in the family. The overt and covert interpersonal role conflicts can then be correlated, for psychodynamic purposes, with the motivations, both conscious and unconscious, within each family member. This is because a social role always serves the purposes of either gratification or defense, whether manifested in action or in fantasy. At the same time, the social role is the basis upon which action within the family group—or any persistent group—is integrated. Thus the degree and kind of social role conflict at any one time indicates the amount and type of strain in cultural-value orientations, interpersonal relations, and intrapsychic processes.

Using this method of analysis, the investigators have found that there are two sources of strain in the cultural-value orientations. The first arises from lack of fit within the values of the original culture—Irish, Italian, or native American. The second grows out of the incongruity between the values of the original Irish or Italian culture and the dominant American values toward which these two groups are in transition. The amount of cultural "distance" which has to be traversed by these groups—and therefore the degree of shift in values—is quite extensive. Thus, the second source of strain is more significant for interpersonal conflict than the first, though both are important.

In comparing the differences between the "sick" and the "well" families with respect to these strains, the investigators have found several interesting but still tentative correlations. All families studied, both "sick" and "well," are characterized by quite definite role and value conflicts. However, the two sets of families can be distinguished from each other along several parameters. The "sick" families have attempted to change a broader spectrum of values and at a more rapid pace than have the "well" families. The result is that the parents experience intense intrapsychic conflict and potential or outright confusion in their mutual role relations. This produces a disequilibrium in their relations with each other, with their children, with relatives, and others.

For the most part, however, the actual value

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conflict is unrecognized or denied. The associated role conflicts are accordingly projected to either the marital partner or the children—occasionally to the grandparents. In their projected form they are both distorted and inaccessible to conflict resolution. For this reason, the children are socialized in terms of the role conflicts existing within and between the parents. The children are thus in a position where no role they take can solve the parents' role problem—they are "damned if they do and damned if they don't." Usually, one child is selected, for reasons connected with the residues of the parents' own sibling relationships, to bear the brunt of this pathological stabilization of the parents' role conflicts. The selection of a child for this purpose transforms the disequilibrium between the parents into a pathological equilibrium which is extremely difficult to break up. If the affected (disturbed) child improves under psychotherapy at a rate faster than the parents, another child is often selected as the stabilizer of the pathological equilibrium, and this child tends to develop symptoms.

In the "well" families, although value conflicts do exist, they are not so extensive as in the "sick" families. Only a few value orientations are subject to change, and the transition process occurs very slowly. Associated with this more orderly transition, the parental roles, which are the actual sites of value conflicts, are accessible to consciousness and thus to conflict resolution. There is little need to deal with them in projected form or through distorted symbolic communication. Therefore the socialization of the children takes place in a more consistent fashion. Value conflicts between the children and the parents are less the product of projection by the parents, more a matter of the children's having absorbed new values from their friends, in school, and in the community.

There is, however, no sharp dichotomy between the "sick" and "well" families. "Sick" families have some areas of adequate conflict resolution, and "well" families have some areas of pathological equilibrium. To put this in more ordinary language, all families are involved to some extent in neurotic interaction, and all family members in both groups show mixtures of neurotic and healthy personality mechanisms. Thus the population of families under investigation form a series in which the sickest families, showing the most extensive pathological equilibria, are at one end of a continuum, the healthiest, with the fewest irreconciled role conflicts, at the other.

Two practical considerations arise from this transactional approach. The technique of therapy, as well as the method of inquiry, is directed not toward the isolated individual but toward the disturbed person embedded in a pathological family and cultural setting. Both treatment and investigation require attention to extensiveness of the disturbance. The understanding of mental illness becomes a question not of locating an isolated factor, nor even an overdetermined causality, but of an interplay of homeostatic mechanisms which have gone astray. Treatment involves the restoration of homeostatic controls across cultural, social, psychological, and somatic boundaries. Treatment methods must therefore be rationally adapted not only to the individual and his somatic and psychological strains but to the strain within the family in its cultural setting. To accomplish this, the training of the therapist must be extended so that a broader range of significant transactions can be brought within his range of skills, to understand and alter.

The Outlook for the Future

These new approaches inevitably bring forth questions concerning what new developments can be expected in the future. Judging by the past, movement is bound to be slow. Up to the present time, the area of the psychiatric patient and his family has shown more promise and less achievement than almost any other segment of psychiatric work. For more than thirty years the profession has been aware that family forces are both genetically and currently involved in the pathological state of the individual. This insight, however, has not led to effective formulations of the *nature* of the involvement, nor has it produced any but the most minor contributions to diagnosis, prognosis, and therapy. It is generally apparent, and poignantly so in this area, that theory exer-

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cises a strong, though sometimes unavowed, influence over what is observed and how it is stated. Accordingly, effective progress must wait upon further advance in theory construction of the kind we have just been considering. Only when such theories have been well worked out in fine detail will students from the many disciplines concerned with this area be in a position to form and develop a scientific tradition.

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CHAPTER 6

THE COMMUNITY OF THE PSYCHIATRIC PATIENT

Edward Stainbrook

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EVERY BEHAVIORAL EVENT occurs in a specifiable physical and social space. For an understanding of any specific human behavior, this basic observation dictates a comprehensive theory of human action which interrelates the process and dynamics of the structure-function systems conceptualizing the physical and natural world, the body, the personality, and society and culture. In medicine, particularly, the epidemiological analysis, the etiologic determination, and the therapeutic alteration of disease must be based upon an adequate evaluation for each diseased individual of this total context of disease determinants.

In an informal way, at least, medicine has always been aware of the necessity for a general theory of human behavior in a comprehensive conception of health and disease. Nevertheless, the formal medical science of the nineteenth century considered diseases almost entirely as occurrences within the physiological system. The major etiologic statements either asserted a constitutional diathesis predisposing to dysfunction or considered dysfunction to be initiated solely by changes in tissue or cellular structure and function. The long-retained idea of the "functional" psychoses is but one inheritance of the insistence that either structural or functional alterations in the body were the prime causes of disease.

We are all familiar, nonetheless, with at least the aphoristic acknowledgment by the medicine of the last century of the etiologic importance of individual and social behavior. Since the prevailing theories of personality and of society and culture were not aptly related to disease theory, however, very little scientific evidence accumulated about the interrelations of human action, social organization, culture, and biological processes.

¶ A General Theory of Behavior

The twentieth century, in its early decades, was characterized in medical science by the introduction of theories of personality struc-

ture and function and by increasing research in psychophysiology. More recently, the acceptance within medicine of the sciences of sociology and anthropology has provided the conceptual methods for making correlative statements in the theoretical languages of biology, personality, and society about events in the life process. It is true that these more recently emerging behavioral sciences are struggling separately with their own theoretical models and with the task of facilitating the translations of description and explanation from one theoretical system to the others. Moreover, these system-constructs, used to conceptualize the body, the person, and the human group, must be represented as open systems constantly transacting with each other. In this respect Talcott Parsons' statement about a general theory of action is applicable also to an open-system conception of physiology, personality, society, and culture. In his *The Social System*[20] Parsons writes, ". . . the concept of system as a guiding conceptual scheme is of the first importance as an organizing principle and guide to research. It may thus be said that the concept of a theory of systems is the most strategic tool for working toward the attainment of a system of theory."

The theoretical stance which currently enables us to make meaningful statements about the ecology of behavioral disorders is, then, the conception of reciprocally adjusting, transacting open systems conceptualized in structure-function and process terms. Depending upon the characteristics of their organization, upon their interrelating communication and other transactions, and upon their separate histories, these systems of the human group, the person, and the body are, at any behavioral moment, transmitting or absorbing excitation in relation to each other, affording or denying action for excitatory discharge and goal seeking, and, in general, facilitating or impeding mutually healthful adaptation. Hence, the adequate specification of any etiologic matrix of behavioral disease requires the description of any antecedent or consequent structure-function deficit in the body, its effect upon or its being affected by the organization, history, and functioning of the personality even as the personality, itself, affects and is affected by the human groups constituting its here-and-now relatedness.

The therapeutic plan of alteration then follows as the rational assessment of how and when to evoke ameliorative change in the body, in the person, and in the organization and culture of the significant human groups in which the person may activate a role. Obviously, different modalities of treatment are necessary for alteration of the different systems, although changes in one system—for example, changing the perceptual and conceptual assumptions of a person about the reality of another—may also alter the pathogenic stress arising from another system. Moreover, since every system has a history which has modified it, and this is particularly true of the personality, it is necessary to be quite clear about the extent to which any structure-function alteration of a system, either directly, or indirectly by modification of another system, can change the history of the system. Perhaps we shall someday be convinced, especially in relation to personality and character, whose differentiation and integration are based so largely on learning and experience, that the only rational way to alter the effect of history on the person is by means of more history, that is, of more learning and experience.

From the standpoint of epidemiology, our task is to specify the total field of disease determination. The processes by which the biological past is enregistered in genetic biochemical patterns which transmit communicative guidance to the structure-function development of the contemporary organism are, of course, of basic importance in relation to the subsequent vulnerability of the person to pathologic strain. Also crucial for our explanations are the history and dynamics of the internal reality with which the person encounters the constantly oncoming present. Indeed, from some points of view, this has been almost the total explanation of behavioral illness. Our concerns here, however, in epidemiology as well as in etiology and treatment, will be restricted largely to the influence of the person's social and cultural space upon psychiatric disease.

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The Sick Role

Any man may define himself as ill, any time, anywhere. Indeed, his dreams may dramatize him as sick without his conscious concurrence or even in spite of his open denial. But only an existing social process, organized for the recognition, acceptance, and treatment of illness and activated by one or more other role-specified individuals, can socialize the individual definition of illness and create a patient role and so keep the individual, even though ill, meaningfully related to society.

The self-perception of "not feeling well" is oftentimes a very vague and undifferentiated subjective experience. The individual who is feeling ill may not, on his part, know very clearly how to define his distress either physiologically or psychologically. He may, under certain circumstances, take a covert sick role in which he alone is involved. This may happen when the individual is actually physically alone but also may be the use of the self-given sick role as a psychological adaptation to his stress. Many such patients, before occupying an overt sick role, privately accept themselves as sick and use their self-validated sick role as a way of rationalizing inadequacies of self-realization, achievement, and participation.

Formerly, the petition to be ill was legitimized largely within the family, and the individual strain of illness was met, with or without formal medical help, by a temporary or even permanent reorganization within the family to support an effective sick role for one or more of the members. Today the modern hospital has become increasingly the social system in which the sick role as a meaningful mode of participation in society is lived out.

The transition of sick-role participation from family to hospital is, of course, very significant in all the chronic diseases, and any epidemiological assessment through historical times or across cultures of the prevalence of schizophrenia, for example, must take into account the historical social changes or the cultural differences in the familial relation to the sick role.

With particular reference to schizophrenia, one may see a whole family organized around the illness of one of its members, sometimes seeming to participate collectively in the covertly maintained sick role of the schizophrenic member. Conversely, as Benjamin Paul[21] has demonstrated in a Guatemalan family, the granting of the sick role by the family may result for the sick one in a restitution of existing psychological deprivation or a resolution of conflict. Somewhat similarly, in an extended family system or in families maintaining self-sufficient economic functions, the stabilizing absorption of the chronically sick member within the microsociety of the family may be achieved. Obviously, too, social pressures from the surrounding environment, either with direct reference to the sick person's behavior or related to other familial interactions, may overwhelmingly stress the family organization and so operate to change a covert sick role into an overt one.

As Hollingshead and Redlich[13] have shown, the social-class membership of the patient may also determine many of the medical transactions related to his illness and so influence the destiny of his sick role and, hence, of his disease.

There are "shameful" as well as "respectable" sick roles in our society. Severe psychiatric illness is the taking of a shameful sick role. In such a case, if the patient accepts his illness, he defeats his self-esteem. Hence, the admission of sickness may be avoided not because the patient does not want to be helped but because he does not want to be demeaned.

Because of the internalized culture of each individual, many of these determinants of sick-role recognition, acceptance, and outcome are operative for the prospective patient in that crucial period of time during which he may perceive himself as ill but in which he has not yet been socially defined as overtly sick. This is complicated further, in general medicine as well as in psychiatry, by considerations as to whether entrance into a hospital is to be part of the sick-role action. The psychiatric hospital has special cultural meanings, again at different positions of social-class perception.

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In this latter respect it is highly desirable to have specific knowledge about how the incoming patient is already perceiving the hospital as a social world and what expectancies he brings concerning his own role in the hospital. As a first admission, he has probably never had a formal or informal training in how to be a psychiatric patient. Moreover, the assault of his uneasiness on his ego-functioning may prohibit or distort the realistic learning about what his role in the hospital society should be. In such a setting the distorted or fantasy-directed conception of himself, which he may play out actually as the most secure way of being in the hospital, may lead him, as Gregory Bateson has observed, into a game of madness which he may not be able to abandon.

For the psychiatric patient the hospital is the life space, the social group, and the institutional system in and through which he is going to act and interact, frequently for an indefinite time, as someone who is perceived as ill and as someone who may or who may not conceive himself as sick. In most instances the patient will have undergone some experience with others in his induction into the sick role before entering the hospital. He will always have had a history of his own intrapsychic dialectic about the perception and acceptance or rejection of his illness before any sharing with others. The patient, therefore, has already had a frequently complicated experience with the sick role before he is admitted to the hospital. Indeed, the hospital is a special institutionalization of the sick role which may enter into the destiny of the ill person at different phases and with different meanings in the course of his illness. Caudill,[2] particularly, and Stanton and Schwartz[26] have described the human behavior in the small society of the psychiatric hospital.

Schwartz[24] has succinctly conceptualized a simple framework for thinking about the patient's mode of role participation in the hospital society. He suggests that, for each patient, answers be derived from the following questions:

1. What mode of participation with others characterizes the patient's illness?
2. What is the hospital staff's response to the patient's pattern of participation?
3. What configuration of patient-staff interaction gets stabilized?
4. Does this configuration of transaction reinforce illness? If so, how can it be changed?
5. If altering intervention is attempted, how is it represented to the staff and how instituted?
6. What effects follow intervention?

In recapitulation, therefore, the sick role can be considered as a sociological construct and discussed as an abstraction from a specific human-action process. It is a patterning of potential individual behavior through time in relation to a social system of medical practices and a cultural system of medical theory and is essentially a set of special expectancies about the behavior of the role occupant and about the behavior of others toward him. As indicated elsewhere, Parsons[20] has described some essential aspects of the institutionalized expectation system relative to the sick role. Exemption from normal social role responsibilities, exemption from responsibility for being helpless, assumption of the undesirability of being sick and acceptance of the obligation to want to be well, and the obligation to seek and to cooperate with technically competent help are the aspects of the sick role underlined by Parsons.

In addition to these positive and negative sanctions relating to the social conditions of being sick, there are other important aspects of the sick role. Of primary importance for the problem of conflict over the acceptance of the sick role is the perception of the social meaning of such a role. This varies cross-culturally as well as across social classes and relatively to different diseases or manifestations of illness. Since social sanction of the sick role in the formal sense depends upon the recognition by the medical institutions in the society that he who is stating his illness in terms of his symptoms has, in fact, a disease which merits a sick role, the nosology of the medical culture and the associated sentiments and values will be one of the fundamental influences in the decision to allow or to deny a legitimate sick role to the suppliant.

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Hence, the ideological aspects of the medical culture itself may determine the social perception of the meaning of illness. If, for example, a statement made by a prospective patient about his unhappiness is refused by a physician as a legitimate expression of a recognizable illness, the person who comes to a physician with this symptom will be denied a sick role and an entrance into the medical helping process. Such a person may be urged to become a religious penitent, or he may be told categorically that he is not ill. Whether the encountered physician allows or denies the petitioning patient a sick role depends partly upon the personality characteristics and educational sophistication and experience of the physician and partly upon the prevailing theory of disease in his medical culture. In contemporary American medicine it is becoming more usual for the physician to accept some motivational unrest as the explanation for the patient's coming for help, even when the patient's statement of symptoms does not seem to point to primary disease in the physiological system. The increased scientific knowledge of human behavior also now available to the physician enforces the acceptance of both disease and uneasiness as legitimate concerns of medical-practice processes and institutions.

Nevertheless, it is common knowledge that the sick-role legitimation of an individual's expression of his uneasiness may depend upon what his statement of his symptoms is, to whom he makes his symptom presentation, and in what social context he asserts his illness. As an example, the medical culture of a military society may deny a recognition of sickness for many evidences of behavioral and physiological adaptations to psychological stress. In World War II the Germans and Russians apparently made the sick role much less easily available for battle-stress reactions than did the American and British armies. Hence, if the incidence of "war neurosis" is comparatively assessed among these various armies, it must be remembered that the formal measure of disease incidence is not the counting of how many men were uneasy, anxious, depressed, and physiologically strained, but of how many were accepted as sick by the medical culture in which they found themselves.

In this sense, in World War II the American and British medical military culture, by broadening the perception of what statements of uneasiness were acceptable petitions for the sick role, effectively used action in the social system itself to absorb individual stress and to support individual strength.

So, too, not only in the military culture but elsewhere, there may be confusion about how to control individual behavior when the illness-legitimizing system is not clear about the meaning of any deviant behavior. As Parsons suggests, we seem more and more, in our American society, to be using the sick role as a method of control for criminal and delinquent behavior. We cannot discuss the significance of this trend for the social system of the psychiatric hospital. Here, we want only to point out the conflict that obtains within the hospital in deciding whether certain individual behavior should be perceived as an illness or as behavior which ought to be punished or, at least, condemned. Illustrative of this confusion in the medical culture is a recent letter of inquiry in the *British Medical Journal* asking how to distinguish an anxiety neurosis from "lack of moral fibre."

These illustrations are sufficient to indicate that the perception of an illness by the members of the medical system of a society is based, like most perception, upon a set of assumptions about what an illness should be, and that these assumptions have considerable individual, social, and cultural variability. Nevertheless, it is largely the doctors of a society who mediate the use of the sick role as a pattern of action in the social system.

The assessment of the sociology of the sick role is important also in relation to any epidemiological studies of behavioral disease. For example, Halliday,[11] leaning heavily on the writings of Donnison[5] on civilization and disease, states that in the period from 1900 to 1939 in Great Britain there occurred a progressive increase in psychoneurotic and psychosomatic disease. This may be an accurate observation, but it is also an acceptable hy-

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pothesis to postulate that such an increase may have been conditioned to an undetermined extent by changes in the medical culture relative to the decisions about what symptoms merit a sick role and under what diagnostic title.

Socially and culturally related changes in medical theory and practice therefore condition the frequency and characteristics of sick-role use, and hence of disease incidence. The sick-role values and action patterns are discoverable and describable aspects of the social system. By giving our attention to the sick-role practices of a society as well as to the manifestations of disease in the physiological and personality systems, we may avoid some of the ambiguities and nebulosity now involved in discussions about the cultural relativity of the abnormality or deviance of human behavior.

¶ Social Class and Psychiatric Illness

In so far as the past is a partial determinant of the present, an individual is his internalized and integrated past functioning in the here and now. Social institutions and culture, or, better, their behaviorally enregistered effects, are part of the person's internalized reality as well as a large part of the significant current external reality of the individual. By means of the integrating, remembering, "impressed" individual, the childhood and later society encounters the society of the present adulthood.

Social and cultural stress may arise, consequently, in several different ways. The life styles, values, and positively and negatively sanctioned action patterns learned in childhood may, as individuals mature, come into conflict with the desirable, rewarded, or necessary behavior of the adult society. This can occur either because the childhood society was not sufficiently adequate preparation for adulthood, because an adequate developmental experience of transition from childhood to adult society was not provided, or because, as in our American middle- and upper-class society of the last few decades, we innovated different child-rearing techniques and values into the society of childhood without effecting a corresponding change in the goals, values, and socially rewarded behavior of the adult society. This past-present culture conflict can also occur because rapid change in the adult society outruns the change in childhood preparation. So, too, because of social and also geographical mobility, culturally induced stress arises as a result of the cross-class, cross-regional, or cross-national acculturation process.

Moreover, with more particular reference to specific psychopathology, the social class and cultural determination of the developmental experiences of childhood presumptively differentially influence the encounter with the life tasks of growth and development by conditioning or limiting the ability of the human group of the family to do its mothering, fathering, and other child-raising transactions. Indeed, from at least birth onward, the influence of society and culture, particularized for each child's social life space, is impressed both dynamically and topically upon almost every learned action of the individual. Even the "unlearned" functions of physiology and biochemistry learn through symbolic and other associative conditioning to participate in interpersonal and psychosocial processes.

Hollingshead and Redlich[13] have made some provocative comments with special relevance to the possible influence of social class upon the basic socialization experience of the first five or six years of life in becoming a more or less well-delineated individual in the family group, with an awareness and a healthy acceptance of self-images, familial roles, personal interrelations, and functions. They suggest that schizophrenia seems to be more prevalent in low-class (Class IV and V) families. One part of the etiologic matrix of schizophrenia is probably a "loveless infancy," which for any child, whether or not he is also considered to be genetically vulnerable to schizophrenia, provides an immediate postnatal environment inimical to learning how to master progressively an adaptive and satisfactory state of being in the world. Such an experience in infancy is seen by them as more likely to occur

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in a Class V family than in an upper-class, or Class II, family.

Hollingshead and Redlich also state that defective super-ego structure and dynamics are more prominent in the low classes and point out that 95 per cent of persons in state prisons are from Classes IV and V. In psychotherapy the lower-class patient is more apt to act out. So, also, the lower-class adolescents miss the extended adolescence of the middle and upper classes, with their sublimational and long transitional "rites of passage," and so remain more sexual, aggressive, and dependent.

These authors also remark on the greater ego-weakness of Class V persons relative to the upper-class individuals. On the other hand, obsessive-compulsive characters are more frequent in the higher classes, and oedipal conflicts appear to be particularly intense in Class III.

Other important social and cultural factors in the assessment of a complete etiology of behaviorally manifest illness reside in the interrelations between organizational and institutional structure and function, values, and the capacity of the individual to react adequately to stress. Anxiety, resentment, lowered self-esteem and personal meaning, thwarted cognitive and emotional development, enforced passivity, and the threat of helplessness may be induced in persons partly because of the ways in which our current industrialized mass society and our rapid and somewhat chaotic urbanization function. Fragmentation of the productive task, the decrease of meaningful participation in organizational work, the failure to provide some autonomy in work experience, and the inadequacy of communicative involvement for relatively undistorted reality testing of what is being done, thought, and felt within the total organization, the dependency on secondary, remote controls for the moderation of community behavior, the anonymous and therefore casual and uncommitted relationship to neighborhood and community—these are some of the factors in the community and organizational context of individual behavior that induce needs which then may demand satisfaction or relief within the family group. The family may strain overmuch in meeting these demands and so disorganize, leaving the individual members without the stress-reducing and stress-absorbing support of the familial group.

The "tempo of life," so often referred to as a journalistic description of social and cultural stress, probably does not play too significant a role in the creation of uneasy tension. A more telling evaluation of social stress is to consider the need-induction activities and processes of a society relative to the accessibility and the availability of action patterns and objects for the satisfaction of the induced needs. In this respect, for example, our middle-class-oriented educational system may be inducing needs and goals in low-class children for which the community, during adolescence particularly, is not sufficiently differentiated to provide for the low-class child accessible and meaningfully significant action and goals for adequate need satisfaction.

¶ Culture and Psychopathology

The logical extension from a social class and social and institutional organizational analysis of possible contributions to behavioral illness is, of course, to a consideration of the relation of different cultures to the problems of psychological disorders. Today, we are just at the beginning of a comparative cultural psychiatry. The assessment of the cultural variability of psychiatric illness as to etiology, incidence, detection, ideational content, action dynamics, and treatment is a formidably complicated problem.

At a purely descriptive level certain culturally determined differences seem reasonably clear. Suicide, depressive reactions, sexual deviation, hysterical dissociative states and sensory and motor dysfunction, and obsessive and compulsive character and its decompensated obsessive-compulsive neurosis are distributed differentially across cultures. There is considerable evidence to indicate that psychophysiological and psychosomatic illness are related to the social and cultural context—particularly to various life styles and their associated values about goals and actions. Ruesch,[23] among

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others, has also suggested the possible relations between social class and psychophysiological adaptive failure.

The schizophrenic reactions, while observable in every society and culture, nevertheless are demonstrably influenced, topically and dynamically, by the culture and the organization of their particular society. A contemporary summation of the available knowledge about society, culture, and psychopathology is made by Linton[17] and Opler.[18]

A change of residence and social participation for an individual as he moves from one country to another, after having learned more or less adequately how to behave as a member of an original society of cultural orientation, may induce conflict, deprivation, and general cognitive and evaluative error and uncertainty in his perceptual assumptions about his new social and cultural world. "Acculturation stress" may thus be considered in terms of conflicting goals, values, and action. The determinants of psychopathology arising from acculturation, or related to it, however, are many.

The motivation for migration may itself have arisen as an attempted adaptation to painful stress, uneasiness, and inadequacy. Some of those who migrate on their own initiative may already be psychiatrically ill or highly vulnerable to social and other stress. In an assessment of the history of those individuals who suffer an "acute alien paranoid reaction" during usually their first year in a new culture, an interestingly significant percentage of this group are found to have had a previous psychotic experience in their native countries.

Recent studies have pointed to the higher incidence, relative to native populations, of first state hospital admissions of recent migrants, even of those who have moved from one state to another within this country. It also seems likely that the rate is highest among the most recent migrants, thus giving support to the proposition that for some people who get into the psychiatric hospital, the migratory moving itself is intimately associated with the illness.

Since a basic requisite for successful interaction with others is an adequate communicative evaluation of reality, the presence of linguistic difficulty in communication is a significant factor in the development of psychopathology. Hence, the "alien paranoid reaction," which is an acute schizophrenic reaction related to acculturation experience, seems to be associated positively, in terms of frequency beyond expectation, with both isolation from people as well as with diminution and distortion of informational and transactional responses from others because of an inability to understand and to use the proper linguistic and symbolic interaction. Since an individual's social and cultural articulation depends so much on role knowledge and confident expectation about role reciprocity and complementarity, inadequacy in language behavior inevitably means deviant general behavior. Hence, part of a program of preventive psychiatry would be an insistence on providing, for cross-cultural migrants, an urgent and intensive learning experience with the language of their new cultural group.

The linking of the character and personality of individuals to a national character attributed to their whole culturally visible society has a long history in formal writing as well as in folk talk. The concept of national character has, however, rather limited sociological value. From the standpoint of culture and its relation to individual behavior, we would be more concerned about how the various culturally specified life styles for different occupational, sexual, and age-referred roles rewarded or punished various character traits and, most particularly, in what ways the mothering and fathering behavior and the associated child-rearing values and lore influenced the learning of early character formations.

Certain individual adaptive responses, such as repression, reaction-formation, or denial, to internal and internalized need demands and to social and physical reality stimuli may be culturally reinforced. The "hysterical character" of the nineteenth century related to Western European and American sanctions against sexual fantasy, feeling, and action may be one illustration of this. How much has been learned of the formal logic of a society and

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how much cognitive development has occurred in an individual may also determine the ease with which repression can be supported and the readiness with which magic or alogical thinking is used, particularly in the failure to distinguish between "having a thought" and the anxiety-supported feeling of having the thought actually happen.

Some aspects of Japanese character which Westerners, at least, perceive as overpoliteness masking an underlying hostility are undoubtedly developed by general social values and action patterns transmitted as taught and learned culture in child-raising and general education. Similarly, cultural influences on character formation are determined by the extent to which a culture emphasizes fantasy as gratifying behavior for need satisfaction rather than as it permits direct, expressive action or, indeed, even creates negative sanctions about fantasy tension reduction as well. ("As a man thinketh in his heart, so is he.") According to Opler, for example, Irish-American psychiatric patients are very apt to elaborate their needs in fantasy, whereas the Italian-American patient may more directly and expressively act out his tensions. In Brazilian society the behavioral observer is impressed by the common social reinforcement of the individual denial of the emotional meaning of accidents and other external physical violence and threat.

Perverted sexual behavior and sexual deviance in general are differentially distributed across social classes within the same society and within cultures. Some of these differences also depend upon the variability in different societies about what behavior is sex-typed and associated with the general social roles of masculinity and femininity. In our own society it is frequently assumed that deviation from the sexual-role behavior of an earlier historical period means a demasculinization, and hence feminization, of the contemporary male. Whatever the present and presumably psychodynamically motivated value judgment of these changes may be, it must be held in mind that social changes in the acts of behavior to be learned as part of the general masculine and feminine role behavior of the society make much of human maleness and femaleness a culturally relative matter.

The incidence of the various addictions to food and to more specific pharmacodynamic substances such as alcohol and drugs is significantly conditioned by social and cultural variables. This is so not only in relation to the factors determining preferred modes of tension reduction or contributing to conflict or deprivation but also with reference to the availability and distribution of the social action patterns of drinking and drug using and to the cultural values associated with such behavior.

In a very definite sense, the addictions, in general, may be considered to be metabolic diseases. In diseases of metabolism, the etiologic precipitants may occur in one, or some pattern, of the four functions of intake, anabolism, catabolism, and excretion. Obesity, alcoholism, and drug addiction are initiated by deviant intake behavior of ultimately biochemical substances which overstress physiological mastery and lead to sometimes reversible and sometimes irreversible structure-function bodily changes.

Facile typological concepts do not offer any more than first approximations to an understanding of the subtle interrelations between pharmacodynamic effects, individual needs, psychodynamic gratification aims and goals, and cultural values about addicting substances. The psychiatry of the late nineteenth century began to point to personality differences between the morphine user and the alcoholic, an observation preceding the current folk statement that an alcoholic gets drunk, goes home, and beats up his wife, whereas a "dopey" takes a "shot," goes home, and is beaten up by his wife. The question was then debated as to how much this was a self-selection of drug effects based on individual psychodynamic operations, either autoplastic or alloplastic, and how much cultural preferences were involved. At the present time many Oriental and Middle East countries have negative sanctions against alcohol and permit social usage of the *Cannabis* derivatives and of other drugs. It is thinkable, of course, that the cultural sanctions arose as projections of the individual

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dynamics, which are, in turn of course, related to internalized cultural values and perceptions.

The intake behavior initiating and sustaining addictions of various degrees and kinds is highly dependent on socially induced needs such as, for example, the peer-group demands in adolescence. Narcotic addiction has, within the last decade, become somewhat of an endemic among adolescents in urban regions in this country. This has occurred largely because drug using became a part of the approved peer-group culture. The intensity of the pleasure-giving experience is also dependent not only on group induction but also on the group-supported expectations of what the drug effect will be. Hence, whether or not the first intake of an addicting substance will give enough of a pleasurable effect to lead to subsequent repetition and so to a developing addiction depends on the total context of the intake act.

As has been suggested, the schizophrenic reactions are universally occurring behavioral illnesses. This fact does not necessarily support an endogenous or genetic-disease concept of their character. It is also true that because of psychological regression, or of neurophysiological de-differentiation, or of both, schizophrenic patients, seen cross-culturally, look more alike in their basic behavior than do the nonregressed, adequately socialized individuals of various cultures, just as the world's children seem more commonly akin and less specifically culturally differentiated from each other.

No adequate studies give us any evidence of high truth value that the subtypes of schizophrenia are referable to specifiable social space. It is more likely that we shall find that the catatonic and, particularly, the hebephrenic reactions are more related to the vicissitudes of the helping process and to the sick-role experience than to an essentially separate etiology of the schizophrenic reaction forms.

It is not yet clear how valuable the nineteenth-century conception of primary and secondary symptoms may be in an assessment of cultural variation in schizophrenic symptom expression. Cross-culturally, one of the problems of disease detection and acceptance of an ego psychosis such as schizophrenia resides in the extent to which each culture has developed secondary process thinking, in Freud's sense, and so has created in its general enculturation of thinking behavior and cognitive differentiation a generally obvious and commonly detectable difference between alogical and logical thought; that is, the closer the ordinary logic of a culture is to magical thinking, the less is there a tendency to consider any person to be schizophrenic on the basis of thinking disturbances alone. In Brazilian rural society, for example, it was normally considered possible to talk with the spirits or with God, even though, probably, only schizophrenic patients did so in a hallucinatory way. A significant and presumably culturally determined aspect of schizophrenic behavior in Brazilian low-class society, which has also been documented by others as occurring in other somewhat similar societies, is the relative absence of severe avoidance-withdrawal behavior from human beings. As a hypothesis, this may be related to the characteristics of the extended family and to the giving and acceptance of dependency transactions with minimal guilt and anxiety. It also seemed obvious that the "secularization" of the paranoid distortions of the external reality paralleled an increasing social status and social-class position. Hence, feelings of helplessness and inadequacy, particularly in males, seemed in the low class to be comprised dynamically either by projecting the accusation, "You keep me helpless and passive," to the spiritual universe with the resultant hostility and persecution, or by the megalomanic restitution of identifying with the omnipotent deities. The middle- and upper-class males seemed to homosexualize more openly their passive and dependent needs in a disclaiming projection to other men, and their delusional restitutions of personal power and esteem used powerful contemporary human figures.

It is obvious that this condensed review of some of the facets of what is only a beginning social psychiatry points to the urgent need for increasing research in the development of new knowledge about the etiological matrices of

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behavioral disease and for continuing validation of the impressive body of hypotheses and tentative information we now have. It seems obvious also that the formulation of a comprehensive theory of human behavior, with separate but inwardly consistent scientific models of body, personality, society, and culture, must be the basic and continuing task of psychiatry. Whatever diagnostic and therapeutic hope the contemporary exciting new developments in molecular biology alone may bring, psychiatry will always have to deal with man as individual and social man.

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CHAPTER 7

IMPORTANT STATISTICAL DATA ABOUT MENTAL ILLNESS*

Benjamin Malzberg

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THE FIRST SERIOUS ATTEMPT at a census of the mentally ill in the United States was made in 1850. This was in connection with the general census of the population. Mental patients were counted not only in mental hospitals but also in their homes. Similar counts were made in 1860 and 1870. According to these censuses, there were 15,610 patients with mental disease in 1850, 24,042 in 1860, and 37,432 in 1870. The number per 100,000 population increased from 67.3 in 1850 to 97.1 in 1870. All of these totals were considered to be seriously defective, however. The first census to which reliability was attached was that of 1880, according to which there were 40,942 patients with mental disease in hospitals. In addition, through the cooperation of physicians, a total of 51,017 patients were found outside of hospitals. This made a total of 91,959, representing 183.3 per 100,000 population. In 1890 those enumerated in institutions increased to 74,028. Owing to the fact that physicians had not been asked to cooperate, as in the previous census, the total of those counted outside the hospitals fell to 32,457, giving a grand total of 106,485. Whereas the patients in hospitals showed an increased ratio to population, those outside of hospitals showed a marked decrease. Because of these serious errors in counting mental patients outside of hospitals, the Bureau of the Census finally abandoned the effort. Beginning with 1904, the census of such patients has been limited to those in hospitals for the treatment of mental disorders.

According to the census of 1904, there were

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150,151 patients in hospitals, more than twice the corresponding total in 1890. In fact, there were more patients in hospitals in 1904 than were counted both within and without hospitals in either of the preceding censuses. The hospital population provided a rate of 183.6 per 100,000 population in 1904, compared with *total* rates of 170.0 in 1890 and 183.3 in 1880. The next census, taken in 1910, showed a total of 187,791 in hospitals, an increase of 37,640 in 6 years. The rate per 100,000 population increased to 204.2 In 1923, 13 years later, the census showed a population of 267,617 in mental hospitals, or a rate of 245.0 per 100,000 population. Thus, between the first census in 1850, which included patients both within and without hospitals, and the census of 1923, which included only patients in hospitals, the rate per 100,000 population increased almost fourfold. (These data are summarized in *Patients in Hospitals for Mental Disease, 1923*.[13, p. 11])

In 1926 the Bureau of the Census began to issue annual statistics. Since 1947 they have been prepared by the National Institute of Mental Health. These reports indicate a steady upward trend. The total of such patients on the books of state hospitals reached 574,881 in 1950, or a rate of 381.4 per 100,000 population. (Computed from data in *Patients in Mental Institutions, 1950 and 1951*.[14, p. 36])

Before examining the significance of this trend, we may consider the distribution of mental disease throughout the United States, as shown in 1950.[14, pp. 36-38] Data for this large group are available by census divisions and states. For the country as a whole, the state hospital population represented a rate of 381.4 per 100,000 population. These rates varied from a minimum of 253.1 in the East South Central States to a maximum of 513.4 in New England. The former division includes Kentucky, Tennessee, Alabama, and Mississippi. New England includes Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut. Almost as high as New England was the rate of 471.1 for the Middle Atlantic States, which include New York, New Jersey, and Pennsylvania. Next in order was the Pacific division with a rate of 371.0. This region includes Washington, Oregon, and California.[14, pp. 36-38]

Among the individual states, the rates varied from a minimum of 200.1 in New Mexico to a maximum of 649.7 in New York. New Hampshire, Massachusetts, Connecticut, Illinois, and Delaware had rates well above the average for the country. Most of the low rates occurred in the South.[14, pp. 36-38]

Before concluding from these data that there is less mental disease in the South than in the Northeast and the Pacific regions, we must consider the following: In the first place, the South, as a result of its higher birth rate, has a greater part of its population at the younger age levels. Since the incidence of mental disease is lowest among the young, the rate for the general population is correspondingly low. In the next place, it is known that hospital facilities are not as prevalent in the South as in the North; hence, the admission rate tends to be lower. This is especially true with respect to Negroes, who constitute so large a proportion of the population of these states. Therefore, the total over-all rate is unduly low. On the other hand, rates of mental disease are highest in industrialized, urban areas, such as predominate in the North. The Pacific Coast has problems peculiar to itself, largely because of the phenomenon of migration. We may conclude then, that the rates are lowest in the South, but that they are spuriously low.

We may return, now, to the significance of the data with respect to the increase over the years in the number of mental patients. The interpretation of almost all those inclined toward the eugenic point of view is that there has been a great relative increase in the prevalence of mental disease in the United States. Opponents of this view maintain that the increase is due primarily to an increase of hospital facilities, which made it possible to admit more patients. For the country as a whole, there is undoubtedly much truth in this statement. Broadly speaking, however, both groups overlook the very simple fact that the population of the hospitals must increase, even if the rate of mental disease were constant. Until recently, admissions always exceeded discharges and deaths during a year. In 1950, for example,

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there were 141,493 admissions (excluding transfers) to the state hospitals in the United States, but only 125,798 separations (exclusive of transfers). Thus the admissions exceeded the separations by 15,695, increasing the hospital population by that amount. Obviously, therefore, we cannot conclude, from the statistics of resident patients alone, whether or not there has been an increase in mental disease.

What is desired is a count of new cases of mental disease in a stated period, usually a year. However, it is impossible to submit an entire population to psychiatric scrutiny. As a practical matter, it is necessary to count new patients in those places where they can be readily identified, and we must therefore return to a consideration of patients admitted to mental hospitals. We may consider the annual number of new admissions to hospitals for mental disease, or, as they are usually called, "first admissions."

Such data were first reported for the United States for 1922. In that year there were 71,676 first admissions to all hospitals for mental disease, or a rate of 68.2 per 100,000 population. Since 1926, these statistics have been presented annually. We may select certain of these years to show the increase in first admissions. In 1935 there were 101,462 first admissions, or a rate of 79.7 per 100,000 population. In 1941 there were 107,861 first admissions, or a rate of 82.0. In 1950 there were 151,074 first admissions, or a rate of 100.6. Thus, between 1922 and 1950, the rate advanced from 68.2 to 100.6 per 100,000 population, an increase of 48 per cent.[14, p. 22]

Can we infer from the increase in annual rates of first admissions that there has been a corresponding growth in the incidence of mental disease? Were the conditions which determine admission to a mental hospital, especially to a state hospital, constant, we should have to conclude that there has been a relative increase in the incidence of mental disease, but we cannot do this, for the reason that the conditions surrounding admissions have not remained constant throughout the country. New hospitals have been constructed, and new standards of treatment have been introduced throughout the United States. Part of the increase in first admissions is, therefore, a response to the improvement in hospitals. Consequently, to an unknown degree, the rates of first admissions to all mental hospitals in the United States indicate, in part, a possible increase in the incidence of mental disease but also an increase in hospital facilities.

We may overcome this difficulty by considering the history of admissions to the New York civil state hospitals. Let us bear in mind that what we desire is a body of data with respect to new cases of mental disease, but, since such information is not available, we use as an approximation the number of first admissions to all hospitals for mental disease. This number is less than the true total of new cases, because an unknown number of mental cases never receive medical attention and are therefore not discovered, and another unknown total is treated by private practitioners, who are not even necessarily psychiatrists. We must therefore assume that the ratio of first admissions to the unknown total of new cases arising in the state during the same period is sufficiently constant for practical purposes. If this is not the case, if the ratio has changed from year to year, with an approach to unity in more recent years, then any upward trend in rates of first admissions may have resulted from a more accurate count rather than from an increase in the number of patients with mental disease. Beginning in 1843, and coming to fruition in 1890, New York State adopted a system of state care, as a result of which the total of new cases gradually adjusted itself to the parent population of such cases, and justified the assumption that there has been a stabilization in their ratio.[5]

Data with respect to first admissions to the New York civil state hospitals are available since 1910. They are summarized in Table 1, where average annual rates per 100,000 population are shown from 1910 to 1950. Except for decreased rates during the two World Wars, there has been a steady upward trend in the rate of first admissions.

When a trend such as the preceding could not be explained by extraneous social factors, the ground of argument was shifted. Now the upward trend was declared spurious, on the

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TABLE 1. First Admissions to New York Civil State Hospitals, 1910–1950, per 100,000 Population*

FISCAL YEAR	MALES	FEMALES	TOTAL
1910	63.7	57.0	60.4
1912	65.5	59.4	62.5
1914	68.1	61.2	64.6
1916	70.0	63.7	66.9
1918	70.4	64.9	67.7
1920	67.8	62.5	65.2
1922	69.3	61.0	65.1
1924	68.2	61.3	64.7
1926	71.8	61.5	66.4
1928	77.1	63.1	70.1
1930	78.9	64.9	71.9
1932	90.8	74.2	82.4
1934	99.0	82.9	91.0
1936	102.9	88.3	95.6
1938	107.8	92.3	100.0
1940	108.2	95.5	101.8
1942	110.9	97.2	103.8
1944	102.8	102.7	102.7
1946	100.7	103.4	102.1
1948	104.4	101.4	102.9
1950	109.9	102.4	106.0

* The rates are based upon the average number of first admissions during 3 years; that is, the rate for 1910 is the average for 1909–1911, inclusive.

basis that the general population has been aging for several decades, and, as a larger proportion of the population reached old age, the rate of first admissions with mental disease increased. It is, of course, true that the general population has aged, though not to the extent that is often implied. It is also true that there has been a remarkable increase among first admissions of those aged 60 or over. But it does not follow that the rate of increase of the aged has been the same among the mental patients as in the general population. To test this, we may compare the average annual rates of first admissions to all hospitals for mental disease in New York State during four periods —namely 1919–1921, 1929–1931, 1939–1941, and 1949–1951. In making these comparisons, we may ask the following question: What would have been annual rates of first admissions in 1930, 1940, and 1950 if, in these years, the general population had had the same sex and age proportions as in 1920. In the latter year the rate of first admissions was 109.1 per 100,000 population. In 1930 the corresponding rate would have been 118.2, in 1940 it would have been 136.7, and in 1950, 150.0.[10]* Thus in 30 years, the rate of first admissions, constant for age and sex, increased by 37 per cent. The evidence appears conclusive, therefore, that there has geen a genuine increase in the rate of first admissions, and it may be inferred further that there has been a corresponding increase in the incidence of mental disease.

Thus far we have considered mental diseases in their most general aspects—the number of such patients, their rates of admission, and the question of their relative increase. We shall consider next certain important characteristics such as the distribution according to types of mental disorder, the age distribution of new admissions, and certain comparisons with respect to environment and race.

We may start with the distribution of mental disorders. In 1950 the data were available for 100,223 first admissions to state hospitals for mental disease in the United States. Of this total 71.7 per cent were included in eight groups of psychoses, as follows: dementia praecox, 23,637, or 23.6 per cent of the total; psychoses with cerebral arteriosclerosis, 15,187, or 15.2 per cent; senile psychoses, 10,822, or 10.8 per cent; manic-depressive psychoses, 5,240, or 5.2 per cent; general paresis, 3,000, or 3.0 per cent; psychoneuroses, 4,653, or 4.6 per cent; involutional psychoses, 4,863, or 4.9 per cent; and alcoholic psychoses, 4,485, or 4.4 per cent. A group even larger than many of these consisted of 14,691, or 14.7 per cent, who were admitted without a psychosis, but who were diagnosed as cases of epilepsy, mental deficiency, alcoholism, etc.[14, pp. 77–89]

Diagnosis, even in the purely physical disorders, and with the aid of laboratory procedures, is not yet an exact science. Therefore we cannot expect a higher degree of accuracy in connection with mental diseases. Standards of diagnosis may differ from state to state, and therefore the data for the country as a whole

* This study includes an extended analysis of the question of an increase in mental disease.

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are probably subject in some degree to the error of mixed categories.

For this reason we shall consider New York State, where statistical data have been gathered in a standardized manner for many years. Diagnoses are more uniform from hospital to hospital, owing to the teaching influences of the New York State Psychiatric Institute. Furthermore, the data are influenced only slightly by the inclusion of a group without psychosis. In New York this group represents about 1 per cent of the admissions to the state hospitals, as compared with 14.7 per cent for the whole country.

During 1950, there were 16,012 first admissions to the New York civil state hospitals. Of this total, 13,440, or 83.9 per cent, were included in 7 groups. The largest was dementia praecox, which included 4,658, or 29.1 per cent. The others were as follows: cerebral arteriosclerosis, 3,379, or 21.1 per cent; senile psychoses, 2,439, or 15.2 per cent; involutional disorders, 1,093, or 6.8 per cent; alcoholic psychoses, 1,078, or 6.7 per cent; general paresis, 420, or 2.6 per cent; and manic-depressive psychoses, 373, or 2.3 per cent.

Compared with the country as a whole, we find higher percentages of first admissions with dementia praecox, psychoses with cerebral arteriosclerosis, and senile psychoses. Involutional disorders also appeared to be more prevalent in New York. On the other hand, manic-depressive psychoses represented only 2.3 per cent of the first admissions in New York State as against 5.2 for the country as a whole.

¶ Psychoses with Cerebral Arteriosclerosis

The most interesting annual series of first admissions, from a statistical viewpoint, is that presented by the group of psychoses with cerebral arteriosclerosis. The records in New York State began in 1912. During that year there were 166 such first admissions. They represented 2.9 per cent of all first admissions. They increased year by year, and passed 1,000 in 1928. They passed 2,000 in 1935. In 1940 the total was 2,581, and in 1950 it reached 3,379. With respect to all first admissions, this group increased from 2.9 per cent in 1912 to over 20 per cent in 1950. Finally, the rate of first admissions increased year by year from an average annual rate of 2.4 per 100,000 population in 1913 to 22.9 in 1950.

TABLE 2. **First Admissions with Psychoses with Cerebral Arteriosclerosis to New York Civil State Hospitals, 1913–1950, per 100,000 Population***

FISCAL YEAR	MALES	FEMALES	TOTAL
1913	*2.4*	*1.9*	*2.2*
1914	*2.8*	*2.0*	*2.4*
1916	*4.4*	*2.3*	*3.4*
1918	*4.6*	*3.3*	*3.9*
1920	*5.5*	*3.8*	*4.7*
1922	*6.6*	*4.3*	*5.4*
1924	*7.1*	*5.1*	*6.1*
1926	*8.7*	*6.4*	*7.6*
1928	*10.1*	*7.4*	*8.7*
1930	*11.5*	*8.7*	*10.1*
1932	*15.1*	*11.2*	*13.1*
1934	*17.8*	*14.2*	*16.0*
1936	*19.3*	*16.1*	*17.7*
1938	*20.1*	*16.9*	*18.5*
1940	*21.8*	*18.0*	*19.9*
1942	*25.2*	*21.0*	*23.1*
1944	*25.1*	*22.8*	*23.9*
1946	*22.7*	*21.3*	*22.0*
1948	*22.7*	*19.3*	*21.0*
1950	*24.6*	*20.4*	*22.4*

* The rates are based upon the average annual number of first admissions during 3 years; that is, the rate for 1913 is the average for 1912–1914, inclusive.

There is no doubt, therefore, that there has been an increase in these disorders, as measured by rates of first admissions up to 1950. However, there have been objections that the upward trend is merely a result of the aging of the population. The force of this argument may be determined by studying the average annual rates of first admissions with these psychoses in 1920, 1930, 1940, and 1950. As psychoses with cerebral arteriosclerosis are more prevalent among males than females, it is necessary to consider changes not only in age but in sex proportions. Therefore the question

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was asked: What would have been the rates of first admissions with psychoses with cerebral arteriosclerosis in 1930, 1940, and 1950 if the general population of New York State had had the same age and sex proportions as in 1920?

In 1920 the rate of first admissions was 21.3 per 100,000 population aged 45 and over. In 1930 the standardized rate was 44.4. In 1940 it was 66.7. In 1950 the rate fell to 62.2, but this was still in excess of the rate for 1920 by almost 200 per cent. The corresponding increase for all mental disorders was only 37 per cent.[10, p. 176]

¶ Senile Psychoses

We may next consider the senile psychoses. These, too, have shown an upward trend for several decades, though the rate of increase is less than that for psychoses with cerebral arteriosclerosis. In 1909 there were 606 first admissions with senile psychoses to the New York civil state hospitals. These represented 11.6 per cent of total first admissions. There was very little fluctuation in these disorders for several decades, but from 1935 to date there has been a steady upward trend. Whereas these disorders represented 8 to 10 per cent of all first admissions prior to 1935, they have since grown to 15 per cent. Between 1930 and 1950, the average annual rates increased from 6.3 to 16.5 per 100,000 population. Unlike psychoses with cerebral arteriosclerosis, senile psychoses are more prevalent among females.

TABLE 3. First Admissions with Senile Psychoses to New York Civil State Hospitals, 1910–1950, per 100,000 Population*

FISCAL YEAR	MALES	FEMALES	TOTAL
1910	6.1	7.1	6.6
1912	5.8	6.9	6.3
1914	5.3	6.6	6.0
1916	5.1	7.2	6.1
1918	5.6	7.3	6.4
1920	5.1	7.6	6.4
1922	4.9	8.0	6.4
1924	5.2	8.0	6.6
1926	5.8	7.7	6.7
1928	6.1	8.0	7.0
1930	5.3	7.4	6.4
1932	5.6	7.9	6.8
1934	6.0	9.3	7.6
1936	6.6	10.2	8.4
1938	8.1	11.4	9.7
1940	9.4	12.8	11.1
1942	10.7	14.9	12.9
1944	13.4	18.2	15.9
1946	13.3	18.8	16.1
1948	12.5	19.6	16.2
1950	12.9	19.4	16.3

* The rates are based upon the average annual number of first admissions during 3 years; that is, the rate for 1910 is the average for 1909–1911, inclusive.

To rule out possible changes in the annual rates that might have resulted from sex and age variations over the years, it was necessary to standardize the rates. It then appeared that there was no change between 1920 and 1930. The average standardized rate of first admissions with senile psychoses per 100,000 population aged 45 and over rose to 37.2 in 1940, and increased still further to 41.3 in 1950. In 30 years the rate increased by 30 per cent.[10, p. 176]

Since the upward trend in senile and arteriosclerotic disorders cannot be ascribed to the factor of age, we must look for another explanation. I set forth the following hypothesis:

> The human organism must break down at some time. In younger persons, the organism is subject to one set of diseases, for example, tuberculosis. The control of such diseases has extended the expectation of life, and consequently more people are reaching that period of life at which circulatory and other degenerative diseases become manifest. A generation ago, those surviving to middle age probably constituted a better physical selection on the whole, than those reaching the same age periods today. Consequently, in corresponding age periods, we now find greater morbidity and mortality from degenerative diseases. With these are associated the physical conditions that produce senility and cerebral arteriosclerosis. In brief, then, we find increasing rates of both senile and arteriosclerotic mental disorders, because the individuals constituting the susceptible age groups today are probably not selected as rigorously as were the corresponding age groups of an earlier generation."[5, p. 497]

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¶ General Paresis

Whereas psychoses with cerebral arteriosclerosis were important statistically because of their great increase, general paresis is interesting for the opposite reason. For almost three decades there has been a steady decline in the relative incidence of this disease, as measured by rates of first admissions. In the years 1929 to 1931, for example, there were 2,719 first admissions with general paresis to the New York civil state hospitals. Ten years later, despite a large increase of the general population, there were only 2,681 such first admissions. Ten years later, there were even fewer first admissions, only 1,145, despite a further increase in the general population. Prior to 1915 first admissions with general paresis represented 12 to 13 per cent of all first admissions. Today, they represent less than 4 per cent. The rate of first admissions has decreased steadily from 8 per 100,000 population to an average of 2.8 in 1950.

TABLE 4. First Admissions with General Paresis to New York Civil State Hospitals, 1912–1950, per 100,000 Population*

FISCAL YEAR	MALES	FEMALES	TOTAL
1912	12.0	4.0	8.0
1914	13.2	3.2	8.2
1916	13.8	3.4	8.6
1918	14.0	3.6	8.8
1920	13.2	3.0	8.1
1922	12.6	2.9	7.7
1924	12.1	2.8	7.8
1926	11.5	2.9	7.2
1928	11.6	3.0	7.3
1930	11.4	3.1	7.3
1932	12.1	3.4	7.8
1934	12.3	3.4	7.8
1936	12.1	3.5	7.8
1938	11.1	3.4	7.3
1940	10.3	3.4	6.9
1942	9.5	3.1	6.2
1944	8.4	2.8	5.5
1946	7.1	2.3	4.6
1948	5.2	1.8	3.4
1950	3.8	1.4	2.6

*The rates are based upon the average annual number of first admissions during 3 years; that is, the rate for 1912 is the average for 1911–1913, inclusive.

There are marked sex differences with respect to general paresis. This disorder is much more prevalent among males. Rates of first admission are from three to four times higher among males. Both sexes, however, have participated in the decrease in the prevalence of general paresis.

The use of standardized rates shows the decline more clearly. In 1920 the rate of first admissions was 12.9 per 100,000 population aged 15 years or over. In 1930, on the basis of the same sex and age proportions of the general population of New York State as in 1920, the rate fell to 10.9. In 1940 the corresponding rate was 8.4, and in 1950 it fell still further to 3.0.[10, p. 176] There was a decline of 77 per cent in the annual rate of first admissions with general paresis between 1920 and 1950.

One can only speculate as to whether this downward trend will continue. It is known that syphilis began to increase in frequency during World War II. Whether this will ultimately result in more cases of general paresis and other forms of neurosyphilis depends upon the accuracy of case finding and the thoroughness of early treatment of syphilitics.

¶ Alcoholic Psychoses

Relative to all first admissions, those with alcoholic psychoses have been decreasing steadily since 1910 in New York State. In that year they represented 10.5 per cent of all first admissions to the civil state hospitals. Today they represent about 7 per cent. This is an artifact, however, due to the relatively large increases of other groups of psychoses. A better picture of the trend of the alcoholic psychoses is therefore obtained from the rates of first admissions. These began to decrease in 1918 and reached a low point in 1921, probably as a consequence of the successful application of wartime prohibition. After 1921, the annual rates grew until by 1941 they were higher than at any time since 1910. After 1941, however, there was a decline, the average annual rate

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falling to 5.4 per 100,000 population in 1946. The rate rose after 1946, and increased to 7.3 in 1950. These recent shifts in annual rates

TABLE 5. First Admissions with Alcoholic Psychoses to New York Civil State Hospitals, 1910–1950, per 100,000 Population*

FISCAL YEAR	MALES	FEMALES	TOTAL
1910	9.7	3.0	6.4
1912	9.4	3.0	6.2
1914	7.2	2.4	4.8
1916	6.7	2.4	4.6
1918	5.9	2.1	4.0
1920	3.0	0.8	1.9
1922	3.6	0.7	2.2
1924	5.3	1.3	3.3
1926	6.6	1.7	4.1
1928	7.4	1.5	4.4
1930	7.4	1.4	4.4
1932	8.1	2.0	5.1
1934	9.9	2.4	6.2
1936	10.2	2.7	6.4
1938	10.9	2.3	6.6
1940	11.3	2.4	6.8
1942	11.4	2.7	6.9
1944	8.0	2.4	5.1
1946	8.3	2.4	5.3
1948	10.0	3.1	6.4
1950	11.0	3.2	7.0

* The rates are based upon the average annual number of first admissions during 3 years; that is, the rate for 1910 is the average for 1909–1911, inclusive.

seem to indicate that the alcoholic psychoses decrease during war. Because of fluctuations in the size and composition of the general population during World War II, we cannot be certain of this. Some investigations of the age composition of such admissions, however, lead to the belief that the wartime changes probably were significant, and they suggest some relation between mental disorders and war, similar to that which is known to exist between suicide and war.

At any rate, we know that the rates of first admissions with alcoholic psychoses increased between 1920 and 1940. Ruling out possible changes due to the age and sex proportions of the general population by standardizing the rates, we obtain the following results: the rates rose from 3.6 per 100,000 population aged 20 years or over in 1920 to 8.0 in 1930, to 10.6 in 1940, an increase of 294 per cent in 20 years. The standardized rate decreased to 9.9 in 1950.[10, p. 176]

Manic-Depressive Psychoses

Relative to all first admissions, the manic-depressive psychoses increased from 1909 to about 1920 in New York State. The rate of first admissions also increased during this period, reaching a maximum of about 9 per 100,000 population. Since 1933 the rate has decreased steadily, reaching a minimum of 2.5 per 100,000 population in 1950. Males and females showed similar trends. But as the dis-

TABLE 6. First Admissions with Manic-Depressive Psychoses to New York Civil State Hospitals, 1910–1950, per 100,000 Population*

FISCAL YEAR	MALES	FEMALES	TOTAL
1910	4.5	7.4	6.0
1912	5.7	8.6	7.1
1914	5.7	8.4	7.0
1916	5.8	9.9	7.8
1918	6.6	12.0	9.3
1920	6.4	12.1	9.2
1922	6.8	12.1	9.4
1924	6.7	11.8	9.2
1926	6.7	11.6	9.2
1928	7.1	12.3	9.7
1930	7.4	11.7	9.5
1932	8.3	12.4	10.4
1934	7.6	12.2	9.9
1936	5.8	10.4	8.2
1938	5.0	9.8	7.4
1940	4.4	8.2	6.3
1942	3.7	6.9	5.3
1944	2.7	7.0	4.9
1946	2.6	6.0	4.4
1948	2.4	4.3	3.3
1950	1.9	3.1	2.5

* The rates are based upon the average annual number of first admissions during 3 years; that is, the rate for 1910 is the average for 1909–1911, inclusive.

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order is much more prevalent among females, we may consider their rates in more detail. First admissions with manic-depressive psychoses increased among females up to 1922. In that year they represented 20.8 per cent of all first admissions, with an average annual rate of 12.6 per 100,000 female population. Since 1922 there has been a marked decrease, culminating in a minimum in 1950. In that year, female first admissions with manic-depressive psychoses included only 3 per cent of all first admissions. This was due to an actual decrease in the number of admissions, for, despite a large increase in the female population of the state, the female first admissions with manic-depressive psychoses decreased from 862 in 1933 to 229 in 1950. The annual rate of first admissions among females decreased from a maximum of 12 per 100,000 female population to a minimum of 3.0 in 1950.

We may obtain another measure of the trend in manic-depressive psychoses by considering the standardized rates of first admissions for 1930, 1940, and 1950. Again using the age and sex proportions of the population of New York State as in 1920, we find the following rates: 17.7 in 1920, 17.4 in 1930, 11.1 in 1940, and 7.1 in 1950. There was a minor decrease between 1920 and 1930, but between 1930 and 1950 the rate decreased by 60 per cent. In the case of the females, the standardized rates decreased from 23.3 per 100,000 aged 15 and over in 1920 to 21.2 in 1930, to 15.3 in 1940, to 9.4 in 1950. The decrease between 1920 and 1950 amounted to 60 per cent.[10, p. 176]

¶ Dementia Praecox (Schizophrenia)

Finally, we may consider the trend with respect to dementia praecox, which represents the largest group of admissions to the state hospitals. Dementia praecox includes close to 30 per cent of all first admissions. Data with respect to such first admissions are available since 1909. Except for some minor fluctuations, the trend has been upward. The average annual rate rose from approximately 10 per 100,000 population in 1910 to 31 in 1950. During this period, males and females showed similar trends, but the annual rates were, until recently, higher among males.

Referring again to standardized rates, in order to make the proper comparison with respect to age and sex, we find the following rates per 100,000 population aged 15 and over, for 1920, 1930, 1940, and 1950: 31.7, 31.6, 37.6, and 54.6. Thus, the prevalence of dementia praecox, as measured by first admissions, was almost constant between 1920 and 1930, but there was an appreciable increase between 1930 and 1940, and an even greater increase between 1940 and 1950.[10, p. 176]

There has been a notable change during the past decade in the sex distribution of dementia praecox. Thus, prior to World War II, male first admissions with dementia praecox always exceeded females, both in absolute numbers and in rate per 100,000 corresponding population. Since 1944, however, this has been reversed, females now being in excess. This may be due in part to the admission of male veterans to federal hospitals instead of state hospitals. It will be necessary, therefore, to study rates closely in succeeding years to be sure that we are experiencing a fundamental change in the sex ratios with respect to dementia praecox.

¶ Age

From a consideration of trends in the more important numerical groups of mental disorders, we may now pass to an analysis of certain of their characteristics. The most important would appear to be the age distribution. We may begin with first admissions to all hospitals for mental disease in the United States in 1950. There were 142,353 first admissions, of whom only 1,171, or 0.8 per cent were under 15 years of age. Those aged 15 to 19 included 5,145, or 3.6 per cent. There were 48,602 between ages 20 and 39, or 34.1 per cent; 45,233, or 31.8 per cent, were aged 40 to 59; and 40,682, or 28.6 per cent, were aged 60 or over. The median age was 45.8 years.[14, pp. 36-38]

This distribution differs in a fundamental respect from that for New York State. In 1950, 22.5 per cent of the total first admissions in New York State were aged 70 or over, as

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TABLE 7. First Admissions with Dementia Praecox to New York Civil State Hospitals, 1910–1950, per 100,000 Population*

FISCAL YEAR	MALES	FEMALES	TOTAL
1910	10.8	10.0	10.4
1912	10.6	9.8	10.2
1914	12.6	11.6	12.1
1916	14.6	12.7	13.7
1918	18.4	16.2	17.3
1920	19.9	17.6	18.8
1922	19.2	16.3	17.8
1924	18.4	16.7	17.6
1926	19.4	16.7	18.1
1928	20.3	16.8	18.6
1930	20.0	17.0	18.5
1932	22.9	20.3	21.6
1934	24.4	22.4	23.4
1936	25.3	22.6	24.0
1938	26.0	23.2	24.6
1940	26.0	25.1	25.5
1942	26.1	24.4	25.2
1944	23.3	25.9	24.7
1946	23.7	29.1	26.4
1948	27.8	30.4	29.1
1950	31.5	31.0	31.2

* The rates are based upon the average number of first admissions during 3 years; that is, the rate for 1910 is the average for 1909–1911, inclusive.

against 16.9 per cent for the country as a whole. If we draw the line at age 60, we find that 35.4 per cent of the first admissions in New York were aged 60 or over, compared with 28.6 per cent for the whole country.

Whatever the true percentage, both distributions agree in showing that there is a real problem with respect to the aged. Thus, in 1930, there were 6,642 first admissions to all mental hospitals in New York State aged 60 or over, or 23.2 per cent of the total. In 1940 such admissions had reached 13,869, or 29.7 per cent. This increased still further to 20,670 in 1950, or 35.4 per cent.

This reflects more than a mere increase in the proportion of the aged. If we consider rates of first admissions per 100,000 of corresponding age, instead of absolute numbers, we find the following: among males the rate increased at ages 60 to 64 from 139.7 per 100,000 in 1920 to 198.0 in 1950. At ages 65 to 69, the rate increased from 178.6 to 264.0. At ages 70 to 74, the rates were 190.1 and 395.4, respectively. Similarly among females, the rates at ages 60 to 64 increased from 134.0 to 169.2; at ages 65 to 69 they increased from 149.0 to 219.2; and at ages 70 to 74 they increased from 208.4 to 372.0. Hence, we find that not only are more elderly people entering hospitals for mental disease, but they are doing so at an increasing rate.[2, p. 206]

Rates of first admissions are at a maximum in the older age groups. They are at a minimum at the youngest ages. In between, the rates increase steadily from age to age. For example, among males in New York in 1950, the rate of all first admissions to all hospitals advanced from 22.8 per 100,000 at ages 10 to 14, to 123.5 at ages 30 to 34, to 136.6 at ages 50 to 54, to 198.0 at ages 60 to 64, etc. Among females, the rates increased from 18.6 at ages 10 to 14, to 129.2 at ages 30 to 34, to 137.0 at ages 50 to 54, to 169.2 at ages 60 to 64, etc.[2, p. 205]

This steady increase is characteristic, however, only of mental disease as a whole. If we consider individual groups of mental disorders we find some important differences. In the case of general paresis, for example, the rates rise from a minimum of less than 1 per 100,000 at ages 10 to 14 to a maximum of about 7 per 100,000 at ages 50 to 59.[2, p. 207] They drop off to less than 5 per 100,000 at the advanced ages. In the case of the alcoholic psychoses, the rates rise to a maximum in the fifth decade, and then taper off to a minimum of less than 4 per 100,000 in old age.[2, p. 209] In the manic-depressive psychoses, the rates rise to a maximum in the fourth decade, and decline rapidly thereafter.[2, p. 217] Similarly with respect to dementia praecox, there is a rapid rise to a maximum in the late twenties and early thirties, and a steady decline thereafter.[2, p. 219] On the other hand, the senile psychoses and psychoses with cerebral arteriosclerosis begin in the fifth decade and rise steadily to maxima in old age.[2, p. 211, 213]

Reviewing such data, I wrote as follows:

The probability of a mental disorder is a direct function of age. The probability is low in child-

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hood, rises rapidly in youth and maturity, grows at a more moderate rate during the involution period and then advances rapidly to a maximum in old age. In this growth the aging process is implicated both directly and indirectly. It is evident in the specificity of such a disease as epidemic encephalitis. Constitutional factors seem related to the relatively early periods of life at which dementia praecox and the manic-depressive psychoses manifest themselves. We observe limitations with respect to general paresis and the alcoholic psychoses, which are clearly due to a combination of physiological, constitutional, and social factors operating during the prime of life. But the effect of age is seen most clearly in the direct consequences of physical and mental deterioration, resulting from senility and from arteriosclerotic changes.

Each period of life is therefore susceptible in large degree to certain characteristic types of mental diseases.[9]

¶ Environment

We may next ask whether there are any gross environmental differences in the relative distribution of mental disorders. By this is meant, are the rates of first admissions higher in urban areas than in rural areas? Are there any differences corresponding to differences in the size of urban populations? Based upon data for New York State from 1949 to 1951, it may be said that mental disease is more frequent among urban populations than among rural populations.[4] The rates are in the ratio of almost 2 to 1. This is true of all the major groups of mental disorders, including the old-age psychoses. On the whole, the rates grow uniformly larger as we progress from the rural areas to cities. There is great fluctuation in the rates of first admissions in the larger cities —New York, Buffalo, Rochester, Syracuse—but these rates, nevertheless, are well above those for the rural populations. The greatest relative differences are in connection with general paresis and alcoholic psychoses.

There is a further differentiation of the rural population into those living on farms and the nonfarm population. It is significant that the rates of first admissions among the former are now higher than for the nonfarm population, especially with respect to dementia praecox.

The non-farm population has grown significantly in recent years, a fact which is associated with a population movement from cities back to suburban and rural areas. . . . It has been shown that migration over long distances is associated with increased rates of first admissions. . . . This trend is reversed, however, when migration occurs over short distances, as represented by the nonfarm population. This is, in large part, a selection of higher economic groups. As such groups tend to have rates of first admissions below the average, they are probably responsible for the contrast in rates between the farm and non-farm populations.[4, p. 237]

¶ Racial and Ethnic Groups

Racial and ethnic differences have not, on the whole, received the consideration they merit. This is due primarily to the absence of a detailed racial classification of the people of the United States. The most obvious comparisons, and the only ones which can be carried out on a large scale, are those between Negroes and whites. If one were to accept statistics of first admissions in southern states at face value, it would appear that Negroes have lower rates of mental disease than whites. This is a clear reversal of the truth. On the contrary, rates of first admissions are far higher among Negroes than among whites. The fallacy in the statistics for the South resides in the fact that admissions are low for Negroes, owing to inadequate provision for their care and treatment. In New York, on the contrary, where no racial discrimination of any kind is practiced in admissions to the state hospitals, we find clear evidence of the excessive rates for Negroes.[6, p. 450-476] Detailed analyses of the average annual rates from 1939 to 1941 showed that the total rate of first admissions was twice as high among Negroes as among whites. The Negro excess was especially noticeable in connection with general paresis and the alcoholic psychoses. The problem resolves itself into whether the excessive rates among Negroes are

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due to racial factors or to social factors. The latter are clearly associated with high rates of general paresis and of alcoholic psychoses. Migration is also a very important factor among Negroes.[7, p. 350-364]

A group of ethnic interest is the Jew. Most writers have attributed an excessive amount of mental disease to Jews. It was shown in a series of studies that this conclusion was based upon inadequate data and upon wrong methods of analysis. The question was therefore studied in detail for New York State and for New York City, and it was shown that, far from being in excess, Jews actually had lower rates of first admissions than the remainder of the population. It has been customary to emphasize the prevalence of functional mental disorders among Jews, such as dementia praecox, but in this major group, the rate for Jews was not in significant excess. Therefore, whatever may be said about "nervousness" in general, or about the prevalence of the psychoneuroses, the evidence shows that Jews have less than the general average with respect to the psychoses. Attention should be directed to the exceptionally low rate of alcoholic psychoses among Jews. Even though their habits of drinking have changed during the past generation in the United States, their rate of alcoholic psychoses is still near the zero mark.[8]

On the other hand, the Irish, whether native-born or foreign-born, have higher rates of alcoholic psychoses than any other population group, including Negroes. This same excess was shown in connection with senile psychoses, psychoses with cerebral arteriosclerosis, and manic-depressive psychoses. The rate of dementia praecox was also among the highest. On the other hand, the Irish had the lowest rate with general paresis.[11]

There is a very complex combination of racial and environmental factors in relation to mental disease, not easily susceptible of differentiation. My impression is that biological factors in mental disease are more closely associated with family lines than with race. To determine the racial and ethnic factor, it will therefore be necessary to transfer our interest to family data within these populations. We are only opening the door at present to this type of investigation.

¶ Conclusion

It remains to ask what happens to the patients with mental disease who are being hospitalized at increasing rates. The general impression has long been that the prognosis is unfavorable, the rate of discharge being low and the death rate high. These conclusions were drawn from incorrect premises, however, despite the fact that Pinel had pointed out the correct methods of analysis more than a century ago.[11] Only recently has the correct procedure been adopted. This consists in tracing the histories of cohorts of first admissions to mental hospitals over uniform periods of time, beginning with the date of hospitalization. Such studies are now available for Ohio,[12] Pennsylvania,[1] and New York State.[3] They are all in good agreement, showing that the probability of discharge within a short period is high, and that rates of recovery or other degree of improvement are encouraging. Because of the greater number of first admissions, reference may be made to the results for New York State.

Cohorts of first admissions during five successive fiscal years, beginning April 1, 1943, were submitted to analysis. The closing date of observation in each case was March 31, 1949. The members of a cohort had equal periods of exposure, and this varied from a minimum of 1 year for the cohort of 1947–1948 to a maximum of 5 years for the cohort of 1943–1944.

Of the male cohorts, an average of 42 per cent were discharged within 5 years after admission, and 36 per cent were discharged from the books within 2 years. Those leaving the hospitals either by direct discharge or by placement in convalescent care (parole) within the first year amounted to approximately 30 per cent. Rates of discharge were low among first admissions with psychoses with cerebral arteriosclerosis, amounting to only 16 per cent at the end of 5 years. First admissions with senile psychoses had an even lower rate of

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discharge, namely 6 per cent. However, of manic-depressives, three fourths were discharged within 2 years, and two thirds left the hospitals within 1 year, either by discharge or by parole. By the end of the fifth year, 83 per cent had been discharged. Of first admissions with involutional psychoses, 50 to 55 per cent left the hospital within 1 year, and 68 per cent were discharged within 5 years. Of dementia praecox, 45 per cent left within 1 year, and 53 per cent were discharged within 2 years. These three groups of disorders had higher rates of discharge than corresponding cohorts of circa 1910. An equally favorable result occurred among general paretics. Of this group, only a fourth were discharged within 2 years, but this was well in excess of corresponding results for earlier cohorts.

Females showed similar results. The average per cent of discharge over 5 years was 44. The percentages were low for psychoses with cerebral arteriosclerosis (17), and senile psychoses (6), but high for manic-depressive psychoses (87), involutional psychoses (70), and dementia praecox (63). As with males, the three latter groups have higher rates of discharge than existed 3 decades ago. General paretics shared in this improvement, a third being discharged within 2 years.

Of the male cohorts, 39 per cent died within 5 years, most deaths occurring during the first year of hospitalization. As might be expected, mortality was high among first admissions with psychoses with cerebral arteriosclerosis, and with senile psychoses. Of the former, 72 per cent died within 5 years; of the latter, 84 per cent died within 5 years. On the other hand, mortality was low during the period of 5 years for dementia praecox (5 per cent) and manic-depressive psychoses (10 per cent). Sixteen per cent of first admissions with involutional psychoses died within 5 years. Mortality rates for these three groups were lower than corresponding rates for earlier cohorts. Half of the general paretics died within 5 years; nevertheless, this was lower than the rate for early cohorts of general paretics.

Females had lower death rates than males. In general, however, the trends were similar. Mortality was high among the arteriosclerotics and seniles, but low for dementia praecox, manic-depressive psychoses, and involutional psychoses. Except for the psychoses associated with advanced age, rates of mortality for females were less than corresponding rates for early female cohorts. General paretics showed a similar decline in mortality.

Because of high death rates, only 10 per cent of the males with cerebral arteriosclerosis remained in continuous residence at the end of 5 years. This was even lower for the seniles (6 per cent). On the other hand, because of a high rate of discharge, only 6 per cent of the manic-depressives remained at the end of 5 years. Because of their lower discharge rates, 30 per cent of the cohort with dementia praecox was still in residence after 5 years.

Among females, high mortality left only 12 per cent of the arteriosclerotics and 11 per cent of the seniles in residence after 5 years. Of the manic-depressives, only 4 per cent were still in residence. Thirty-five per cent of first admissions with dementia praecox were still in residence at the end of 5 years.

Except for the psychoses of old age, it appears that the results of therapy in mental hospitals are not only favorable, on the whole, but that there has been a significant improvement in outcome in recent years. Since the close of these follow-up studies, new types of treatment have been introduced, most notably the tranquilizing drugs. One may therefore look forward to a further improvement in rates of discharge and, in general, to an encouraging prospect for the treatment of mental disease.

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CHAPTER 8

THE GENETICS OF MENTAL ILLNESS*

Franz J. Kallmann

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IF THERE IS A GRAIN OF TRUTH in the idea that the unique behavioral norms of man during his stay on this planet have a gene-specific basis, then it is clear that, in order to understand the genetics of mental illness, we have to explore the genetics of mental health. The very fact that a specific type of psychopathology may result from an obscure deficit, traceable to either the action or inaction of a mutant gene, assures the reasonableness of this premise.

In line with an elementary genetic principle, the occurrence of a mutational change is sufficient evidence for the existence of a normal allele (the corresponding member of a pair of genes located at a definable point of a chromosome). The normal gene, even if its biochemical equivalents have yet to be identified,[72] can be assumed to make a vital contribution toward maintaining adequate health and normal behavior.

One of the corollaries of modern genetic theory, therefore, is that such phenomena as personality integration, emotional balance, and mental health are more than the result of chance circumstance reflecting only mild cultural pressures, or a fortuitous absence of disturbing experiences in childhood. More appropriately, the given phenomena are viewed as end products of a multitude of genetically potentialized properties and functions that are continuously molded by "ethnoplastic" forces —"the myriad elements constituting the life cycle of a human organism."[80]

The Place of Psychogenetics in the Science of Man

The very gaps in our knowledge of this self-perpetuating interaction between the genetic and nongenetic components of man's existence kept a door, or at least a porthole, open to the

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influx of speculative conceptual schemes regarding the roots of human behavior. Moreover, much of the background for inquiries into the genetics of normal and abnormal behavior patterns was formed by "a cleavage between natural and social science . . . which really was a cleavage between substance and action, body and soul, the objective and the subjective."[48] Under these circumstances it was rather inevitable that psychogenetic theories, covering the field of physiological, psychological, and psychiatric genetics, should have become the subject of much hypothetical argumentation.

Now and then, this ill-founded debate, widely referred to as the "nature-nurture" controversy, would boil over so vehemently that Muller[109] called it "an excellent example of wishful thinking by two sets of fanatical opponents, both of whom ought to know better." More to the point and certainly somewhat humbler was Braceland's[14] description of modern dynamic psychiatry as a slowly emerging medical discipline having the difficult task of coordinating two disparate ways of appraising mental disorder: the humanistic approach (insight into the meaning of human existence) and the scientific approach (knowledge of human nature derived from being "a part of the science of man").

Be that as it may, the current trend is toward increasing recognition of genetic principles in the medical and behavioral sciences —psychiatry and clinical psychology not excluded. This development, reflected in the gradual convergence of psychodynamic and physiodynamic theories of health and behavior, was given added impetus by two provocative events in the biological sciences. The first was the discovery of a causal relation between a high degree of specificity in many hematologic and metabolic functions, and the properties and actions of genic elements.[56, 111, 115] The second was the focusing of world-wide attention on the health hazards of nuclear radiation.[21, 36, 51]

Cautioned by the stark tenor of these authoritative reports, medical men everywhere have begun to consider possible prophylactic measures against the cumulativeness of genetic irradiation damage. The prevailing view is that exposure to mutagenic energy sources calls for the lowest safety levels consistent with medical necessity. Current estimates of the maximum dosage of medical radiation per individual allowable for safety during the first thirty years of life vary from 4.6 to 10 roentgens.

At the same time, there is greater realization of the imperative need for "the collection of more detailed information . . . about all kinds and all levels of genetics . . . to counteract dysgenic effects on the structure of human populations."[78, 95] With man's prospects of "meeting the evolutionary tests of survival and extension" hinging primarily on his ability "to avoid the missteps of blind nature,"[101] it is apparent that we must learn to put to optimum use our knowledge about basic genetic phenomena.

¶ General Genetic Principles

Chromosomes and Genes

The modern theory of genetics evolved from a rough picture of heredity as a kind of shuffling of the cards at the time of fertilization, to the all-encompassing concept of the molecular origin of life. The groundwork for this intricate scheme was laid in 1900 upon confirmation of Gregor Mendel's experimental garden-pea data, presented before the Brünn Natural Science Society in 1865.[35, 75]

Convinced of the statistical meaningfulness of the observed distribution of certain plant characteristics (shape and color), the Austrian biologist set forth his hypothesis of the "unblended" separation and subsequent recombination of stable genetic units. The gist of it was that single characters behaved as if determined by paired particles (later called genes) in the germ plasm.

Another implication was that of the two members of a pair joining to form the zygote (one-celled stage of the new individual), one being derived from the father (male germ cell) and the other from the mother (female germ cell). When new germ cells are formed by the matured individual, the paired mem-

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bers separate again, without having had a chance to influence each other or enter the same germ cell (law of segregation). It also follows from Mendel's hypothesis that two corresponding or allelic genes occupy the same linear position on two homologous chromosomes (coiled filamentous structures in the nucleus of a cell).

Parenthetically, it may be mentioned here that a plant or animal is called a homozygote for a particular gene and is expected, under ordinary environmental conditions, to show its characteristics, if that gene is received from both parents. A heterozygote (hybrid) originates when the given gene is received from only one parent and, at the corresponding locus, a different one from the other parent.

In some cases the Mendelian trait displayed by the heterozygous individual will be intermediate between the traits represented by homozygotes; in others the possession of only one member of a gene pair will suffice to produce the trait (dominant), while its partner remains unexpressed (recessive). Homozygousness is necessary for the expression of a recessive trait in the individual's appearance (phenotype), as heterozygousness merely allows the gene to remain part of the individual's genic formula (genotype) to be transmitted to the offspring.[78]

It was not just by chance that discovery of the chromosomes[150] took place in the thirty-four-year interval during which Mendel's findings remained unnoticed. The nuclear filaments, observed under the microscope as threadlike bodies with a peculiar staining reaction, were seen to divide in the process of ordinary cell division and to be redistributed as duplicates, with each germ cell receiving half the parental chromosome structure. This pattern was consistent with Mendel's experimental observations and made it possible to combine the knowledge derived from breeding experiments with that provided by cytogenetic, biochemical, and evolutionary studies. When advances in experimental, clinical, and population genetics merged with the *avant-garde* units deployed by other biological disciplines, more precise formulations of the chromosome theory became feasible.

Although chromosomes were visible microscopically and known to consist largely of nucleo-proteins (substances of high molecular weight made up of proteins and nucleic acids), the original concept of a gene was of a minute, invisible protein particle, or large molecule, situated in a certain segment of a chromosome and distinguished from the molecular structures of adjacent segments by a high degree of specificity of its biochemical action. This old construct of a gene has been elaborated into that of a clearly differentiated functional region (locus) which preserves its identity, produces a specific effect, and is capable of duplicating itself. Its self-duplication is executed by attracting from the cellular surroundings (nuclear fluid) the raw materials for reconstructing the same type of directional center, rearranging and binding them into a pattern identical with its own.[100] Because of this unique faculty of genes to construct exact duplicates of themselves and thus serve as the synthesized product of chemical reactions that they themselves have directed, genic activity is basic to all growth and reproduction.

Chemically, genes have been described as DNA segments (desoxyribose nucleic acid) of perhaps several hundred nucleotides which apparently carry the ingredients for the synthesis of a specific macromolecule.[10, 92] The genetic specificity of these primary functional (informational) units is assumed to depend on proportions and sequences of base pairs in a particular DNA segment. Replication is probably accomplished by separation of complementary nucleotide chains, followed by synthesis of complementary daughter chains. An essential part of this hypothesis is the assumption that the functional process of gene action involves a transfer of DNA specificity to RNA units (ribonucleic acid), which, in turn, may serve as templates in protein synthesis.

With the present balance of evidence pointing to proteins as primary gene products, it is easy to conceive of a mutant gene's effect as the possible cause of either a quantitative deficiency or a qualitative alteration of the given protein. Obviously, one or the other can result in pathological changes.[30]

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From the standpoint of physical and mental health, the potentialities for maintaining it on a satisfactory level apparently depend on the ability of all genic elements to work together by means of meticulously coordinated reactions, thereby establishing what is called "the balance of the genes." By and large, this physiological state is analogous to general conditions of integration described by such terms as homeostasis, adaptiveness, and emotional equilibrium.

By the same token, the species characteristics of human populations rest on rigid specifications as to number, size, shape, and relative positions of the original sets of chromosomes found in every cell of the body. Whether a human cell contains forty-eight chromosomes, as has long been accepted, or only forty-six "essential" ones, as has recently been discovered, the numerical constancy is maintained by reduction to one half the number in the course of fertilization.

Since there is no correspondence of a species' complement of chromosomes with its position on the evolutionary scale, the modern definition for such an intrabreeding Mendelian population rests on the concept of "a reproductive community of individuals who share a common gene pool."[34, pp. 1, 2] Accordingly, subspecies or ethnic groups are "subordinate Mendelian populations differing in relative frequencies of genes or chromosomal structures, and usually also in external appearance and . . . physiological properties."

Because human subpopulations undergo continuous boundary changes in other distinguishing (isolating) factors—geographic, cultural, socioeconomic, and the like—a well-established formula is used to describe a random-mating population in equilibrium (no selective advantage of one allele over the others at any locus, and absence of mutations). Known as the Hardy-Weinberg law,[58, 152] this formula, together with an analysis of adaptational and selective phenomena, is indispensable for an understanding of continuing intrapopulation variations from generation to generation as a corollary of simple Mendelian principles.

Mutation and Variable Gene Expression

As the prototype of genetically produced and genotypically transmitted changes, both evolutional and pathological, mutational processes play a crucial role. Generally speaking, a mutation occurs during gene reproduction, either spontaneously or in response to mutagenic agents, but always as an expression of the failure of two synapsed genes to reproduce in the form of exact replicas of themselves.

The given change may be structural (deletion, duplication, inversion, translocation) or chemical (substitution of one component for another, or a shift in the order of components). Depending on whether the affected chromosomal point or portion is altered to a greater or lesser extent, the mutational effect may be extremely deleterious (lethal), moderately severe, or slight and only detectable statistically in large populations by a change in certain health and survival values. In any case, mutations are apt to be transmitted to the next generation via the germ cells.

Subsidiary genes, which cause quantitative changes in the expression of a major mutant gene, are referred to as modifier genes if they contribute to the variable expressivity of a trait. Although generally difficult to identify, they are called suppressor genes if they are responsible for incomplete penetrance of the main gene. The failure of a major mutant gene to be expressed at all (lack of penetrance) can be determined by studying populations known to be homozygous for the given trait, that is, children of two affected parents or one-egg co-twins of affected persons. The extent to which either group falls short of an expected manifestation rate of 100 per cent represents the degree of incompleteness of the gene's penetrance.

Other variations in the expression of a gene may arise either from the fact that it produces different effects depending upon its location on the chromosome (position effect), or from a tendency to exert different effects upon various organs from one and the same location (pleiotropic effect). Positional changes

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may subject the gene to different cytoplasmic influences or may make it necessary for the gene to express itself in different linkage groups. The effect of a major mutant gene may also be simulated by a chromosomal aberration (supergene).

Of course, every gene may undergo a number of mutational changes, although only two of these mutants, present in a population, can form a pair occupying a certain position on a particular chromosome in any one individual. A good example of such a series of multiple alleles is represented by the blood groups.

Under conditions of linkage of two or more different sets of genes (proximity of location on a chromosome), a study of the frequency of the given genes' separation in the offspring allows an estimate of the relative chromosomal positions of linked genes. This method has made it possible to construct highly important chromosome maps that may be verified "in a number of ways by direct microscopic observation."[100]

One of the main genetic principles is that the phenotypic expression of simple genes with a distinguishable normal or pathological effect is not an independent entity; rather, it is "a unified action of a field type which results in a hierarchical order of not strictly delimited fields."[55, p. 182] A gene does not directly produce a given trait, nor can it be expected to be "the absolute . . . or simple determiner" of a trait.[100] It merely sets in motion a chain reaction that may be modified by environmental factors, prenatal or postnatal, as well as the action of other genes, before culminating in the production of a particular trait.

Hence, a gene effect may vary from complete expression to no apparent expression, although there is usually only one major conspicuous effect or characteristic symptom whereby the gene's presence is identified under ordinary circumstances.

Modes of Inheritance

Where a single mutant gene is potent enough to express itself distinctly against a vast number of other genetic background factors, its phenotypic effect will tend to be pathological. In this single-factor type of inheritance, the distribution between the sexes of a dominant or recessive gene is usually equal (autosomal). Exceptions are due to the effect of genes transmitted on the sex chromosomes (XX in females, XY in males). In recessive X-borne conditions, males are more frequently affected than females. The sex prevalence is reversed in dominant sex-linked traits, while Y-borne characters occur only in males.

Distinguished by transmission in the direct line of descent and by inheritance from one parent, autosomal dominant traits are apt to be rare (self-eliminating) and incompletely expressed. Their appearance in the phenotype requires only one member of a gene pair (heterozygousness), and unions between two afflicted persons are uncommon.

Simple recessive traits, expressed only by homozygotes, require inheritance from both parents, who are frequently unaffected phenotypically (heterozygotes). No parent, whether heterozygous or homozygous for such a trait, can possibly have an affected child (homozygote) unless he marries another carrier of the given gene. Consanguineous marriages are apt to increase the chances of this type of mating, especially in the case of a relatively rare and severe disorder. Transmission along collateral rather than direct lines of descent is the rule, a principle which militates against the common practice of accepting the verdict of an "inherited" disorder only where the symptoms are clinically traceable to one of the direct ancestors of the patient.

For statistical purposes it may be borne in mind that many mutant genes in man do not conform to simple schemes of single-factor inheritance. Some genes are neither strictly dominant nor strictly recessive but somewhere in between (incomplete dominance or recessiveness). While a dominant trait will not be manifested by every heterozygote, a recessive gene may express itself mildly in a heterozygote whose corresponding factor for health is only incompletely dominant. Such modalities promise to be helpful in devising new techniques for the detection of carriers.

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Intermediate gradations always characterize the additive effect of polygenes which interact in determining small variations in normal personality characteristics in a given population.[92] In this multifactor type of inheritance, cumulative contributions are made by an assortment of genes which individually produce only minor effects.

In an intermarrying population with random mating, the resultant distribution of polygenic traits can be plotted in a bell-shaped curve showing variations from the lowest to the highest grades. With medium-grade persons expected to be in the majority, and with the two extreme types the least numerous, the total effect will not fall in the pathological range, unless placed there either by clinical definition or by a mutational change in one of the polygenes involved.

In line with these broad principles of quantitative inheritance, it is now generally agreed that the list of polygenically determined traits includes the reaction norms of height, intelligence, longevity, and variable resistance to selective types of infectious disease. As to inadequate intellectual potentials, for instance, undifferentiated high-grade defects (morons with no other clinical symptoms) are assumed to form the lower end of the Gaussian distribution curve of intelligence in the general population, while low-grade defects do not fit into any scheme of continuous variation.

Formulated in this comprehensive fashion, the polygenic theory of familial mental deficiency is consistent with the idea that "a Kallikak family tends to propagate its own culture as well as its own heredity and, by assortative mating, continually accumulates its own kind of both." According to Allen,[3] this concept reflects "a reassuring convergence of genetic and behavioral thought."

Assortative mating trends are genetically identified as interfering with random mating. From the standpoint of population genetics, the effect of this interference may be *positive* (increase of marriages among people with the same traits) or *negative* (resistance to marriage on the part of people with the same traits). The consequences of positive assortative mating may either be desirable (intelligence, musical talent) or undesirable (deafness).

¶ Methods of Genetic Investigation

The methods used in genetic studies in man differ according to whether an analysis deals with the health problems of entire populations or certain groups of families. In either case it is essential to note that gene-specific variations follow the theory of probabilities.

Mendelian ratios express no more than the average expectancy of a genically determined trait in a representative population sample. Diversified statistical procedures are needed to test the validity of inferences drawn from individual observations.[90, 107] This principle applies to all genetic mechanisms and attributes —physical or mental, normal or pathological, frequent or rare. Here, however, only those statistical methods will be discussed that are necessary in psychogenetic studies.

Family-History Method

Since statistically representative samples of particular subgroups of people or populations are a principal requirement, genetic data obtained from individual families (pedigrees) or sets of relatives (one pair of concordant or discordant twins) usually prove of limited value. Family histories are seldom published because of familial concentration of exceptionally fine health in one generation after another, or because of the rare occurrence of a severe pathological condition in a particular family. Also, it is obvious that an affected person would have to be fertile in order to have a similarly afflicted child, or his parents would have to have had at least seven children if he is to have six affected siblings.

At best, therefore, the usefulness of the ordinary family-history method is restricted to counseling problems and the study of rare pathological traits which are easily traced genealogically and known to be fairly constant in penetrance and clinical expression. Single pedigrees demonstrate mainly how often sim-

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ilar varieties of a familial trait may occur in the members of an affected family. They are not expected to furnish conclusive proof of the operation of heredity as such, or of the usual mode of inheritance observed.

Generally, the various systems of constitutional typology are the equivalent of pedigree studies in the area of population genetics. In the opinion of Rees and Eysenck,[117] the major part of the measurable variation in any human group is accounted for by two factors alone—growth in length and growth in breadth.

Census Method

For purposes of a comprehensive genetic analysis, the applications of total-population surveys (census method) are also limited. Exceptions are surveys concerned with small and sufficiently cooperative populations (isolates) as well as those dealing with relatively uncomplicated traits ascertainable by enumerative procedures (questionnaires, vital statistics, registries of reportable diseases and defects). Even without close personal contact with the members of the communities to be surveyed, pertinent population data may be obtained censuswise on the distribution of freckles, pellagra, or blood groups (if blood samples are available). The situation is different for possible linkage phenomena, the selectivity of dietary deficiencies among the members of certain families, or the genetics of a special form of blood incompatibility between mother and child.

Similarly, a line has to be drawn between the relative frequencies of tasters and nontasters on the one hand, and inquiries into possible psychological deviations of nontasters on the other. Hence, the census method is neither economical nor fruitful when it comes to genetic problems presenting difficulties of diagnosis or ascertainment (reluctance of families to disclose embarrassing private affairs with nonspecialized research personnel) or to questions calling for data on differential fertility rather than general marital fertility rates. The application of ordinary census procedures is equally unsuitable in problems where differential morbidity-risk estimates, rather than actual prevalence statistics, are needed.

Morbidity-Risk Data

When statistically corrected expectancy rates are used in a genetic analysis, the comparative scheme is focused on the probable or empirically observed morbidity risk (expectancy) of members of certain families with respect to particular traits and their phenotypic variations under different circumstances (different periods of time or life, various ethnic or socioeconomic settings, etc.) By definition, the disease expectancy of a person is "the risk of becoming ill during one's lifetime, if one lives long enough to pass the period of risk," that is, the time during which the disease may develop.[141] The two principal methods for obtaining expectancy rates in clinical genetics are Weinberg's system (proband-sibship, abridged, and double proband methods) and certain extensions of the twin-study method (twin-family method). Other procedures include Ilse's and Strömgren's methods, morbidity tables, and Bernstein's a priori method.[73, pp. 135–147]

In *Weinberg's system*[151] the chief objective of a comparative analysis is to determine whether a given trait occurs more frequently in blood relatives of a representative number of probands or index cases (persons disclosing clinical evidence of the trait in question) than in the general population. The observed number of affected persons among the siblings of the probands (full sibs, half-sibs, step-sibs) is analyzed in terms of varying parental matings (affected or unaffected).

In the case of full sibs, both parents may be phenotypically free of the disease, but, for purposes of a genetic analysis, they are distinguished by the fact of having produced at least one affected child, the proband. In other words, parental matings with no affected child cannot be reached by a procedure which begins with a sample of patients of a certain variety within the boundaries of the area covered by the study. This statistical bias in the ascertainment of index sibships is corrected by omitting

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from the analysis all patients obtained as probands.[127]

In order to adjust inequalities in age distribution, the actually observed (absolute) morbidity figures are related to the total number of persons who have survived the given period of manifestation, increased by half the number of persons who at the time of the study are still within the age limits of this period (abridged method). Persons who never reached the beginning of the manifestation period because of death or who are too young to have reached it are not counted. The resulting morbidity rates are average expectancy figures, valid for persons who are old enough to have developed the usual clinical symptomatology of the disease in question.

The range of the given manifestation period is to be chosen in accordance with clinical experience. Obviously, statistical accuracy in employing the abridged method depends as much on a fairly uniform distribution of the persons observed within the accepted period of manifestation as it does on the representative size and diagnostic uniformity of the total group studied. Several methods are available for testing the assumed homogeneity of clinical subgroups.

The corrective procedures of Weinberg's system are also used in the twin-family method, which combines the principles of the proband-sibship and abridged methods with those of the twin-study method, as well as in the analysis of normal control data for a comparable general population, that is, a group of persons not ascertained through known consanguinity to the given type of proband.[78]

Twin Studies

The twin-study method is a quasi-experimental procedure which has been profitably employed in exploring the genetics of both normal and abnormal behavior patterns. Introduced as a genetic-research tool by Galton,[41] the method is based on the regular occurrence of two genetically different types of twins, one-egg (monozygotic) and two-egg (dizygotic). Whereas one-egg twins are always of the same sex, two-egg twins may be of the same or opposite sex.

In the original version of the twin-study method, the comparison of observable similarities and dissimilarities in the histories of genetically similar and dissimilar members of a family is limited to twin subjects. This procedure requires access to a representative series of one-egg and two-egg twins, of the same or different sex, presenting evidence of a diagnostically well-defined trait to which the principles of the proband method can be applied. The most useful criterion for an unbiased sampling of twin index cases (rather than pairs) is provided by an approximate agreement between a twin sample and the parent population in regard to the proportion either of opposite-sex pairs or, when known, of one-egg pairs.[1]

In the United States the general twin rate is 2.19 per cent of all babies born since 1928. This rate is reduced to about 1.9 per cent by excess twin mortality within the first year of life, while the 2-to-1 ratio of same-sex to opposite-sex pairs observed at birth persists in all age groups. After the first year of life, there is no significant difference between the mortality rates of twins and nontwins, so that the proportion of twin individuals in the population remains nearly the same at all ages.

While morbidity statistics obtained from twin samples are to be related to twin subjects rather than pairs, twin data on normal personality characteristics are expressed in terms of varying degrees of intrapair similarity or dissimilarity, and not in terms of concordance or discordance. An effective statistical technique employed in estimates of genetic components in normal personality variations is Holzinger's h^2: the variance of two-egg twins minus the variance of one-egg twins, divided by the variance of two-egg twins.[108] In order to establish the significance of the h^2 values, an F test may be used for the ratio of the two-egg over the one-egg variance.

In another version of the twin-study method, called the co-twin-control method,[49] observational or experimental data are obtained from a few selected pairs of one-egg twins whose

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aptitudes, physiological reactions, or adjustive patterns can be compared under different life conditions, or in response to planned differences in management. In spontaneously discordant pairs (one schizophrenic and one nonschizophrenic, or one deaf and one hearing partner) longitudinal comparisons of chemical and psychometric tests may prove illuminating as to etiology, treatment, or personality assessment, provided the given twins are monozygotic.

For determining the zygosity of same-sex twins, the method of choice is the modern similarity method, with its dermatoglyphic (qualitative and quantitative) and blood-group data.[75, p.63] In particularly important instances, where all other diagnostic criteria are indecisive, reciprocal skin grafts may be performed. Twins cannot be monozygotic if their blood groups differ or full-thickness homografts are rejected. The fetal-membrane method is no longer in use, since it is now known that not all one-egg pairs are born with only one placenta.

In the third version, the twin-family method, the comparative scheme is extended to complete sibships of twin index cases and their parents. The six dissimilar sibship groups to be compared are one-egg twins, two-egg twins of the same sex, two-egg twins of opposite sex, full sibs, half-sibs, and step-sibs. The main advantages of this procedure lie in its effectiveness as a sampling method and its inconspicuousness as a pluridisciplinary approach to total population surveys which require combined cross-sectional and longitudinal investigations in a cooperative family setting. So broad is the scope of this combined procedure that it fulfills nearly all requirements specified by Cattell *et al.*[29] for the use of the multiple-variance method in investigating functionally (not necessarily genetically) unitary traits in the normal range of personality development.

In analyzing twin-family samples in terms of expectancy rates, it is essential, too, to compute all statistics from twin index cases rather than twin pairs. This requirement applies especially when many pairs are represented by a single index case, and morbidity-risk figures are to be compared within the sample. Regardless of the advisability of using the same means of computation for penetrance and concordance estimates, however, the number of index cases from concordant pairs is eventually halved in computing concordance rates, in order to correct for the twofold representation of concordant pairs in the sample.[1] With this stipulation, differences between one-egg and two-egg groups of twins will have the same statistical significance whether they are evaluated in terms of concordance or of morbidity expectancy.

Procedural Considerations

Like any other scientific procedure, twin studies have their limitations, hence it would be a mistake to let the method bear the full burden of proof in zealous attempts to isolate multiple and continuously interactive variables.[72] Yet it would be equally inappropriate to belittle the value of twin studies solely on the grounds of some inherent imperfections in applicability.

Twins, as a research species, fall short of perfection. For one thing, they are prone to prematurity and birth trauma and may carry some genes which are sensitive to asymmetrical cytoplasmic influences in the prenatal period. For another, twins cannot be separated before they are born, nor can they be kept in cages. What is more, they are destined to enter a world in which parents specialize in the practice of rearing their own children, so that similar and dissimilar twin partners can neither benefit from nor be observed in entirely different cultures.

Fortunately, once a twin has survived his first year of life without definite signs of organic damage, he is bound to be undistinguished from single-born individuals, even to the extent of having a complete ego of his own. Just as there is no evidence that premature babies are more likely than full-term infants to develop a psychosis, so are there no statistical indications that infections, emotional disturbances, or other tangible disabilities are more prevalent in twins than in the general

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population. On the contrary, twins are known to vary as much in their personalities, intellectual performances, and stress-symptom thresholds as do single-born people. Compared with the latter, twins have not been shown by any investigator to be less healthy, less longevous, or less selective in regard to their own formula of adjustment.

The popular notion that the behavior patterns of one-egg twins are alike chiefly because of unusual similarity in their early environments has yet to be substantiated. If confirmed, the argument "would only strengthen rather than weaken" correctly formulated genetic theories.[72] No psychodynamic concept is inconsistent with the general biological premise that "heredity acts, in part, by influencing the selection, and in fact the creation, of the environment of the given individual."[100]

In Muller's opinion, another factor should be considered in this respect. As a rule, the tendency of one fetus to gain an advantage over the other is assumed to be stronger in one-egg than in two-egg twins, as the former are more closely associated and more prone to mirror-imaging than the latter. However, since this factor "acts to decrease the resemblances between identical twins more than those between fraternal twins . . . it leads to an underrating rather than an exaggeration of the influence of heredity."

In any case, although the refinement of twin studies may have been somewhat impeded by the complexities of human nature, this method has made it possible gradually to amass a wealth of empirical data which have to be considered in the formulation of every psychiatric theory of fundamental intent. In particular, for a great number of normal personality characteristics, it has been shown that consistent intrapair similarity is not observed in the absence of genotypic identicalness.

Two-egg twins of the same sex tend to differ as much in their personalities as any siblings reared together or apart. It is only in one-egg twins that even pronounced differences in life experiences are not potent enough to erase basic similarities in appearance and general personality traits.

¶ Genic Control of Disordered Metabolism and Behavior

Realization that a well-integrated metabolism is a requisite for normal behavior and balanced neurohormonal functioning has assured the strategic position of biochemical genetics in current psychiatric research programs. An important by-product of this development is that genes are now fairly generally accepted as exerting their effects through control of metabolism, their action taking place in the same fashion as that of "any other agent that influences the course of a biochemical reaction."[149] Through the use of experimental techniques in studying specific products of gene action, investigations into the causal relation between gene-specific metabolic deficiencies and disordered behavior patterns have gained in volume as well as in purpose.

In exploring a chain of reactions between the direct activity of a gene and the observable end product, some difficulty arises from the fact that "valid generalizations about these reactions are more likely to concern the initial links than the terminal ones." What has been clearly established, however, is (1) that many mutational changes in biochemical reaction potentials "are due to changes in quantity, quality, or activity of enzymes, enzyme complexes, or other macromolecular systems that undergo specific kinds of chemical combinations and thus cause non-random orientations of molecules"; and (2) that "enzymes and other macromolecules have their specificities determined by direct gene action in which the genes participate by serving as models or templates."[149, p. 188] The question of whether it is always by direct gene action that a specific protein, nucleic acid, or polysaccharide is formed or destroyed has yet to be supported by experimental evidence.

Generally speaking, it can be said that a deviant metabolic chain reaction is apt to be set in motion by a mutant gene effect which produces either a quantitative or a qualitative alteration in one of the many thousand protein

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varieties in the body. This concept of a faulty link in protein synthesis follows the pattern of Garrod's classical work on alkaptonuria[45] which led to the tentative hypothesis of a 1-to-1 relation between genes and enzymes. Recent developments in the analysis of these "inborn errors of metabolism" have been so rapid and diversified[30, 92, 123] that it is not possible to present more than a few illustrations here.

Gene-Specific Defects in Protein Synthesis

An almost complete loss of the ability to synthesize gamma globulin antibodies (agammaglobulinemia) is produced by a sex-linked recessive gene.[50] The ensuing lack of resistance to bacterial infections is so precarious that prior to the discovery of antibiotics it seems to have caused the death of many affected infants.

A reverse effect of pharmacological advancement has been observed by Dean and Barnes[31] in South African families with a dominantly inherited disorder in the metabolism of pyrrole pigments (porphyria). In these porphyric Afrikanders, painful abdominal attacks and severe emotional disturbances are almost always precipitated by drugs, especially barbiturates.

The action ascribed to the autosomal recessive gene for sickle-cell anemia has been identified as a qualitative change in the synthesis of hemoglobin. Compared with normal hemoglobin, deoxygenated abnormal hemoglobin has a lower solubility which reveals itself clinically in the sickling of red blood cells and is demonstrable electrophoretically. Chemically, the difference between the molecular structures of normal and sickle-cell hemoglobins seems to lie in but two amino acid residues, with the gene-controlled substitution of two methyl groups in sickle-cell hemoglobin for two carboxyl groups in normal hemoglobin.[68, 112, 114] This change of less than 0.1 per cent of the molecular weight of hemoglobin "is sufficient to result in a fatal disease."[122]

Among the many other pathological conditions known to be associated with inherited deficiencies in protein synthesis are hemophilia, albinism, and alkaptonuria.

Metabolic Deficiencies Incompatible with Normal Brain Function

The biochemical deficiencies identified as recessively transmitted causes of intellectual inadequacy have been divided into the following four groups of metabolic disorders: lipids, amino acids, carbohydrates, and pigments.[70]

The first group consists mainly of the cerebral lipidoses and is typified by amaurotic idiocy (Tay-Sachs disease) and gargoylism. A consistent pathological feature is the tendency of the nerve cells throughout the nervous system to be distended with lipid material.

In the second group, which is associated with disordered amino acid metabolism, phenylpyruvic oligophrenia exemplifies a quantitative deficiency of an enzyme protein rather than a qualitatively altered form of the normal enzyme. According to Knox and Hsia,[82] phenylalanine hydroxylase is the deficient protein that disrupts the metabolism of phenylalanine and leads to excessive urinary excretion of phenylpyruvic acid. The degree of mental defect is usually severe and is thought to be the result of a diminished rate of oxidation.

Another well-documented example is Wilson's disease (hepatolenticular degeneration), distinguished by a genetically determined deficiency of ceruloplasmin.[124] Identified as a plasma copper protein with a molecular weight of 151,000, this blue globulin contains eight atoms of copper per molecule. Through its enzymatic properties as an oxidase, it regulates the absorption of dietary copper from the gastrointestinal tract.[125] Apparently, a ceruloplasmin deficiency is followed by an excessive accumulation of copper and its subsequent diffusion through the blood into almost all tissues of the body.

The third group of special mental-deficiency states is associated with aberrant metabolism of carbohydrates. In galactosemia,[62, 69] galactose is not normally metabolized because of an almost complete deficiency of the protein

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phospho-galactose-uridyl transferase. In healthy persons this enzyme is responsible for the conversion in the liver of galactose-1-phosphate to uridine diphosphate galactose.

Similarly, glycogenosis (von Gierke's disease) represents a failure in the breakdown of glycogen, a polysaccharide with a treelike structure.[24] The accumulation of the carbohydrate in various organs is due to a deficiency of a specific glycolytic enzyme (glucose-6-phosphatase).

The fourth group, characterized by altered metabolism of pigments, is represented by Hallervorden-Spatz disease. A slowly progressive muscular rigidity is the outstanding clinical symptom, with the brain showing a gross accumulation of pigment in the globus pallidus and substantia nigra.

The common denominator for all these varieties of gene-specific mental defects is some biochemical mishap, the variations in phenotypical expression depending on external trigger factors. Just as porphyrics may have no acute distress without barbiturates, so sickle-cell anemia patients may be saved from an infarction unless oxygen tension diminishes. Similarly, agammaglobulinemia is not apparent in the absence of bacterial invasion, while the clinical symptoms of phenylketonuria, galactosemia, and Wilson's disease "can be at least partly prevented or reversed by the dietary exclusion, respectively, of phenylalanine, milk, or copper."[123]

Awareness of such far-reaching therapeutic potentialities ought to be sufficient in itself to stimulate further work in all areas of biochemical genetics. This need extends to pathological conditions where the part played by genetic elements is either still unclear, as in mongolism, chondrodystrophy, and the like, or is known to be indirect, as in blood incompatibility between mother and child or an association between certain blood groups and physical vulnerabilities.

Biochemically Obscure Disorders of Genetic Origin

There is no doubt that many remaining neurological and psychiatric disorders are genically controlled and develop from some biochemical deficiency state. In most of them, however, pathogenetic details have not yet been worked out in biochemical terms. The list is headed by a number of clinically severe conditions with gross anatomical lesions and a more or less dominant mode of inheritance. In this group are Huntington's chorea, retinoblastoma, the hereditary ataxias and craniofacial dysostoses, the familial forms of paralysis agitans and hypercholesterolemia, and the dermodysplasias (neurofibromatosis, tuberous sclerosis, von Hippel-Lindau's syndrome).

In the category of presenile brain atrophies, the action of a dominant gene influenced by other modifying genes is considered more plausible in Pick's than in Alzheimer's disease.[130] Recent advances in the genetic analysis of Recklinghausen's disease have at least made it possible to establish the mutation rate of the syndrome as well as the occurrence of somatic mutations.[26]

The scarcity of basic biochemical data is equally pronounced among those disorders which are *not* usually transmitted as Mendelian dominants (autosomal recessive, sex-linked, multifactorial). Here one finds the progressive muscular dystrophies and atrophies, convulsive disease, dyslexia, Leber's optic-nerve atrophy, Schilder's disease, and most genetically determined forms of early total deafness.[75, 77]

In the group of mental disorders with no circumscribed anatomical lesion, no biochemical substrate is known for manic-depressive psychosis (apparently associated with an irregularly dominant disturbance in affect regulation), although various leads exist toward the eventual identification of a genically controlled biochemical basis for schizophrenia and alcoholism. As to compulsive drinking patterns ("alcoholism-prone" individuals), the underlying metabolic deficiency may be traceable to one or more of the following components (found to be significantly different in alcoholic men): serum sodium, serum potassium, serum calcium, blood glucose, urinary creatinine, urinary hippuric acid, urinary sodium, and urinary chloride.[155]

Regarding the biochemical deficiency that

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may produce the specific potentials of a schizophrenic reaction pattern, the following theories have been proposed to explain the primary vulnerability factor on a genetic basis:

1. Inability of the liver or certain cellular systems involved in liver function (reticulo-endothelial elements) to transform exogenous toxic substances into endogenous protein-bound chemicals (Block, Georgi, Kallmann, Patzig).
2. Inborn error in the phenyl-tyrosine-adrenaline cycle (Fabing[41]).
3. Synaptic inhibition with secondary stimulation phenomena (Marrazzi).
4. Taraxin toxicosis (Heath).

In connection with the phenyl-tyrosine-adrenaline theory, Fabing has pointed out that most of the hallucinogenic (producing hallucinations), psychotomimetic (producing psychotic symptoms), and psychodelic (stimulating the mind) drugs studied in recent years contain the benzene nucleus, either as indoles or as aromatic amines. The remarkable factor is that "the human body, despite its constant and amazing accomplishments in synthesis, cannot make the benzene or aromatic nucleus, except in rare instances where it is locked tightly within the structure of female sex hormones."

The following major areas of current biochemical research in schizophrenia are listed in Fabing's report: (a) adrenal cortex and medulla (Pincus and Hoagland, Funkenstein *et al.*); (b) imidazoles and glutathione (Young *et al.*, Altschule *et al.*); (c) adrenochrome and adrenoxin (Hoffer *et al.*, Rinkel *et al.*); (d) serotonin, indoles, and 5-hydroxyindoles (Eyspamer, Hoffer *et al.*, Woolley and Shaw); (e) aromatic compounds and tryptophan metabolites (McGeer *et al.*, Sherwood, Riegelhaupt); (f) serum copper (Leach *et al.*, Akerfeldt, Abood); and (g) histamine and catechol amines (Lovett Doust *et al.*, Sulkowitch and Altschule).

Although the primary physiodynamic substrate of a schizophrenic psychosis remains veiled in mystery for the time being, there is no overestimating the potential value of successful progress in the search for definitive biochemical correlates of gene-specific deficiency states. With all available facts pointing to complex modes of causation in most psychiatric disorders, it is clear that the prospects for conquering such illnesses will only be brighter after well-planned exploration on the cellular and metabolic levels. In Fabing's opinion[41] it is likely that "our knowledge about exact etiology will come in parts, and perhaps even in bits and pieces."

¶ Psychogenetic Twin Data

For a statistical evaluation of the genetic aspects of behavior disorders, only the comparative morbidity-risk data obtained by serial twin studies will be reviewed here (partly because of space limitations). In regard to psychopathological intrapair variations in one-egg twins, it may be re-emphasized that, from a genetic standpoint, unusual behavior of any kind is looked upon as the outcome of a complex and continuous chain of events in the individual's adaptive history, and not as the fixed expression of an unalterable metabolic defect that is always present at birth. Accordingly, the boundary between a normal state of adjustment and those minor behavior deviations commonly referred to as psychoneurotic is only vaguely defined and never static.

In line with this principle, a spirallike development toward marked behavioral dissimilarity, such as has been reported for chronic alcoholism, delinquency, or suicide, sometimes results from an apparently insignificant difference in the original adjustive patterns of one-egg twins.[72, 131, 134] In other words, even the finest genetic endowment can go awry, either because of an unusual combination of adverse circumstances—intrinsic or extrinsic in origin—or because of prolonged abuse. However, extreme disparities of this type are the exception rather than the rule.

Psychoneurotic Behavior Patterns in Twins

As to psychoneurotic reaction potentials, Eysenck and Prell[40] were among the few who

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availed themselves of the opportunities afforded by the twin-study method. They interpreted their findings as favoring the classification of a "neurotic personality factor" as a biological and largely gene-specific entity. The genetic contribution to this "neurotic unit predisposition" was estimated as high as 80 per cent.

Less specific was Slater's[131, 133, 134] definition of neurotic symptoms as exaggerations of polygenically determined personality variants, less closely related to a given type of stress than to the basic personality. Despite "almost identical personality," seven of his one-egg pairs failed to present concordant psychoneurotic histories. Therefore, critical deviations in a person's history were assumed to be due to relatively chance occurrences, such as the personality of the marital partner. For instance, one twin "might suffer a mischance which would lead to a vicious circle of ill-health, social failure, hardship, discouragement and increased ill-health, while the other totally escaped."

According to this theory, the genetic basis for neurotic symptoms lies in graded constitutional vulnerabilities in more than one dimension, that is, "in a number of distinct qualities, each of them subject to normal variation."[94, p. 97] The majority of persons who break down with a neurotic illness are likely to be handicapped by "minor deficiencies along a number of different lines rather than . . . by an extreme deficiency along one line only."

In another twin study (62 same-sex pairs between the ages of twelve and fifteen years), Shields[128] found evidence for one-egg twins (69 per cent) being twice as likely as two-egg twins (31 per cent) to have the same degree of adjustive difficulty. With each child rated "on a four-point scale of psychiatric maladjustment," twins of either zygosity had no higher incidence of neurotic adjustment problems than did single-born controls, but male twins and nontwins far exceeded their female counterparts in presenting adjustment difficulties. Little more than one half the total group of South London school children were classified as nonneurotic. Nongenetic explanations for the observed differences between one-egg and two-egg twins were rejected, perhaps somewhat summarily, especially in regard to the frequent similarities in type and severity of neurotic behavior patterns.

Male Homosexuality

One of the highest one-egg concordance rates reported has been that for homosexual behavior in the adult male.[75] In Sanders' series of 7 one-egg pairs, 6 were found to have been concordant as to overt homosexual tendencies. In the second series, 44 one-egg pairs yielded a nearly perfect concordance rate, with the index cases standing at least midway on the homosexuality scale applied, and with pronounced similarity in the role taken by twin partners in their individual sex activities. In the two-egg group (51 pairs) nearly 60 per cent of the co-twins of predominantly or exclusively homosexual index cases showed no evidence of overt homosexual behavior at any age, and only 11.5 per cent were given homosexuality ratings of 5 or 6 on Kinsey's scheme. Interestingly, all concordant twin partners in this entire series denied any mutuality in overt sex relations.

The most plausible genetic explanation for these findings would seem to be a gene-controlled disarrangement in the balance between male and female maturation patterns, resulting in a shift toward an alternative minus variant in the integrative process of psychosexual maturation. In the opinion of Mayer-Gross *et al.*,[94, p. 178] "there is some genetical basis for the development of homosexuality and some influence is probably exerted also by the attitude prevalent in society and the circumstances of the patient's upbringing . . . the proportional contribution of heredity and environment probably varying not only in different ages and countries, but also from one individual to the other."

Mongolism

Another condition with a well-established one-egg concordance rate of close to 100 per cent is an entirely different defect of more obvious organicity, namely, mongolism, the history of which "presents a pattern of contradictory observations and false hypotheses

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that should make all students wary."[3] While discordance was not observed in a series of 6 one-egg pairs,[4] the concordance rate for 23 two-egg twins was so low that it did not exceed the morbidity risk of their later-born siblings (approximately 4 per cent).

The implication of this finding would seem to be that the search for the etiological factor in mongolism has been narrowed down to a more or less permanent change in the mother's endocrine or reproductive system. Apparently, the noxious influence during a mongoloid pregnancy is not transient but acts on a genetically predisposed embryo, or upon the ovum, or upon the embryo prior to the earliest stage when twinning occurs by division. For this reason, and in view of the fact that the relative importance of high maternal age ("long challenged by countless exceptions") is also regarded as adequately substantiated, Allen's[3] present hypothesis is that mongolism may prove to be the result of some unusual type of blood incompatibility between mother and child.

Cerebral Palsy

Serial twin studies have also aided in investigating the etiology of cerebral palsy, for which twins have been shown by the data of Allen (60 twin cases) and Thums (90 pairs) to be rarely concordant.[75] There is a high rate of stillbirth or neonatal death in the co-twins of cerebral palsy cases, but no evidence for a specific genetic susceptibility to prenatal or natal injury. Apparently, many twins with cerebral palsy are survivors of adverse conditions which proved fatal to their twin partners.

The circumstances most likely to affect both twins of a pair include nonspecific maternal and genetic causes, as well as prematurity per se, but probably not mechanical trauma during birth.

Convulsive Disease

The most extensive series of epileptic twin pairs (30 one-egg, 130 two-egg) is that of Conrad,[22] with concordance rates of 66.6 and 3.1 per cent, respectively. Unless plainly repudiated, the results of this study represent strong evidence for the genetic origin of true convulsive disease.

According to Lennox and Jolly,[87] cerebral dysrhythmia is an electroencephalographic expression of the epileptic genotype, assumed to be the result of a dominant gene by the Boston group, and of polygenic factors by Alström.[5] In epileptic twins, 25 per cent of two-egg and 100 per cent of one-egg pairs have been reported to be equally dysrhythmic, despite marked dissimilarities in clinical symptoms.

Criminal Behavior

In the area of criminal behavior, there is still an emphatic need for well-planned cross-sectional and longitudinal twin data. Based on the findings of Kranz,[83] Lange,[86] Stumpfl,[142] and others, criminality concordance rates vary only from 14 per cent in opposite-sex pairs to 54 and 66 per cent in same-sex two-egg and one-egg pairs, respectively. This distribution indicates that both family milieu and basic personality traits play important parts in shaping the habitual criminal. Therefore, the trend toward similar criminal behavior in two-egg pairs may stem largely from the effect of unfavorable environmental influences.

Measured by the same yardstick, concordance in one-egg pairs can often be expected to extend to specific personality features likely to lead to a life of crime (brutality, ruthlessness, predatoriness, irresponsibility), rather than to the particular kind of crime perpetrated. With criminality itself determined in many cases by constellational factors, discordance may occur even in one-egg pairs, where one partner "manages to keep within the bounds of law, while the other having once taken a criminal step remains outside the law and does not find his way back."[133, 134]

Manic-Depressive Psychosis

One of the behavioral disorders that are not sufficiently explained on a situational or experiential basis, one of the least common and most irregularly expressed conditions for which detailed twin data are now available is manic-depressive psychosis.[75] According to twin-family studies, typically cyclic psychoses, if

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diagnosed on the basis of periodic, self-limited mood swings before the fifth decade of life and only in the absence of progressive or residual personality disintegration before or after such episodes, do not occur interchangeably with schizophrenic syndromes in the same sibships or twin pairs. Therefore, the potentialities for a cyclic psychosis are assumed to be genotypically specific and to be somehow associated with an incompletely dominant disturbance in a neurohormonal control mechanism, which ordinarily protects a person from having harmful extremes of emotional responses.

Compared with the general average frequency of manic-depressive psychosis which does not exceed 0.4 per cent (probably because of a reduced reproductive rate of the carriers), there is a difference from 26.3 to 95.7 per cent between the concordance rates of two-egg and one-egg twins. Corresponding family-risk figures vary from 16.7 per cent for half-sibs to 22.7 per cent for full sibs and 23.4 per cent for the parents of cyclic index cases. The affective-metabolic instability produced by the manic-depressive genotype seems to be correlated with predisposing factors for gout, obesity, diabetes, and cardiovascular disorders.

Involutional and Senile Psychoses

Involutional melancholia and other nonperiodic forms of depressive behavior in the involutional and senile periods have been shown by twin data[76, 77] to be unrelated to the manic-depressive group of disorders. Instead, it is indicated by increases of involutional psychoses in the families of schizophrenics, and of schizophrenic psychoses among the relatives of involutional cases, that there is an indirect link with the schizophrenic genotype through certain forms of emotional instability characteristic of schizoid personality traits. The twin concordance rates differ from 6.0 per cent for two-egg pairs to 60.9 per cent for one-egg pairs.

Other disorders in the senescent period may arise either from gene-specific metabolic dysfunctions peculiar to the *senium*, or from an age-specific intensification of long-existing but minor deficiencies in general emotional adjustment. Concordance for senile psychosis varies from 8.0 per cent for two-egg pairs to 42.8 per cent for one-egg pairs.

Schizophrenia

Regarding the interaction of genetic and nongenetic determinants in the etiology of a schizophrenic psychosis, strong evidence has been accumulated in support of the theory that some gene-specific metabolic deficiency is at the root of the disorganizing personality disorder which often leads to adaptive incompetence. In Allen's opinion[2] the potentials of such a disordered behavior pattern may stem more directly from a change in primary gene action than can be assumed for a correlated anatomic defect.

On the whole, schizophrenia occurs in every segment of the human population, regardless of social, economic, or cultural status. It is observed in slums and in the wealthiest families. Variation in its prevalence from group to group is surprisingly limited, at least in the absence of special conditions of inbreeding.

This limitation is true of urban, rural, and primitive communities, of the Hutterites as well as the Swedes living north of the Arctic Circle, and probably even of very special populations, such as people reared in orphanages or those afflicted with total deafness since early childhood. Except for families with a hospitalized case of schizophrenia or an unusual degree of consanguinity, the general expectancy of the disorder is close to 1 per cent (0.9 per cent). This finding more or less precludes a universal species vulnerability, or explanations based on such general emotional group experiences as may be related to dominant cultural value systems or other social-class variables.

The hypothesis that the recurrence of schizophrenia follows selective patterns of distribution has been substantiated by many independent studies. In families with a clear case of schizophrenia, the morbidity risk of the given kinships is not only much higher than that of random population samples but also varies within the family itself. The observed trend is consistently toward an increased frequency of schizophrenia rather than any other type of disorder, with the magnitude of

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the increase proportional to the degree of consanguinity to the schizophrenic relative. For instance, full sibs (11.5 to 14.3 per cent) have a higher expectancy than half-sibs (7.1 per cent), and half-sibs a higher risk than step-sibs (1.8 per cent). The highest schizophrenia rates are found in the children of two schizophrenic parents (68.1 per cent) and in the one-egg co-twins of an unselected series of schizophrenics.

The difference in concordance between two-egg (14.7 per cent) and one-egg (85.8 per cent) pairs of twins approximates a ratio of 1 to 6, whether the twins lived together or apart. This difference is so significant that it cannot be explained on nongenetic grounds alone.

Parental schizophrenia rates tend to vary from one population to another, according to an adult person's chances of becoming a parent despite certain signs of emotional instability. Under ordinary circumstances the majority of schizophrenic hospital patients, both early and adult cases, have been found to have nonschizophrenic parents (87.5 to 90.8 per cent). While every region has its quota of schizophrenic mothers whose children are normal, there are very worthy parents with a schizophrenic child. The observed schizophrenia rates for the parents of representative samples of schizophrenics approximate 10 per cent, and there is no significant difference between the morbidity rates of fathers and mothers.

As to the morbidity risk for the offspring of matings between one schizophrenic and one nonschizophrenic parent, it has long been established that the expectancy is close to 16 per cent and depends largely on the biological qualities of the second parent.[73] However, the question of how to designate a mode of transmission that seems distinguished by a specific unit factor for the entire syndrome, plus a number of modifying genes responsible for the variable clinical expressions of the main genotype, is more or less a matter of semantics.

For several reasons it still seems appropriate to interpret the main adaptive defect in a potentially schizophrenic person as the result of a basically recessive unit factor, although it is quite irrelevant with respect to the over-all genetic theory whether the given main gene is classified as primarily dominant or recessive, or fails altogether to show simple segregation ratios. The modern concept of human heredity does not hinge "upon the counting of simple Mendelian ratios,"[2] and it seems that most pathological conditions in man are neither fully dominant nor completely recessive, but only relatively so, depending "upon the facility with which the trait is detectable in the heterozygote."[63]

The really important point is that, regardless of whether or not all heterozygous carriers of such a mutant gene might react abnormally if placed under sufficient biological stress, the genetic potentials of a schizophrenic behavior pattern are highly specific and associated somehow with a basic integrative deficiency. Clinically, it is of particular value that the varying phenotypic expressions of this deficiency apparently depend on the type and degree of constitutional defense reactions that can be mobilized against the gene-specific vulnerability to stressful life experiences.

General Eugenic Considerations

The deeply rooted reluctance to recognize genically determined elements in the etiology of mental illness will inevitably have harmful consequences. The common denominator for damaging trends of this kind may be seen in the toleration or promotion of general attitudes that are liable to divert attention from important public health issues.

Apparently, the tendency to de-emphasize genetic factors as potential causes of behavior disorders is an occupational hazard of all mental-health professions and is older than psychiatry itself as a social phenomenon. Whether accomplished by fiat or the Promethean power of allegoric expression, this tendency easily grows into a habit. While it may be obscurable by fluid levels of abstraction, it is sufficiently potent to deflect much investigative and therapeutic effort. Hence, neither conceptually nor for purposes of guidance, can the resultant attitude be expected to be of real help.

Aside from harmful omissions in treatment and family guidance, damage may be caused

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by disregard of two general genetic phenomena: (1) the hazards of a gradual increase in the number of poorly adapted carriers with a chance of reproduction, such as may result from assortative mating trends and improved medical techniques; and (2) further increases in the mutation rate of populations due to excessive use of ionizing radiation.

The theory that an increasing load of mutations in future generations will be the penalty for relaxing natural selection by medical advances has been supported by many genetic experts.[7, 25, 30, 51, 99, 102] It is based on the estimate that the average person is heterozygous for at least eight genes of a specified variety. Under the conditions of equilibrium prevailing for present gene frequencies, there would be an effective genetic loss in the population of 20 per cent, resulting from the total of these "more or less familial patterns of weaknesses."[102]

With a large part of this segment apt to be salvaged for reproduction by modern medical procedures, the frequency of mutant genes will inevitably rise to a new level. Accentuated by the accumulation of gene-specific disabilities due to ionizing radiation, the adverse consequences for future generations may reach a point where the population's survival is threatened.

General public health measures for the prevention of such hazards will require the organization of "much more systematic research about all kinds and all levels of genetics"[21] as well as the foresight implicit in a concern with the health of future generations. Beyond doubt, real progress in this direction will also enhance the understanding and management of the genetic aspects of mental illness.

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CHAPTER 9

THE PSYCHIATRIC INTERVIEW

Ian Stevenson

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THE PSYCHIATRIC INTERVIEW as practiced in most American psychiatric facilities has undergone a marked change during the past fifty years. Formerly, a question-and-answer type of interview satisfied the requirements of psychiatric interviewing, as it did and still does satisfy those of medical history taking with regard to exclusively physical illnesses. But the modern psychiatric interview, although it includes questions, puts much more emphasis on a free-flowing exchange between the psychiatrist and the patient. This alteration in our practice has resulted from changes in the kinds of information we want about patients and in our ideas of how we can best obtain this information. We also have learned the limitations of verbal communications. We now notice not only what the patient says but his manner of saying it as well, for this may show what his words conceal. And we have learned that, when two people talk together, what they say depends not only upon what they want to tell each other but also upon what they think of each other. In what follows we shall discuss first the information a psychiatrist usually wishes to obtain in an initial interview, next how the psychiatrist's relationship with the patient influences what the patient tells him, then the psychiatrist's optimal attitude and some techniques which can increase the yield of an interview.

The theory and technique of psychiatric interviewing both receive attention, although to be sure not as much as they should, from American research psychiatrists. We may hope that from their efforts will emerge changes fully as great as those which the last fifty years have brought. This will require, among other things, that each of us challenge constantly his own habits and remain unwilling to practice, for the rest of his lifetime, only whatever his teachers have taught him.

We shall discuss the psychiatric interview chiefly with regard to the initial evaluation of a patient. Sometimes we can achieve this in one interview, but quite often we need several. Moreover, the initial interview or interviews should blend with the psychiatric examination.

The following chapter discusses the psychiatric examination and the methods of including part of the examination in the psychiatric interview and of making a transition from the interview to the more definitive examination (Chap. 10).

¶ What the Psychiatrist Wants to Learn

The psychiatrist should learn first what the patient usually most wants to tell, namely, a description of his symptoms and the story of their onset and progress. After this, the importance of life stresses in precipitating mental illness requires a detailed review of the patient's current environment. The discussion of this can lead easily into talk about the patient's early environment and thence toward his family history. From this may naturally follow an account of the patient's own earlier life—his personal history.

Most psychiatrists understand the importance of eliciting this material in initial interviews, and only two items deserve further emphasis. First, much importance must be attached to a detailed account of the patient's symptoms. We should try to imagine what the patient has experienced and now experiences. We should try to see the world as he sees it, but we can do this only if we let him talk to us in great detail. Moreover, many psychological symptoms require study not only as direct experiences of the patient but also with regard to the purpose they serve the patient in adapting to other people or to other forces within himself. In short, we enter into detail so that we may know both what functions are disturbed and how these functions relate to others. Secondly, the study of the patient's current environment must be emphasized. Although we all recognize the importance of major life stresses in precipitating mental illnesses, we often neglect, to our and the patient's disadvantage, the careful study of how the patient lives. Only by entering into his daily life, as it were, can we come to appreciate the subtle but cumulatively powerful relationships between the patient and others close to him. And usually only such an appreciation will permit us to dissect the respective contributions of the patient and those around him to the strain he experiences.

While listening to the history, the psychiatrist should attend not only to the bare facts of peoples, places, and events as chronicled by the patient; he must study, no less, the meaning of these events for the patient and the attitudes which the patient showed to them then and, if those have changed, the attitudes he now shows toward them. In studying attitudes the psychiatrist must include, additional to the patient's words, observations of the patient's emotions.

There is another important reason for observing the patient's emotions as he talks. The psychiatric interview begins and includes much of the psychiatric examination. The patient's recital of his complaints and his history contributes valuable data about the illness. But that illness is a product (in most instances) of the action of stresses on sensitivities. The psychiatric interview should therefore study the special sensitivities and vulnerabilities of the patient. As the patient talks, the psychiatrist should scan him and his remarks for signs that certain events or topics are of special importance to him. The signals which reveal such events or topics deserve a brief review.

One may ask the patient directly about the events, people, and thoughts which bother him most. More often than is usually done, we should ask for this information directly. At the same time, we should remember the frequent, almost invariable, inability of patients to give a direct and complete answer to direct questions. In studying physical illnesses we can ask patients about the occurrence of nausea, bloody stools, or swollen feet and usually expect reasonable and valuable answers. But we cannot ask a patient to tell us about his marriage, his parents, or his employer and expect that the words he returns us can alone contain all we need to know. Several factors are responsible for this difference. In the first place, our society strongly emphasizes the importance of other persons having a good opinion of us. For psychiatric patients this becomes especially important, since they usually think poorly of themselves and have become doubly dependent upon approval by

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other people. When a patient finds himself in a psychiatrist's office, he has additional reasons for winning and preserving the favorable opinion of the psychiatrist. Consequently, with his words he attempts to portray himself (unless he is very depressed, or self-effacing) as a person who is in all respects lovable and "normal." Secondly, even the patient with the greatest candor has within himself large and important aspects of mind and behavior which lie quite outside his awareness. With the best will in the world, he cannot tell what he does not know about himself. And finally, even if he knew much more than he does, words would still furnish only a feeble channel for the communication of life's richest experiences, both of suffering and of happiness.

Working against these limitations of verbal communications, the psychiatrist fortunately has other clues to what he wants to learn. These lie in the various signs of emotion shown by the patient as he talks, for our most important experiences become bound to emotions, or, more accurately, they become important because they affect us deeply.

Emotions show themselves in many and sometimes unexpected ways. The patient's arrangement and manner of presenting his verbal statements reveal much. The psychiatrist should note what the patient says first (both at the beginning of an interview and subsequently in response to questions), what he talks about most, what he returns to many times, and what he omits or glides over quickly. Thus the psychiatrist needs to learn what the patient specially wants to talk about and what he specially wants to avoid talking about. Unusual speed of speech, hesitations, blockings, amnesias, and confusions all deserve attention as signs of emotion and, hence, clues to the significance of events or topics. The order of the patient's remarks deserves attention, and especially the connections of thoughts associated in one sentence or adjoining ones. Verbal associations betray affective links.

The psychiatrist should notice changes in the pitch and timbre of the patient's voice as he talks. Such changes express alterations in the tensions of skeletal muscles, of which many other indications can appear in the patient's face and limbs. Accordingly, the psychiatrist should watch for the play of emotion in the patient's face, in the posture of his body, and in the movements and gestures of his limbs.

Changes in the patient's viscera deserve equal attention, for emotions affect the autonomic nervous system as markedly as the central nervous system. The special apparatus of physiology has revealed the occurrence of many important visceral changes during emotional disturbances. Not many of these lie exposed to the unaided eye of the interviewing physician. Nevertheless, he may notice changes in the patient's breathing and in his heart rate, observed, perhaps, in the beat of the carotid artery in the neck. He can notice flushing and pallor of the face and sometimes perspiration. The patient's mouth may dry up, or tears may glisten in his eyes. During an interview, emotional changes may bring (and sometimes remove) the patient's symptoms. Thus palpitations may occur, or a headache may disappear. A patient with a psychophysiologic skin reaction may scratch a tender spot on the skin when the conversation touches something tender in his mind. Each patient has his own special mode of expressing his emotions, almost as characteristic as his gait or his fingerprints. Some patients, for example, rub their eyes, others glance swiftly away from the interviewer, and still others swallow whenever they experience anxiety. The psychiatrist should watch the patient for characteristic traits especially in the early parts of the interview, partly because the patient is then usually most anxious and partly because the psychiatrist can use what he then learns to identify moments of anxiety later in the interview.

The identification of an important emotion only begins its study by the psychiatrist. With techniques described later, he should try to open a further discussion of the topics which have evoked the emotion, although he may often defer this to a more appropriate time. In that discussion he wants to learn in what way this topic is important to the patient and how it became so. Exactly what thoughts does the patient have about the event, person, or topic which cause these strong emotions? The

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psychiatrist cannot consider that his study of an emotion is complete unless he has elicited from the patient the details of the accompanying thoughts. For this he returns again to the patient's words through which alone (outside art) the patient can communicate his thoughts.

The detection of emotion during the psychiatric interview contributes to the examination of the patient which, as already mentioned, starts at the beginning of the interview and indeed cannot and should not be separated from it. During the interview the psychiatrist has ample opportunities to examine other aspects of the patient's mental functioning, as described in the following chapter.

A final purpose of the psychiatric interview is the evaluation of the patient's readiness for psychiatric treatment and efforts to improve this when necessary. Since this properly belongs to psychiatric treatment, it is mentioned here without further discussion. But the psychiatrist should remember it during his interviews. Although his assigned tasks may resemble those of a juggler keeping five balls in the air, unless the psychiatrist can accommodate in his technique a study and strengthening of the patient's motivation for treatment, he may conduct a superb interview which leads to nothing.

¶ The Physician-Patient Relationship

As mentioned earlier, the patient's wish to tell his story is frequently obstructed by his wish to win and preserve the psychiatrist's approval and assistance. This interference is experienced by all patients to some degree. But each patient varies from every other one in the experiences which have led to this shielding of himself and to other behavioral patterns. And each psychiatrist differs from all others in his capacity to stimulate or reduce such patterns in his patients.

When the patient was a child, like everyone else he learned from experiences what to expect that his parents (and other people) would do. He then generalized many of these expectations, learned with certain persons, to guide his behavior with other persons. Sometimes his generalizations guided him correctly, at other times inappropriately. A dog conditioned to respond to a sound with a frequency of 512 cycles per second may respond (unless carefully trained) to a range of sound say between 475 and 550 cycles per second. The more careful and prolonged the conditioning, the more discriminating will be the dog's response to different stimuli. But his discrimination may weaken under stress or without proper reinforcement. In much the same way, humans may discriminate poorly as well as correctly. They may respond to physicians as if these were duplicates of their parents. Such misperceptions on the part of a patient never occur first with regard to the psychiatrist; on the contrary, they have happened often before and have contributed importantly to the patient's difficulties with other people. But the psychiatrist should especially notice how the patient perceives him, first because he can study this directly instead of depending upon observations of other people, and secondly because the patient's perceptions of the psychiatrist furnish important clues to his difficulties with other people.

The more closely the psychiatrist resembles the significant persons of the patient's earlier life, the more he will be likely to evoke the behavior in which they trained the patient. (The frequency of 512 cycles per second stimulates the conditioned dog, mentioned above, to the greatest extent, even though he may respond to a lesser extent to other frequencies.) Suppose that the psychiatrist, after studying in advance a portrait of the patient's father or better still a moving-picture sequence, should carefully disguise himself in appearance and manner to resemble the patient's father. We could hardly blame the patient for responding to the psychiatrist-actor as if somehow his father had wandered to the psychiatrist's office and sat behind his desk. After a moment of initial surprise, the patient would engage in conversation, so he would believe, with his father. Now suppose that the disguise has been arranged very poorly, that, in fact, the psychiatrist has put on a mustache like the father's but does not shave his head to a similar baldness or imitate the father's gruff voice or smoke

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cheap cigars. If, then, the patient still acts as if the psychiatrist is his father, the psychiatrist would have important evidence of poor discrimination.

By partially resembling earlier persons in the patient's life, the psychiatrist may stimulate the conditioned reflexes of his patients in many ways. Each deserves brief mention here and much attention in the interviews. First, as already mentioned, the psychiatrist's physical appearance influences the patient's responses. The psychiatrist's sex and age, especially, but other features of appearance hardly less, strongly guide the patient in thinking what it will be useful or safe to reveal. Secondly, the patient responds to the social role of the psychiatrist as he conceives it. In this he mingles his concept of the role of the physician. Two features usually blend: physicians have authoritative roles in our culture, with power to recommend and execute drastic treatments or to commit to certain hospitals. This aspect of our work leads the patient to confuse us with policemen, sergeants, judges, teachers, and, most important of all, with fathers. But physicians also have a role of succoring the sick and weak; in this connection a patient frequently achieves a mental montage of a physician and his own mother. Thirdly, our behavior may also stimulate, in the patient, patterns of behavior laid down in earlier experiences. Some of this behavior derives from our professional work. We ask questions and so we may remind the patient of his mother, who always asked her little boy pressing questions, requiring painful answers, when he came home from school. However, some of what we do our work does not require and may indeed be better off without. Thus suppose we, like the patient's mother, have an inordinate preoccupation with sex, and we question the patient excessively about this. He may then react strongly, although not necessarily irrationally.

In all these various ways the psychiatrist may evoke behavioral patterns in the patient which can partly, or sometimes entirely, interfere with that part of the patient which perceives the psychiatrist as a helpful expert to whom he should tell his story. Patients vary greatly in their capacities to see the psychiatrist as he is and to avoid confusing him with other people. If the psychiatrist is to study the patient's discrimination, he not only must attend to the patient's behavior but must also learn as much as he can about himself. If the patient falsely attributes a mustache to the psychiatrist, the psychiatrist can only evaluate the possible misperception in this if he can recall whether he himself has shaved during the last few days. He must know what he himself brings as stimuli into the interview. He must remember that the patient responds both to what the psychiatrist does and to what he is.

A physician-patient relationship is clearly not fixed or capable of permanent description. It is a shifting complex of behavior which includes changes in both patient and physician. The patient does not necessarily continue in his misperceptions of the psychiatrist, and his speed of correcting them furnishes an important point of prognostic value. During their further contacts, psychiatrist and patient have the opportunity to correct their initial and frequently false categorizations of each other. If first impressions repel, they may discover —with the ever-fresh pleasure this brings— that each is, after all, rather a pleasant person once one gets to know him a little. More often, first impressions attract, because each shows socially conventional behavior. In a new situation our behavior at first tends to conform to the social roles we believe the situation assigns to us. Afterward, closer acquaintance may bring to the fore traits at first concealed. For, with growing intimacy, there emerge various patterns of behavior learned in the less uniformly structured experiences of the family. Thus it happens that, after a time, the psychiatrist does something or fails to do something which frustrates one of the patient's expectations of him, or he may offend in many such ways. These events he must also study carefully.

The usual initial positive attraction of psychiatrist and patient for each other is largely sustained by their fantasies of what each can expect from the other. When the fantasies yield to closer inspection, and when, at the same time, intimate behavior begins to replace

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more formal behavior, the relationship may weaken. At this point, one factor alone saves most physician-patient relationships from dissolving. In the time taken for the patient's irrational expectations of him to collapse, the psychiatrist has a chance to show, one should not say to display, his real professional competence. Then, as the patient learns that the psychiatrist is not what he first thought him to be—perhaps a doting mother or an eternally patient father—he may discover that the psychiatrist, as a helpful physician, can now contribute even more than the mother or father. This transition from a tenuous relationship based on fantasy to a firm one based on an experience of competence demands that the psychiatrist offer the patient something considerably more than he can find in ordinary social intercourse. The following sections of this chapter offer suggestions concerning the content of this "something."

The importance of the physician-patient relationship in influencing what the patient will tell the psychiatrist and what the psychiatrist should tell the patient requires that the psychiatrist constantly evaluate this relationship. He should note how readily the patient talks and all other behavior of the patient toward him. Psychiatrists notice minutiae of social conduct—for example, punctuality, hesitancy in smoking, deference in going through doors—which would and should be overlooked or not noticed at all in other situations. But in an interview psychiatrists should observe all these items of behavior as clues to the attitudes which such behavior expresses. The psychiatrist should also help the patient to use any opportunity which arises to state what he thinks of the psychiatrist. In initial interviews most patients cannot achieve much candor in such comments. The psychiatrist can usually expect conventional formulas. But often, and even in guarded remarks, the patient may say something revealing and relevant. In drawing out the patient's thoughts about ourselves, if we press the patient artificially we will usually only increase his conformity to socially acceptable platitudes. Natural opportunities will arise, however, which we can exploit. If the patient has referred himself or chosen the psychiatrist from several, we can ask him, "Why did you select me to consult?" If he generalizes about physicians or psychiatrists, we can say, "Are you including me in that?" Later, the special value and importance of the patient's discussing his thoughts about the psychiatrist, whenever the patient becomes excessively anxious, will be discussed.

¶ The Optimal Attitude and Behavior of the Psychiatrist

We should often ask ourselves in what ways we can be of more use to our patients than even their best friends can be. The difference may lie principally in the degree to which we show a friend's helpful qualities and, most of all, in the tenacity and patience which permit us (and the best of friends) to sustain a relatively stable relationship with another person over a long period of time. In addition, four other qualities for the psychiatrist—interest, acceptance, detachment, and flexibility—are recommended.

For his task the psychiatrist certainly requires interest in the patient and in his difficulties. This interest can include to a degree the biologist's curiosity about the wonders of living organisms, yet we cannot allow ourselves to become so preoccupied with the details of morbid anatomy and physiology that we lose interest in the whole patient. Our specialty particularly concerns itself with the responses of the whole man. Our interest should be in the patient and for the patient; it should not pursue, disguised as diagnostic fervor, our own special predilections and curiosities. We can rarely prevent these entirely from interfering with our guidance of interviews, but we can at least strive to become aware of ways in which our interest in ourselves may mingle with our interest in our patients. The interest we show in patients should include, and chiefly derive from, an attempt to understand them. Our limited success in this task may matter less than our efforts to try and to improve. We know that a fumbling medical student may learn much from a patient in a psychiatric interview. At present there is so little difference

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in skill between the worst and the best of us that we must rank the wish to understand as hardly less important than the understanding. At any rate, patients respond well to both. Finally, our interest should always include attention to the assets of the patient as well as his deficiencies and difficulties. To this aspect of our interest patients also respond favorably, and with it we may help them to tell us more freely about their sufferings.

The psychiatrist should next try to reach a capacity for complete acceptance of his patients. Our profession does not ask that we approve all that our patients do or abandon our own ethical principles in favor of moral relativism. But we do improve our skill when we can accept patients unreservedly, regardless of what they may say or do which would be quite offensive in another context. Just how offensive people can be, the psychiatrist has a better chance than anyone to learn. But he also can learn more easily just how important it is to all of us to gain and hold the affection of others, despite our shortcomings. Here we can often be of more help than the patient's family and friends. Because they frequently have become alienated by his behavior or their own, so that the patient believes himself to be without the friends we all need, we should have the deepest reservoirs of kindness.

If the psychiatrist does surpass the performance of family and friends in this regard, he often owes his success to the cultivation of a third quality required in his work. We may call it detachment, separating this sharply from the aloofness with which it has sometimes been confused. Because we live outside the circle of the patient's family and friends, we are not so closely—and hence so emotionally—involved in the patient's difficulties as they are. What the patient does cannot affect us so much. It should affect us somewhat, or we would not want to help him or be capable of doing so, but it must not affect us to the extent that the strength of our emotions disturbs our judgment of the patient in the manner that the strength of his emotions has disturbed his judgment. His anxiety prevents him from thinking clearly. He needs a less troubled mind to help him correct his misperceptions and faulty reasoning. Here, again, we can establish maxims more easily than we can follow them, and for this reason among many psychiatrists should know themselves as well as they can.

Every internist taking a history and performing a physical examination finds that he omits less if he follows a routine order of procedure. The psychiatrist's study of his patient should be equally thorough and usually must be longer. But the psychiatrist cannot afford to impose a rigid form on his interviews and examinations. Although careful to think and ask about everything which might relate to the patient's symptoms or difficulties, he should not expect always to learn things in the same order. Nor should he expect ever to learn the same things in every interview, for different symptoms require different emphases in the discussions. Lack of space prohibits a review here of some of the common variations in interviewing which occur with, for example, patients who have depressions, hypochondriasis, schizophrenia, anxiety states, and psychophysiologic reactions. For these variations alone, flexibility becomes another desirable attribute of a successful interviewer, but he also needs this quality especially to ride over the resistances within the patients which often prevent their talking freely about many important topics. Some patients can talk easily about their wives but dare not discuss their parents. Others may pour out a cataract of information about their parents and close up like a bank vault when the psychiatrist inquires about their wives. Infinite variations occur in such resistances, but the physician can nearly always count on finding some. Fortunately, time helps the psychiatrist. Talking itself predisposes the patient to further talking. If the physician yields at first to the patient's reluctance to talk about certain subjects, he can keep the patient discussing other topics and thus prepare him eventually to return to the previously avoided material. This is not to say that the patient should be permitted to seize and retain control of the interviews. On the contrary, the physician should preserve guidance throughout and, if necessary, make his guidance explicit to the

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patient, but he should not use his skill and power to confront the patient prematurely with subjects which are seriously disturbing. This can trouble and even shatter the developing positive attraction of the patient for the physician. The flow of the patient's remarks is sometimes delicately balanced between the wish for help and the fear of injury at the hands of those to whom he gives his confidence. If he experiences painful emotions too much and too early, he may (not unreasonably) confirm his expectation that he could be hurt, even though the interviewer said nothing intended to hurt him. We all turn away from pain and often also from those with whom we associate the pain, even when they have tried to help us. And so the psychiatrist should let things come gently and naturally, perhaps taking this lesson from skillful obstetricians.

¶ The Technique of Interviewing

Arrangements for the Interview

In any interview, stimuli reach the patient not only from the physician but from the entire setting in which it takes place. The psychiatrist will find worth while a study of the setting of his interviews even if, and perhaps especially if, he cannot change the setting. Privacy and reasonable comfort for the patient and the physician are absolutely essential. A separate room best assures complete privacy, but not if telephones ring and secretaries run in and out. A public ward, with its chatter and other hubbub, gives more privacy than a semiprivate room. Bright precinct-station lights should not blind the patient as he talks. The physician and patient should preferably sit so that each can look at the other without having to do so continuously if they prefer not. The psychiatrist should reserve enough time for a satisfactory interview. In the present state of our knowledge, anyone who does not reserve at least forty-five minutes or an hour for an interview identifies himself as practicing some psychiatric formula which does not include listening to patients. Brief interviews may have their place in medicine, surgery, and even in certain authoritative and directive psychotherapies, but they have no relevance to diagnostic and therapeutic psychiatric interviewing at its best. (A later section will discuss reasons for this.) Moreover, one interview even of the length suggested rarely suffices for a thorough exploration of the patient's difficulties, and the psychiatrist will usually have to arrange for several further meetings.

The psychiatrist should always make notes after or during an interview. Apart from the value of having some record of the talk, the process of making notes passes the material through the mind of the psychiatrist again and thereby adds to his study of it. If he makes his notes during the interview, he should be reasonably certain that the note taking does not interfere with his own spontaneity. Some psychiatrists can pass this test, others cannot. And he should also be certain that the note taking does not trouble the patient. About this he should not necessarily expect to hear from his patients, many of whom will communicate their objections indirectly rather than with words.

Starting the Interview

As patient and psychiatrist meet, the initiative lies with the psychiatrist. He should introduce himself, lead the patient to his office, offer him a chair, and start the conversation. One can begin well enough with a brief introductory statement such as, "I know about you only the little which Dr. X told me. So it would be best for you to tell me in your own words what troubles you." After this the physician should usually remain silent until the patient's first responsive flow has dried up. He can soon tell whether the patient can talk freely or needs additional help. If the patient needs help, the physician should give it promptly, not letting the patient bathe in the sweat of tense silences. Sometimes the patient does not know what he should give in the way of a history. Since psychiatrists do ask for kinds of information different from that required by internists and surgeons, the patient may simply need a little guidance. Sometimes the patient's

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anxiety mounts so high that it blocks his free expression. In that case the physician can channel the conversation into something less painful to the patient. Often, he can reduce the patient's anxiety by asking questions which free the patient of the fear that he will say too much and of the responsibility for giving emphasis to important topics. Later, the patient may relax enough to talk freely. If such measures fail, often the psychiatrist should ask the patient about his anxiety and should suggest possible origins of it in order to encourage further expression. He can say, for example, "You seem frightened. Can you tell me what makes you so?" If the patient still blocks, the physician can suggest, "Perhaps you are afraid of how I will react to the things you may want to tell me about. Is that so?" The patient may then respond by verbalizing the origins of his immediate anxiety and can then continue with other parts of the interview.

Once the patient has begun to talk, the physician's task consists in helping him to talk freely and in guiding him to speak about the most relevant topics. These will be discussed separately, although in an interview they naturally intermingle.

How to Help the Patient Talk Freely

If the physician has a strong interest in his patients, he can influence most of them to talk freely, because everyone talks better to an interested listener than to a bored and reluctant one. The awareness of the psychiatrist's interest reinforces the patient's wish to talk and his conviction that the psychiatrist merits his confidences. It may often be difficult to listen without interrupting. The psychiatrist's other medical training frequently impels him to intrude a question about a date or place so that he is sure to know all the data. Or something the patient says may infect him a little with the patient's anxiety or depression. Then he can quite unconsciously deflect the patient from such sensitive topics (for him more than for the patient, perhaps) by asking the patient about something else. Or the patient's depiction of his suffering evokes in the psychiatrist a natural wish to reassure, and he applies a soothing but gratuitous remark to alleviate the patient's fears. All these tendencies he must try to resist. He will not always succeed, because of severe temptation, but the effort to keep silent and to let the patient talk freely will make him a better interviewer. Each little interruption in itself may seem trivial, and usually is, but each adds to a cumulative effect on the patient which tells him "The doctor wants something from me. What is it? How can I tell him what he wants to know?" When patients become occupied in giving us the information they think we want, they can easily forget to tell us what they want and need to say, of which we as yet know nothing. Every time we let the patient talk as he wishes, we encourage him to say something else which, perhaps up until that moment, he thought he ought never to confide in anyone.

In addition to interrupting the patient's line of thought, the interruptions by the psychiatrist also tell the patient more about the psychiatrist. There are advantages to the patient's knowing rather little about the psychiatrist; the less he knows, the less he can censor what he says in accordance with the assumed attitudes of the psychiatrist. This may make for a freer revelation of the patient himself.

Should the psychiatrist then always say and do nothing as the patient talks? Certainly not. He should say and do whatever becomes necessary to sustain the patient's flow and to guide it. Silence may suffice, or it may not. Sooner or later, some further responses become necessary or additionally helpful. In offering these, the psychiatrist may move from silence toward levels of increasing activity, each designed to emphasize to the patient a little more strongly his wish to hear more. Thus grunts of "uh-uh" and leaning forward expectantly stimulate the patient a little more, or sometimes much more than silence. If such gestures prove inadequate, the psychiatrist can questioningly repeat the last word or phrase of something the patient has said. After this come gentle urgings such as, "What happened then?" "Go ahead," and "I'd like to hear some more about that." Should these fail, and assuming that the patient knows in general what he should talk about, his anxiety toward

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the psychiatrist has probably interfered too greatly. The psychiatrist should then bring this into the discussion directly, help the patient verbalize it, and, if necessary, apply appropriate reassurance. Thus he can begin by saying, "Something makes it hard for you to talk to me about this matter. Can you tell me what it is?" Often the patient will respond satisfactorily to such leads. If not, the psychiatrist should suggest possible misperceptions of him by the patient (as in reducing initial anxiety mentioned above). He can say, for example, "Perhaps you are afraid of what I will think of you?" If all such efforts to loosen the patient's tongue fail, the psychiatrist's task usually includes pointing out to the patient his share of responsibility for their difficulties in talking. The psychiatrist might say, for example, "We have to work together on this, I'm sure you know. It's a collaboration between us, and I can do little for you unless you can tell me more about yourself." At this point the psychiatrist may learn of the patient's distrust about the privacy of his communications. On this matter and other similar doubts, the psychiatrist should provide firm reassurance based on actual performance. He should not, for example, assure the patient that what he learns from the patient goes no further and then schedule an interview with the patient's parents without the patient's knowledge.

With this repertoire of techniques increasing serially in stimulating the patient to talk, when should the psychiatrist use his influence? I believe he usually needs to increase his activity in the following circumstances: to show his interest, to reduce the patient's anxiety, to encourage the patient's emotional expression, to control garrulity and irrelevance, and to channel the interview toward topics of the greatest importance. I will defer discussion of the last two of these to a section on guiding the interview, but the first three pertain to helping the patient talk freely.

Some psychiatrists have more interest in their patients than they show. I think young psychiatrists are especially liable to make this error when they mistakenly apply, in initial interviews, the silence which is conventional and sometimes helpful in certain psychotherapeutic techniques. In attempting to stay out of the patient's way, a psychiatrist may say so little as to give the patient the impression he is mute. Some studies have shown that many patients leave psychiatrists after one or two interviews because they do not understand and become alienated by the psychiatrists' unresponsiveness to them. Most patients have already received training by internists and surgeons in the question-and-answer method of history taking. They may misinterpret excessive silence on the part of the psychiatrist as simple incompetence. Moreover, previously important persons have often communicated aloofness, indifference, disapproval of, or even anger toward the patient by means of silence. The patient may confuse the psychiatrist with these persons, and, if so, the interview can perish, or it can become unnecessarily uncomfortable for the patient as well as less productive, since anxiety interferes with thinking and with expression. It makes sense, therefore, for the psychiatrist to remain silent if he can and needs to do no more, but also to offer freely whatever signs of interest the patient seems to require. Such additional communications of interest he can easily insert often enough with nods of the head, with "uh-uhs," or with simple words such as, "Surely," "Naturally," "Of course," and "I see." Words matter less than attitudes. With a friendly attitude we will find the right words, expressing them in a gentle speech and with a kind face. The psychiatrist should also offer, from time to time, more explicit signs of his understanding of what the patient did or felt with remarks such as, "I can see how hard that must have been for you," or "That must have made you feel better." Remarks of this kind should articulate what the patient has rather clearly expressed and should not influence him to agree, against his own knowledge, with the psychiatrist's interpretation of events. When the psychiatrist does not understand what a particular experience meant for the patient, he should usually inquire further, but when he does understand, if he will occasionally echo what the patient says he can lubricate the interview.

Experience will teach the psychiatrist the

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level of anxiety proper with each patient for a flowing interview. When a patient's anxiety becomes too great, the physician should try to reduce it by some of the techniques mentioned earlier. As already mentioned, excessive anxiety during an interview usually derives from misperceptions of the psychiatrist as being more menacing than he is. Anxiety felt by the patient with regard to other persons drives him to talk, while anxiety felt toward the psychiatrist blocks his talking. The psychiatrist should generally try to reduce or keep minimal the patient's anxiety toward him in initial interviews. Certainly, he should note it and may subsequently wish to allow its full exposure, but if the patient becomes very anxious with regard to the psychiatrist before a strong attachment has developed, he may block harmfully or fail to return. Since the patient nearly always hungers for the psychiatrist's approval, his anxiety toward the psychiatrist can often be easily reduced by encouraging and praiseful remarks with regard to the patient's exposition of his difficulties. For example, the psychiatrist can say, at a moment when the patient hesitates and looks inquiringly at him, "Go ahead, you're doing very well. Keep going the way you were."

Yet we need to remember also that anxiety can run too low in an interview. Physician and patient can unwittingly exclude the patient's anxiety from expression and agree that he is much better than he (or a referring physician) thought he was. This comes about when the human wish to reduce human suffering urges the psychiatrist to offer reassurance prematurely. In doing this, the psychiatrist deprives himself of the opportunity of tracing the patient's anxiety to its specific origins. For example, suppose a patient says, "Doctor, I think I am going crazy." To this the psychiatrist can immediately reply, "Oh, no you're not. You don't have the symptoms." More useful remarks would be either, "What do you mean by 'crazy'?" or "What makes you think you are going crazy?" To such questions the patient may then answer with details of his anxious thoughts. It then turns out, perhaps, that he thought he was going crazy because his memory has faltered recently and an aunt who died in a mental hospital also complained of this at one time. Further inquiries remind the patient that she was, in any case, an aunt by marriage. To such specific details, the psychiatrist can then provide specific reassurance. The best reassurance comes from understanding and explanation. Patients can usually distinguish reassurance based on careful inquiry and explanation from shallow statements to the effect that "everything is going to be all right." Their ability to penetrate our weaknesses in this respect provides another reason for avoiding premature reassurance. Such reassurance can seal off further exposures of the patient's anxiety. He may think to himself, "Why should I tell my troubles to someone who minimizes them all as my family does?" Moreover, premature reassurance, when the patient does accept it, tends to promote the patient's excessive dependence on the psychiatrist. If we say, "'Everything is going to be all right" (and there may be times and places when we should), we should realize that we have thereby accepted responsibility for their being so. When we insist that the patient join us in a careful exploration of his symptoms and difficulties, we communicate firmly to him our expectation that he will also share responsibility for his getting well.

We can control the amount of anxiety in the patient rather well by changes in the amount of talking we do. As the patient talks more and the psychiatrist less, the patient's anxiety tends to increase, at least initially, although after catharsis it may decrease again. As much as possible, the psychiatrist should talk to modify the patient's anxiety, not his own. To do this, he needs to remember that patients often tolerate silences rather well and frequently use them to think before speaking. A patient occupied in telling his story may not even notice silences, and sometimes does not seem even to notice the interviewer. But if a patient uses a silence to delete some repellent thoughts, he usually becomes aware of the silence, and his anxiety mounts. Then, if the psychiatrist has not prematurely spoken in order to ease his own tension, the patient will speak to reduce it himself.

A common dissimilarity between the inter-

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views of interested amateurs, such as sensitive internists, and experienced psychiatrists exists in the differing extents to which they permit, encourage, and facilitate the expression of their patient's emotions. This being so, we may ask why the free expression of emotions is encouraged. We do it first because, as I mentioned earlier, emotions give importance to an experience and at the same time communicate that importance to other people. They should also communicate its importance to the person himself. And this they do when the emotions become strong enough. But often patients have not expressed themselves freely to other people. Consequently, the related emotions may recede somewhat, and the patient may think himself untroubled by them. Talking brings the emotions to the surface, and if they come strongly enough the patient may be astonished at the extent to which he has been affected. Patients frequently comment on this with remarks such as, "I never cry when I think about these things at home, but when I come here and talk I seem to cry all the time." This illustrates Sir Charles Sherrington's comment that, in motor activity, talking lies midway between thinking and acting. And it brings us to an additional reason for encouraging the patient's expression of emotions—the therapeutic benefit to him. Although this subject properly belongs to therapy rather than to diagnostic interviewing, the psychiatrist can remind himself that initial interviews begin therapy by observing the simultaneous benefit for both diagnosis and therapy of the patient's freely expressing strong emotions. Moreover, the relief experienced by the patient usually cements his attachment to the psychiatrist and makes the patient eager to talk more at the next interview.

This does not always happen. Sometimes patients recoil in anger or guilt when they find they have talked too freely and shown some emotion they previously condemned and imagined they could not experience. A patient may resent the psychiatrist's hearing him criticize his parents perhaps for the first time, or seeing him cry, or eliciting the confession of some wickedness. One cannot easily predict which patients will react in this way. Fortunately, the best safeguards lie within the patients, for those who are most likely to be hurt by too rapid a release of emotions are those who are most inhibited in the first interviews. They will require several or many interviews before they talk freely. But the psychiatrist should still observe the patient's reaction to the interview itself and notice whether the patient shows concern about the things he says and the emotions he displays. Within the patient's tolerance, the psychiatrist should encourage the patient to express his emotions fully. Weak emotions, like mild pain, are often of doubtful significance, but strong emotions tell both psychiatrist and patient alike that they are working in relevant subjects.

Some of the chief techniques for encouraging the patient's expression of emotions have already been mentioned. The physician should sustain and show his interest over at least forty-five minutes or an hour. In brief interviews the patient rarely has time to overcome his almost invariable initial reserve. In a ten-minute interview, discussion of the weather may take five; in a fifty-minute interview, one can give five to the weather and still do much besides. In addition, emotions cut grooves for similar thoughts which, in turn, bring stronger emotions to the surface. The longer one talks about a particular subject, the more emotion accompanies the evoked thoughts. Fully developed emotions usually occur only in longer interviews, because shorter ones do not permit this self-fueling of emotions to occur.

Beyond the requirements of showing interest and allowing plenty of time, the physician can further increase the patient's emotional expression by careful attention to some additional technical points. These are emphasizing detail in the patient's narration, reinforcing the patient's emotion by communicating understanding of his feelings, and naming the experienced emotion.

When we tell others about a past experience, we partially relive the events we tell and partially experience again the emotions we then had. The extent to which we feel again the old emotions depends upon the vividness of reliving. Simple, uneducated people easily

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slip into a present-tense style of narration in which they seem almost completely to relive what they describe. More educated and more controlled patients, on the other hand, tend to talk in the past tense or to confine themselves to general statements. The psychiatrist should press the patient to provide specific examples of what he says. For example, if the patient says, "My father was always mean to me," the psychiatrist should ask, "Do you remember that? What do you remember?" He should frequently ask, "Can you give me an example of that?" or "Such as what?" Such questions oblige the patient to focus on specific events and, at least partially, to relive them. Moreover, the discipline of documenting general statements contributes to the patient's understanding of his own misperceptions. Once the patient has begun to tell about an incident, the psychiatrist can easily heighten the portrayal of detail by interjecting questions which ask for further details such as, "What happened then?" "What did your father say to that?" and "What did you do after you left the house?" After a little guidance of this kind, the patient will continue to give detail on his own, partly because he knows what the psychiatrist wants and partly because he begins to experience the relief of catharsis which only comes with vivid retelling.

Remembering the influence of the audience on any speaker, the psychiatrist can increase the patient's emotional expression by showing understanding of his emotions and attitudes in the events narrated. This does not need to include or imply an endorsement of the patient's behavior; rather, it implies an awareness that what he then did was natural for him at the time. Remarks (offered in a questioning way) such as, "So you felt no one was on your side," and "At that point you thought your father was trying to control you," can tell the patient that he at last has someone to talk to who can understand him, so he wants to talk more.

Patients frequently come close to the expression of strong emotions without quite permitting themselves to do so spontaneously. Frequently, fears of the psychiatrist's reaction to strong emotion inhibits them. When a tear moistens the patient's eye, the psychiatrist can profitably tell the patient he has noticed the emotion with a remark such as, "I can see it makes you sad to talk about this." Such a statement says to the patient, as it were, "It's all right to cry in here. Go ahead." And frequently such little remarks will help the patient to cry or experience other strong emotions. The psychiatrist gains nothing if he runs too far ahead of the patient in using this technique. Many patients have great difficulty in acknowledging and showing anger. If the psychiatrist too rapidly confronts such a patient with a name such as "anger" or "rage" for these emotions, the patient may shrink back in horrified denial that he could house such feelings within himself. In that case, however, the psychiatrist does not need to retreat all the way. If he finds himself ahead of the patient and encounters denial, he could still say, "Well, of course I could be mistaken, but I think nearly everyone in your situation would have been annoyed at what happened to you." This provides the patient with a hint of the acceptability of some anger which he may later wish to use.

Although the importance of the patient's talking freely has been emphasized, the psychiatrist should retain general control of the interview. Free talking does not mean unlimited free association. The right of the patient to say what he wants does not convey also the right to babble on tediously about irrelevant matters. The psychiatrist has the privilege and even the duty of curtailing circumstantiality and garrulity. But before he does, he should first ask himself (and perhaps the patient) why the patient behaves in this way. There are many reasons, and it is worth finding out which applies. Sometimes the irrelevant chatter results from a long-standing inability to think clearly, a form of mental deficiency. Sometimes it indicates failure of memory, with the patient substituting quantity of detail for accuracy of recall. Sometimes the patient talks about something else in order to postpone talking about some more affecting topic, or to conceal it altogether. This commonly happens in the description of hypochondriacal complaints in which the patient,

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by focusing the attention of himself and everyone else on his heart or stomach, withdraws it from his marriage or disastrous financial predicament. Sometimes the patient with such excessive talk tries to communicate covertly something he thinks about himself but cannot or dare not articulate explicitly, or of which he may even be unaware. The patient who offers unnecessary detail may never have thought that his affairs seem less important to other people than to himself. Or, when a patient recounts details of his previous illnesses and operations in uninvited detail, he may really want us to know in this way how much he has suffered and needs our sympathy.

Before cutting off the patient, or while cutting him off, the psychiatrist should usually inquire about the excessive talk. He can say, for example, "I notice you spend a lot of time telling me about your past illnesses. I can see that they are important to you, but I don't think I understand why. Can you tell me how they are important to you at this time?" If such inquiries prove futile to stem the flow of the patient's irrelevancies, the psychiatrist can then move gently, but if need be also firmly, to deflect the patient. He can say, for example, "Perhaps later we can come back to what you are talking about. But since our time is limited, I wish you would tell me about so and so." This brings us to the various techniques for channeling the interview toward significant topics.

Guiding the Interview Toward Significant Topics

As in his encouragement of the patient's talking freely, the psychiatrist should guide the interview covertly when possible and only secondarily with more open directions. Often, he can use the devices mentioned previously for showing greater interest in a topic of special importance which the patient only mentions. Thus he can channel the patient into another topic without the patient's becoming aware of his influence. But the psychiatrist should be aware of it. He should know that he is guiding the patient, and for a definite reason. In experiments which all psychiatrists should study, subjects have been asked to utter at random all the words they can think of.[18] As they do this the experimenter stands behind the experimental subjects and mutters "uh-uh" after each plural word. These grunts have an extraordinarily powerful effect in increasing the number of plural words vocalized, the effect being somewhat greater when the subject judges that the experimenter means to communicate approval by his "uh-uhs." Now, a patient always knows or thinks that the psychiatrist wants something, and he usually wants to satisfy the psychiatrist much more than experimental subjects want to satisfy psychologists. Consequently, if the psychiatrist interjects his "uh-uhs" unconsciously and pursuing his special interests in sex, religion, money, or something else, the patient will almost certainly go along with him. Both may find the hour enjoyable, but it may be unrewarding because of a one-sided emphasis on their favorite topic.

If the psychiatrist's subtlest signs of increased interest do not guide the patient to talk more of some significant object, then he may direct the patient more openly. He should exploit as much as possible the associations and references already provided by the patient. For example, suppose the patient says, "My headaches are getting worse every day, and my wife says she can't stand it much longer." The psychiatrist can catch the patient's reference to his wife and inquire, "What does your wife say about your headaches?" This broaches the subject of the patient's marriage, and other inquiries and information naturally follow. Sometimes the psychiatrist should not interrupt the patient in order to pursue an association at that time. This can interfere with the patient's flow toward something equally important. But the psychiatrist can make a mental note of the patient's remark and return to it later. He can say, for example, "You mentioned five minutes ago that your wife couldn't stand your headaches. Will you tell me some more about that?" By using the patient's own references and associations, an experienced psychiatrist can conduct an entire and thorough history-taking interview without ever himself introducing a new topic. Since

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the patient seems always to be elaborating further on what he himself first brought out, he cannot reasonably believe that the psychiatrist has forced him to talk of things he did not mention.

Even with the most skillful use of indirect techniques, the psychiatrist will, at times, have to ask questions, bring up new topics, or inquire directly for further details. Although, as already mentioned, the psychiatrist should defer questions about time, places, and details of events omitted in the patient's initial story, eventually he should ask for whatever facts he believes necessary to satisfy the requirements of a thorough history. The proper asking of such questions deserves attention. Slight differences in wording can greatly influence the patient and his responses. If our "uh-uhs" can tell the patient what we want to hear, our explicit questions provide a much more forceful and sometimes harmful guidance to the patient. The questions asked should provide the least possible clues to the answers expected and the least possible channeling of the answers. Most desirable are "open" questions which ask about a topic in general and to which the patient must reply with one or several sentences. The least desirable questions are leading questions to which the patient can answer "Yes" or "No" and then remain silent. Compare, for example, the differing values of asking the patient, "Do you and your wife quarrel often?" and "Tell me about your marriage." The first question, apart from its abruptness which can offend, may evoke a simple "No" from the patient and nothing else, unless irritation. The second question invites and almost obliges the patient to reply with a sentence or more. Moreover, it does not confine the patient in his reply to the present time. The psychiatrist can learn much from noting what the patient selects to talk about first in answer to such a question. To illustrate this important principle further, an exercise for a psychiatrist who wishes to improve his technique is to arrange opposite each other, in a list, closed questions and more valuable open ones. For example, one can ask a patient, "Was the pain severe?" but a better question would be, "What was your illness like?" "Did you miss your daughter when she married?" will yield less than, "How did you feel when your daughter married?" One can ask, "Do you have a bad temper?" but this can be improved by saying instead, "How is your temper?" I do not mean to proscribe all leading questions focused sharply on a specific point, but these should come after more general open questions have given the patient an opportunity to answer freely without the suggestions and guidance of leading questions.

In asking questions which broach new topics, tact and timing reward the interviewer for the extra care they require. Careful phrasing of questions can greatly improve their yield. For example, in talking to an unemployed patient one should avoid saying, "Have you been on relief often?" asking, rather, "Have you had much trouble finding work?" Or, to illustrate further, one can unnecessarily offend a patient by asking, "Have you quit many jobs?" The patient would give the same and more information if asked, "What has led to your various changes of jobs?"

The state of the physician-patient relationship should influence our timing of questions and opening of topics to which the patient may be sensitive. As the patient and psychiatrist became more attached to each other, the patient feels freer to disclose more of himself, and the psychiatrist feels freer to ask him to do so. We can ask questions in the last five minutes of an interview which we could not ask in the first five, and we can ask questions in the fifth interview which would have been inappropriate in the first.

We can make many questions less painful by embedding them, as it were, in a matrix of other questions to which the patient is less sensitive. Thus one can lead a woman patient fairly easily to talk about sexual intercourse if one inquires about this at the end of a series of questions on pregnancies. In asking about further pregnancies, the physician may naturally inquire whether the patient's sexual relations have been satisfactory and, if not, why not. Similarly, one can ask questions about impairment of memory right after asking about the effects of the patient's illness on his vital functions such as sleep and

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appetite. With the question placed in this context, the patient is much less likely to believe that the psychiatrist thinks he is "crazy" than if a question about memory confronts him abruptly as a new topic.

Do not, however, confuse tact with timidity. The physician should never hesitate, out of feeling for the sensitivity of the patient, to ask a question which is necessary for thorough evaluation. In talking to a depressed patient, for example, the physician should discover whether or not the patient has had suicidal thoughts and the likelihood of his acting on these thoughts. Often, he can learn about such thoughts indirectly, but when he cannot, then he should ask his questions directly. A question firmly asked will usually elicit a more direct answer than one offered hesitantly.

The psychiatrist should try to avoid offering gratuitous comments and interpretations which can trip the patient as he tries to tell his story. Instead, he should try to offer simple questions which, while asking for more information, encourage the patient to talk further. For example, suppose the patient says "I feel I need affection and can't get it." One might respond to this with, "Well, we all need affection, and you're not alone in this." A much more useful response would be "What interferes with your getting affection?" This second comment reassures the patient that he needs affection, but it also inquires further about what he himself may do to deprive himself of it. Or again, a patient may say, "I'm afraid I may lose control of myself." To this one could reply with, "Would that be bad?" but an even better response would be, "What do you think would happen if you did?" Or as a final illustration, suppose a patient says, "I was afraid of my parents as a child." The psychiatrist could answer reassuringly, "Yes, many children are afraid of their parents." A more productive answer, however, would be, "What about them made you afraid?"

Ending Interviews

When patients do express emotions freely, we should give them some warning of the end of an interview before it closes. This permits the patient to regain some calmness before leaving the office. About five minutes in advance, one can say something like, "I can see that all this is extremely important to you, and we need to talk about it some more. But our time for today will soon be up, and we will have to postpone the rest."

I find it helpful always to ask the patient at the end of diagnostic interviews if he has anything further he would like to bring out or has any questions he would like to ask. In these final moments patients frequently reveal some matter of great importance to them. Previously, anxiety prevented their reaching these subjects, but as they see the interview closing, they often decide to risk the exposure. Usually, time does not then permit a full discussion, but the psychiatrist can defer this until the next interview.

Much of the best work of interviews occurs after psychiatrist and patient have separated. The patient (and a good psychiatrist also) goes on thinking about the subjects of the interview. New associations and often new emotions come to the surface and provide additional material at the next interview. The psychiatrist can usefully ask patients, on parting, to think further about the things discussed and to note these additional thoughts. Such instructions often stimulate patients who have shown marked resistance to psychological explorations. In the interview itself, their great anxiety frequently prevents their talking or even thinking freely, and they often present defensive and obviously incorrect denials of symptoms and attitudes for which abundant evidence exists in other signs. After the interview and away from the psychiatrist, many of these patients relax and then begin to think constructively about the topics discussed. At the same time, the image of the psychiatrist becomes less awesome. After a few hours or days of rumination, the patient may eagerly welcome a second interview and may talk much more freely.

At the end of any initial interview, the psychiatrist should discuss with the patient plans for further interviews or for treatment. Often, the patient will press him for an immediate diagnostic opinion. The psychiatrist

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may then have to explain that he will need further interviews and perhaps other examinations and tests before offering an evaluation of the patient's illness. He can usually include some initial reassurance covering what he knows up to that point. He should avoid blanket reassurance which he may afterward have to revise, and he should avoid offering prematurely a diagnostic opinion or recommendations for treatment. But always he should tell the patient what he plans to do next. Attention to such details of courtesy and cooperation greatly aids the transition from initial and diagnostic interviews to treatment.

Few single interviews sufficiently reveal the patient's difficulties for the purposes of the thorough evaluation which sound practice requires. Not many healthy people can pass from strangership to intimacy with another person in any hour, or even in several. So we should not expect this of anxious or otherwise troubled patients. Therefore, we must turn to additional interviews and to additional informants, both of which are nearly always desirable. With the patient's consent (rare exceptions to this occurring in the cases of irrational, psychotic patients or young children) we should interview important relatives of the patient, so that we may benefit from their often quite different perceptions of the patient and his illness. The discrepancies between the patient's account of himself and that of a relative frequently astonish us and also remind us how differently people appear to different observers. Our psychiatric interviews can improve if we frequently remind ourselves of their significant limitations in giving us the information we need.

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CHAPTER 10

THE PSYCHIATRIC EXAMINATION

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LIKE THE PSYCHIATRIC INTERVIEW, the psychiatric examination has changed considerably in the past fifty years. Once largely restricted to the examination of severe mental disorganizations, it has now become an extensive study of the whole personality, with special emphasis on thought contents and their accompanying emotions. Moreover, psychiatric examinations are no longer restricted to patients with severe mental illnesses. Although naturally varying in emphasis and detail with different patients, some psychiatric examination should now form part of every careful medical examination.

¶ Introduction

More specifically, the psychiatric examination may uncover significant data under any or all of the following headings:

1. Signs of psychological disturbances which are expressions of the patient's major illness, for example, organic brain syndromes or schizophrenic reactions.

2. Psychological factors which are (partially) causative of a major physical illness or which exacerbate it, for example, anxiety in a patient with peptic ulcer, essential hypertension, or angina pectoris.

3. Psychological reactions to the presence of another illness, for example, anxiety about his condition experienced by a patient with congestive heart failure.

4. Psychological factors which interfere with the patient's cooperation in treatment, for example, a denial of illness or a resentment of authority as represented by the physician.

In addition to studying psychopathology, the psychiatric examination should also encompass the individual characteristics and assets of the patient. Unfortunately, the preoccupation of physicians with ill health sometimes leads them to neglect the healthy aspects of their

patients. Yet the outcome of an illness is influenced fully as much by the patient's assets and strengths as by the nature or apparent severity of his symptoms or illness. Without some awareness of these assets, the physician cannot expect to promote healing by his efforts.

Although modern psychiatric theory emphasizes the adaptations which patients make to life stresses, it is possible to take a harmfully one-sided view of the patient's symptoms by considering them exclusively as defenses. Such narrowness can lead to absurdities such as the explanation of a schizophrenic psychosis as an "escape" from difficulties in living. The schizophrenic patient becomes psychotic because the stress to which he is subjected disorganizes his mental machinery. With this there may come some relief, but it is certainly secondary. Similarly, a young man about to go to college may develop an incapacitating dermatitis a few days before his departure. The illness prevents him from attending college, which he did not want to do. But he did not become ill in order to avoid going to college; rather, his dermatitis was an accompaniment and an effect of the anxious thoughts connected with going to college. Many symptoms have adaptive or defensive value, others do not.

Psychiatric symptoms therefore may be: (1) disorganizations or disorders directly produced by a lesion or learned during a stress; (2) efforts to compensate for these disorders; or (3) efforts to counteract the lesion or stress.

The psychiatrist should remember that his examination may not elicit adequately representative data. This point deserves brief discussion. In a manner quite impossible for the physical state to do, the psychological state can vary widely with changes in the external environment. Two physicians may obtain totally different evaluations of the same patient's mental state. The patient may have different feelings and attitudes toward each; he responds differently to the two different examiners and, consequently, they observe different data in their examinations. For example, if the patient's attitude toward one physician carries unpleasant tension, this tension may impair his mental efficiency. A patient of greater than average intelligence may thus appear intellectually subnormal when his mental efficiency is momentarily so reduced. Another physician, evoking a different response from the patient, might conclude that the patient was highly intelligent. These discrepancies can occur even when the patient consciously wishes to cooperate with both physicians. Although the patient's attitude toward the physician depends partly on the approach of the physician himself, it is also influenced by the distorted perceptions of the physician by the patient, who may misperceive him as resembling some similar past significant person more than he actually does. In addition, the physician is usually a stranger and, in this instance, a person with some authority to make important decisions relative to the patient. Any observer of human behavior, by his mere presence, may modify the very behavior which he would like to observe.

A difference in the evaluation of the mental state may arise not only from differing attitudes of the patient toward different observers; equally, the patient's emotional state may be changed by some other person or event, the effect of which may linger for many hours or days and may still be affecting him at the time of the examination.

Furthermore, the patient's anxiety may be aroused by the examination itself, altogether apart from the thoughts he has about the examiner. Some of this anxiety may be rational; for example, he may know that the physician may make important recommendations about him (such as admission to a hospital) as a result of the examination. Or the anxiety may derive from quite irrational ideas about the examination; for example, the patient may believe that the physician has been hired by the F.B.I. to trick him. Whatever its origin, anxiety about the examination can markedly alter the mental state as observed in the examination.

The examiner therefore needs to remember that the mental state at the time of an examination may be importantly influenced by: (1) alterations in the patient's psychological state induced by recent events; (2) the attitude

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of the patient toward the examining physician; (3) the attitude of the patient toward the examination itself; (4) the attitude of the examining physician toward the patient.

Thus discrepancies in the observations of different physicians do not always reflect different percipiences in the physicians. These differences can arise from changes in the patient's psychological state between one examination and another. The physician should therefore make his first examination as complete as possible, but he should also supplement his observations with the evaluations of other individuals, for example, nurses, occupational therapists, aides, members of the patient's family, etc., who have had an opportunity to observe the patient in varying settings. And he should himself make repeated observations of the patient's behavior, if possible in different settings. Like the history or physical examination, the psychiatric examination should be a continuing process in which the physician is ever observant of new data.

The psychiatric examination, as well as the physical examination, requires evaluation by two standards. In some respects, all healthy human beings resemble each other, and gross deviations from statistical normality may be safely labeled abnormal. In evaluating such deviations, the physician relies upon a broad knowledge of human nature and human behavior in the culture in which he and the patient live. But he must also remember that in some respects everyone is unique. For these aspects, the patient himself furnishes the standard of reference. The physician should therefore try to compare the patient's present condition with his premorbid level of function. Only in this way can he accurately evaluate the patient's mental state.

Sometimes the patient himself can reliably contribute information about his "base line." However, the physician rarely knows the patient's dependability in this regard, at least initially, and so should check the subject's statements with those of others who have known him closely. The patient's relatives and friends can often provide valuable information about the extent of deviation from his usual personality.

Before presenting an outline of the psychiatric examination, we think it important to remind our readers that psychological states have a wholeness the existence of which we can obscure by our habit of examining part functions. We cannot avoid examining parts, but we can reduce the attendant errors by constant remembrance of the interdependence of the parts on each other and of the quality which is given to each part by its membership in the whole. For example, we sometimes differentiate intelligence from personality, as if these two words denoted exclusive functions. Actually, the qualities included in the concept of intelligence, far from being separate, form a major part of personality. Personality may be defined as the sum of the habitual reactions of a person to external events. Perceptions, intellectual functions, and affective states all influence these reactions. We may usefully abstract for our discussions the processes of perception, integration, and response; in life, however, they merge inextricably. Almost any item of behavior may illustrate the instantaneous blending and the impossibility of really separating these processes. For example, suppose the patient angrily accuses the physician of not being sufficiently interested in him. He reveals his misperception of the physician as being similar to his neglectful father and dissimilar to his adoring mother. At the same time, he shows his inadequate understanding of the physician's role and usefulness and of the physician's genuine interest on his behalf. Such understanding might have corrected, to some extent, his initial false perception. He also shows how his own comfort depends upon the interest and affection of other persons, and how threatened he feels when this is lessened. Finally, his anger shows the pattern of his response to this anxiety and his lack of inhibition of the expression of his anger.

A mental examination reveals order or disorders of function. The physician does not examine a mental organ directly in the same manner that he can examine a physical organ, for example, when he auscultates the heart and lungs. His examination of the mental state cannot even be as direct as the examination of nervous tissue. In the latter case the nerves are

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not seen and rarely are even felt. Disturbances of their function are usually deduced from noting changes in the activity of other organs, for example, the muscles. Similarly, in the mental examination, the physician infers disturbances by noting abnormalities in the way the patient perceives, integrates, and responds to external events. He cannot observe the mental processes directly. He must deduce their condition from the patient's verbal statements and from observations of his other behavior.

¶ Outline of the Psychiatric Examination

We shall next present an outline of the psychiatric examination, arranged in headings for easier memorization. Then we shall discuss individual parts of the examination. We offer this outline without any conviction that it surpasses all others. The value of an outline lies chiefly in the prevention of omissions in the examination, and one outline may accomplish this as well as another. Certainly, we should use no outline rigidly in our own thinking, and even less in our examination of the patient. Each examination should differ from every other, according to the needs of the patient and physician and other circumstances. However, our advocacy of flexibility does not condone casual or incomplete examinations. As mentioned earlier, details and emphasis will vary from one case to another, but in every instance the psychiatrist should consider, at least in his own mind, each of the major headings of his outline. Most errors arise from omissions, relatively few from faulty observations. Sometimes circumstances prevent as adequate or as complete an examination as we wish or the patient's condition requires. When this occurs, we should record the deficiency in our notes and never fail to remedy it as soon as conditions change.

The outline presented here has three main sections which correspond, so to speak, to the afferent, central, and efferent portions of a reflex arc. However, because the patient presents his emotions and behavior first to the observation of the examiner, we have placed these first. The physician can often complete this part of the examination during his interview with the patient. Through transitions that we shall mention later, he can then extend the interview into the more detailed examination of the other parts of the outline.

Outline of Psychiatric Examination

General Observations
- Circumstances and setting of examination
- General description of the patient

Emotions and Behavior
- Emotions
- Behavior

Central Organizing Processes
- Intelligence, including memory
- Thought processes
- Thought contents, including self-concept and insight

Perceptions
- Misperceptions
- Illusions
- Hallucinations
- Attention
- Orientation

General Observations

In addition to the usual note about the date and place of examination, the physician should also make some mention of the actual setting in which the examination was conducted. As previously noted, human behavior may differ markedly in different surroundings and under varying circumstances. Strange surroundings, or those which might be interpreted as threatening, may induce such severe anxiety as to obscure other important aspects of the patient's psychological state. The setting and circumstances of examination therefore acquire their importance from the effect they might have on the patient. Any unusual reasons for making an examination—for example, at the request of a court—other than the patient's request for medical assistance should also be noted.

The physician should next attempt something akin to a novelist's sketch of the patient

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as a person, using a photograph of words to convey to the reader a meaningful picture of the patient as an individual. By way of illustration, such a description may include noting the general appearance, demeanor, and clothing of the patient. A female patient who enters the office with hair unkempt, little or no make-up, no stockings, and badly scuffed shoes immediately communicates something of her attitude toward the social norms of dress. What this format means for her (for example, defiance of social customs, hostility to men, or lowered estimate of herself) will only emerge later, but its occurrence should be noted immediately.

To this general description the physician should also add a note concerning the patient's initial attitude toward the examiner, the interview, and the examination, his expectations about these, and his degree of cooperativeness.

Emotions and Behavior

Emotion

If the psychiatric interview is sufficiently complete and ranges widely enough to permit full expression of the patient's emotions in connection with the topics of major significance to him, the emotional content can often be quite adequately evaluated during the course of the ordinary history-taking interview. The previous chapter having discussed this extensively, we shall not here fully consider this aspect of the psychiatric examination.

Dominant Emotions. The physician should observe the dominant emotions of the patient, their intensity and duration, and their appropriateness to the patient's immediate situation and thought content. The physician should know whether a dominant emotion has recently arisen or is habitual, and, hence, more properly called a mood. Sometimes he may watch emotions come and go during an interview and thus gain information about the capacity of the patient to return to his habitual feeling state; at other times he may need to make special inquiries on this point. Thus, he may obtain considerable information about the lability or fixity of the patient's emotional life. He should also learn about the sensations experienced during a given emotion. Some persons have only mild changes of sensations during emotions such as fear and anger; others may undergo what amounts to a severe physiological storm.

Events acquire meanings through the quality of our experiences. As different experiences give different meanings to outwardly similar events, we must always learn the meaning of events for the patient. When we observe a strong emotion in the patient, we know that we have reached something important for him, but why it is important we learn only from getting him to tell us his thoughts. As the patient is frequently a poor witness of his own thoughts, we can often help him and ourselves to a better understanding of his emotions by learning what situations evoke the various emotions in him.

Since much human behavior and a great deal of psychopathology derive from efforts to control or suppress the expression of strong emotions, the study of the patient's various mechanisms for dealing with emotions forms a most important part of every psychological evaluation. Does the patient handle emotions such as anxiety in an integrative and constructive fashion? To what extent have the patient's efforts at controlling or concealing emotions succeeded, and to what extent have they failed? If they have failed, to what extent has the patient's mental organization become impaired?

To summarize and illustrate, if the patient is angry, the physician needs to know what has provoked his anger, why this angers him, how he feels, what he shows, and what he does when he is angry.

When the psychiatrist notices an important durable emotion, such as a depressed or elated mood, he should carefully evaluate the degree of mood change and its present or potential connection with irrational and perhaps dangerous behavior, for example, suicide in depressed patients or wild financial schemes in elated ones.

Appropriateness of Emotions. In evaluating the appropriateness of emotion to a

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given situation, the physician should remember the following modifying factors.

CULTURAL DIFFERENCES IN EMOTIONAL EXPRESSION. Wide variations in patterns of emotional expression occur. To the Scandinavian, the Italian may apear wildly emotional, while the Italian may think the Scandinavian cold and unfeeling. The physician must therefore know the patient's customary or cultural pattern of emotional expression before evaluating its appropriateness.

SUPPRESSION AND CONCEALMENT OF EMOTION. When the patient feels ashamed of his emotions or has other motives for their concealment, his emotional reactions to stressful situations may seem inappropriate.

MASKING OF OTHER EMOTIONS BY A DOMINANT EMOTION. Any strong and lasting emotion can dominate the experience of the patient so as to exclude other emotions from expression in situations which might ordinarily evoke them. For example, a patient extremely anxious or depressed will not smile or cry when stimulated by events which would previously have made him do so. A general decline in all emotional expression, known as apathy, can similarly exclude ordinary emotional expression.

DISPLACEMENT OF EMOTIONAL EXPRESSION TOWARD AN INAPPROPRIATE PERSON OR OBJECT. A person may inhibit the discharge of a strong emotion toward the person stimulating it and later discharge the same emotion toward someone else who, perhaps, precipitates a slighter degree of this emotion but receives the full force of the accumulated earlier emotion. Misperceptions of other people may also lead to inappropriate expectations of them and hence to inappropriate emotional reactions. Such misperceptions probably account for most inappropriate emotional responses. Their frequency emphasizes the importance of observing the roles which the patient assigns to himself and to others. Significant clues to these perceptions may often be found in the patient's emotional reactions to the examining physician.

Inappropriateness (apparent or real) of emotion to thought content may arise in a number of ways.

UNAWARENESS OF TRUE THOUGHTS. The psychiatrist may be unaware of the patient's true thoughts. First, the patient may conceal his thoughts. Secondly, he may reveal them, but the physician may not understand the special significance which they have for the patient. A patient with a schizophrenic reaction may smile or laugh as he mentions the death of his father; however, we may find that the father was a tyrant whose death brought joyful relief to the patient. Thirdly, the patient's thoughts may move so quickly that the physician may observe the occurrence of an emotion but fail to detect its accompanying thought. Apparently inappropriate emotional expression also occurs in schizophrenic reactions as a result of disrupted associations. In talking about something which is quite serious, the patient may be observed to smile or laugh in a manner quite inappropriate to the topic under discussion. Upon being questioned about this, however, the patient may state that an amusing thought entered his mind at the time he smiled. Thus again, the emotion expressed in the smiling may have been quite appropriate for the thought. The abnormality lay in the intrusion of this thought at this time, the result of the disorder in association which is a characteristic feature of this condition.

DISSOCIATION BETWEEN THOUGHTS AND EMOTIONS. The central abnormality here is not that meanings have changed but that thoughts no longer bring the usual accompanying emotions. This kind of dissociation can often be observed in dreams in which, for example, situations which would be quite alarming or quite ludicrous to the waking consciousness fail to evoke anxiety or laughter. When this condition is found in the waking state, it strongly suggests a schizophrenic reaction.

NEUROPHYSIOLOGIC DISORDER IN THE EXPRESSION OF EMOTIONS. In certain brain diseases, such as pseudobulbar palsy, so many cortical neurones are injured that an interference occurs with the modulation of emotional expression. Accordingly, a slightly amusing thought brings a shower of laughter, and a sad thought may precipitate tears. The patient

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usually knows that his emotions are excessive and inappropriately expressive of his thoughts, but he cannot control these reactions.

Behavior

Emotion and behavior overlap and merge and are, to a considerable degree, interrelated. Behavior generally refers to action and expression with the whole body or major parts of it. Behavior may express the same motives as those which give rise to the conscious experience and expression of emotions. On the other hand, a given attitude may not enter conscious awareness as a felt emotion but nevertheless may reach expression indirectly in behavior. For example, if a wife slights her husband, he may not experience conscious anger, but if he forgets his wife's birthday the next day, we might be justified in attributing this forgetting to a hostile motive provoked by his wife's remark. Or the husband, still without showing any anger, may bring into play techniques for making his wife feel guilty. He thus retaliates not openly but by a much more subtle hurting of his wife.

In evaluating the expressive and communicative significance of motor activity, it should be noted that some motor activity is a concomitant of a central neural state. The communicative aspect of this kind of activity is incidental and only medical. It may tell the physician about a central disorder, but it is not created for this purpose. Other motor activity has communicative intention but is not symbolically expressive. And still other motor activity communicates symbolically to those who understand the symbols. Thus we may observe motor activity of the hand in a kind of gradient of communicativeness, as follows:

1. Tremors of the hands associated with organic diseases of the brain, for example, Parkinson's disease. The symptom is a concomitant of a disturbance in the central nervous system having only a medical communicative value.

2. Tremors of the hands associated with anxiety states. No communication is "intended," but some may result if the tremor is noticed by those who can interpret its significance.

3. Tapping of fingers on a table during partially inhibited anger. Here the motor activity is partly an accompaniment of heightened psychological tension but also may have, and be intended to have, communicative value to other persons.

4. Banging the fist against a table. In this act the patient communicates symbolically his anger and his desire to hit another person.

The physician should note the patient's general level of physical tension. Is his activity random and unorganized, or is it channeled into some constructive project? Is he aware of periods of hyperactivity or hypoactivity, and do these disturb him in any way? Is he prone to act out or express his frustrations and anxieties directly through various behavioral outlets? If so, are these techniques successfully adaptive or self-defeating? Can he communicate readily with words, or does he communicate chiefly with nonverbal behavior?

The behavior of the patient with other people and the effect which he has upon them are of major importance in making a comprehensive psychological evaluation. One should note, for example, those persons with whom he shows anxiety, those toward whom he feels superior, those of whom he stands in awe, and those to whom he comes for help. In a similar vein, does the patient evoke pity, anxiety, anger, attention, friendliness, aloofness, etc., in most of the people he encounters? If so, is this a habitual, chronic pattern or one of recent development?

Any study of the patient's interpersonal relations should certainly not be limited to simple observations of his interaction with different persons. Although the patient's behavior with different people varies, he is a unique person with certain needs which dominate his behavior and give it a more or less consistent pattern. One basis for the concept of personality is that there are habits and patterns in behavior which give some predictability to each person's responses to his environment. Therefore, the physician should try to detect the dominant traits of the patient, or his

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recurring patterns of activity as expressed in his behavior with different people. Such traits as ingratiation, aggressiveness, cautiousness, defensiveness, irritability, etc., will occur as leitmotivs over and over again in the patient's behavior with many different people. The major generalizations which he has made from his past experiences thus become expressed in the recurrent traits of his behavior in relations with other persons.

Central Organizing Processes

Under central processes we include all those mental processes which occur between stimulus and response; that is, everything mental which contributes to the organization and utilization of experience. For purposes of study and discussion, the processes may be divided into a number of topics, such as intelligence, thought processes, and thought content.

Intelligence

Intelligence is a term applied to a number of mental components and processes, including speed and accuracy of thinking, richness of thought content, capacity for complex thinking, and the ability to manipulate thoughts and objects. Although accurate and objective estimates of intelligence are often obtained by the use of standardized intelligence tests, motivational components usually modify the expression and influence of the factors measured by such tests to an extent which gives them important limitations in studying human behavior. Despite this reservation, the physician can often aid his evaluation of a patient by making some estimate of the patient's intelligence from the history and from considering the following factors:

Vocabulary and Range of Information. Both of these functions may be demonstrated during the course of history-taking interviews or other parts of the examination. Care should be taken to avoid confusion between intelligence and education.

Memory. The accuracy and extent of the patient's memory for the more remote past can usually be determined from his account of childhood and earlier life given in the history-taking interviews. Recent memory will usually be revealed in the patient's account of the events of the immediate past, such as the circumstances just prior to the examination. The importance of memory in behavior requires the careful examination of the patient with regard to any defect discovered. Do gaps of memory begin and end abruptly? Are they confined to one period or scattered over the whole span of life? Do they include unpleasant events only or pleasant and unpleasant ones indiscriminately? Is the defect of memory due to lack of attention to the environment or to poor retention or recall? Does the patient know he has a poor memory? Does he fill in gaps in memory with confabulations or compensate with garrulity?

Judgment. By judgment is meant a person's ability to use all the resources of his intelligence in solving constructively the problems which he meets. Although behavior supplies the only really reliable guide to judgment, some information about the patient's problem-solving techniques and the kind of decisions he makes may be derived by posing for him certain hypothetical dilemmas.

Thought Processes

Although the processes of thought are chiefly evaluated through the patient's speech, other indicators, such as drawings and special tests, may be employed. In general, one may assume a rather close correlation between the patient's speech and his thought content. Certainly, speech expresses thought, but it often does so imperfectly. Some patients, such as those who are shy or uncooperative, may hide behind their few words an initially unsuspected clarity and richness of thought. And a smaller number of patients may acquire a verbal facility which successfully conceals blurred concepts and other limitations of thinking.

Speed of Thought. The speed of the thought processes communicates valuable information about the patient. Some people think faster than others all their lives. This greater speed of thought (often accompanied by greater speed of speech) may reflect superior intelligence rather than the mood of the person. The physician needs to know whether

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there has been a change in speed of thought and speech from what is habitual for the patient. If so, this usually indicates a change in mood, since, in elation, thoughts and flow of speech are accelerated, and in depression they are retarded.

Besides changes in mood, other circumstances may alter the speed of thoughts and speech. For example, in delirioid states, and in schizophrenic reactions, thoughts ordinarily held unconscious may invade consciousness. The patient may react to this increased imagery by attempts to describe it or to respond to it. The resulting increase in speed of speech may therefore indicate an increase in imagery rather than elation.

Accuracy and Clarity of Thought and the Capacity for Higher Forms of Thinking. As the patient talks, the physician should study the organization of his productions. Various degrees of disorganization may be noted. Thus the patient may talk in grammatical, well-constructed sentences, but these may bear little relation to each other, giving a lack of coherence to the whole. Or individual sentences may be poorly constructed, disorganized, or asyndetic. Words may be fragmented, or new words may be invented. Such neologizing may result in words such as "bastitute" and "mental teleprosy," whose etymology and meaning are reasonably clear. The origin and meaning of other neologisms are often obscure, although they nearly always become intelligible through careful study of the patient and his past experiences.

The relation of individual sentences to each other may indicate some disturbance in associations. When associations are disturbed so that irrelevant thoughts intrude into consciousness, the disturbance is usually reflected in the speech. The interference may be manifest only as a blocking, so that the flow of speech becomes temporarily interrupted. This occurs commonly in states or moments of anxiety. The psychiatrist should note the topic about which the patient is talking at the time of blocking or hesitancy. The affect associated with the topic acts like sand in the mental machinery. Sometimes the intruding thoughts are themselves expressed, giving rise to more or less disorganization of speech. When every thought seems to be verbalized and all filtration of thoughts apparently suspended, the physician should suspect a schizophrenic reaction. A complete disinhibition of the expression of thought, that is, true free association, does not occur in a first interview or mental examination unless a severe mental disorder, for example, a dissociation, is present.

The examiner should note the ability of the patient to pursue a goal idea. When speech is accelerated, as in elation, thoughts often skip from one idea to another in what is appropriately called a flight of ideas. This rapid succession of ideas may result in the expression of no central theme whatever, so that although the patient may appear to have some goal idea in mind, he never reaches it. The physician should note the patient's ability to pursue a line of thought during distracting stimuli. Can he continue a theme after he has been interrupted?

The examiner should try to understand the reasons for a patient's inability to reach a goal idea. Is his stream of thought interrupted by intruding thoughts or by extraneous stimuli? If intruding thoughts interrupt him, are they repetitive, obsessional thoughts or the products of loosened associations? Or does the patient have one dominant thought content which crowds out all others?

The meaning of circumstantiality, in which the patient floods the psychiatrist with irrelevant detail, also deserves attention. Has the patient never learned to focus his thoughts, or does this symptom arise as a response to some anxiety? The patient may tell his story in great detail to win the psychiatrist's approval for "his side," or he may do this to avoid talking about something he wishes to deny or conceal. He may give much detail to evoke sympathy for his suffering, or he may be trying to substitute a wealth of other detail for important gaps in memory. Only careful study can clarify the distinctions between these motivational factors and disorganization of thinking due to organic brain disease.

The examination of thought processes should include study of the patient's capacity for conceptual thinking. Under this heading

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the physician should consider and, if need be, test the patient's ability to perform abstractions.

Rigidity of Thought Processes. The human tendency to form habits affects not only behavior but thought itself, which is a foundation of behavior. Many serious difficulties in living occur because the patient cannot entertain alternative explanations of events or cannot consider alternative responses to them. Earlier associations and generalizations become hardened so that they cannot be broken down to make way for new associations or more appropriate generalizations. Under this heading, one should, therefore, consider the extent to which the patient's mind is open to new ideas and thoughts. Is it closed to explanations and interpretations different from those he has worked out for himself? Or, on the other hand, is he abnormally suggestible and excessively liable to pick up the thoughts of others?

THOUGHT CONTENT

Central Themes. From observations during the history-taking interview, the physician will usually have obtained much information about the main themes or central preoccupations of the patient's thoughts. However, judicious direction of the interview may be necessary in order to uncover central themes which are being avoided or unconsciously concealed. The examiner may be able to quantify somewhat the different values attached by the patient to different subjects by noting how frequently each comes up in the course of conversation. On the other hand, that which is obviously avoided or left unsaid frequently reveals as much about the patient as his overt verbalizations. Because affect is usually directly related to thoughts, central themes of thought should be correlated with the dominant affect.

Abnormalities of Thought Content. Under this heading one should consider such things as fixed ideas, phobias, obsessional ideas, delusions, and unrealistic fantasies. The degree of distortion of thought content and the tenacity with which the patient maintains his distortions should be noted. To what extent does the abnormality of thought content influence the patient's behavior? Are his abnormal thoughts of recent origin or habitual with him? Do they create further anxiety, or is he blandly content in his current situation?

Self-Concept. We consider of the greatest importance the set of thoughts which the patient has about himself, which we may collectively call his self-concept. What does the patient think about himself? Does he exaggerate or minimize his assets and deficiencies? Does his concept of himself and his behavior differ importantly from other persons' views? Does he believe himself to have changed? In what ways is he not his "usual self"? Does his concept of himself match his ideal self? In what ways would he like to change?

Insight. By insight is meant the patient's understanding of his situation, including the main facts of his illness. It includes his concept both of his condition and of his circumstances. Some patients do not know they are ill. Others know they are ill but do not know in what way. Still others know something about how they are ill but accept no responsibility for the illness, which they may blame entirely on other people. The highest forms of insight include understanding of the effect of one's behavior on other people, and also a constructive utilization of what one does know to modify behavior appropriately. Therefore, under this heading, the physician may note the extent to which the patient accepts responsibility for what has happened to him, the extent of his awareness of the effect of his behavior on other people, and the curiosity which he has about his illness and its treatment.

Perceptions

Disorders of perception occur in a wide variety of forms and various degrees of severity. The patient may incorrectly perceive either himself or the external environment. The physician should often inquire first about simple variations in the intensity of perceptions, for example, hyperacusis, myopia, anesthesias, hyperalgesia, etc. Then he should inquire about the more severe disorders of perception. These may range, in approximate order of severity, from misperceptions of other people, through illusions and hallucinations, to states of disorientation and confusion. Intermediate dis-

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orders of perception, such as the hallucinations found in schizophrenic reactions, seem to arise from a combination of motivational influences and the disruptive effects of strong anxiety on mental processes. The more severe disorders of perception, such as confusion and disorientation, are usually noted in the presence of serious interference with cerebral function such as that encountered in toxic states or structural disease of the brain.

Misperceptions

Simple misperceptions of the mildest degree consist of mistaking the role of another person, that is, expecting different behavior from him than he can reasonably be expected to show. These errors are usually based on past experiences, but they are also influenced by strong affects, especially fear. An example would be the patient's expectation that the psychiatrist will always treat him with tenderness and indulgence, just as his mother did when he was a child. To note misperceptions, the psychiatrist should study carefully the patient's comments on different people and his behavior with them. He should notice especially, since he can observe it most easily, the patient's behavior with the psychiatrist.

Illusions or Misidentifications

In the simple misperceptions mentioned above, the patient does not actually misidentify objects and people but only misunderstands their roles. In illusions, an actual misidentification of objects and people occurs. The patient then may mistake the psychiatrist for, say, his brother. The examiner should avoid confusing illusions and delusions. In a delusion, which is a false belief, the patient might think that the psychiatrist was his brother disguised skillfully to look like the psychiatrist.

Hallucinations

Hallucinations are sensory perceptions occurring in the absence of external stimuli. The following aspects of hallucinatory phenomena should be noted:

1. Sensory modality in which they occur.
2. Content of hallucinations, including resemblances of voices or visual appearances to those of persons known to the patient.
3. Circumstances associated with their occurrences or with fluctuations in their intensity.
4. Patient's insight into their occurrence, and his reaction to them. Does he communicate about them freely or does he conceal their occurrence?

Attention

By attention is meant the patient's ability to focus his consciousness on a part of the field of awareness. It may be compared to focusing vision on a part of the visual field. The examiner should consider attention with regard to the following aspects:

1. General direction, that is, toward outside stimuli or toward inner thoughts.
2. Fixation. Can the patient's attention be diverted from its main focus to other stimuli? Is it too easily diverted so that he cannot concentrate? Sometimes we can distinguish active attention, that which the patient directs himself, and passive attention, that which occurs without his interest or willed participation. A combination of inwardly directed and fixed attention is a feature of dissociated states, in which the patient attends largely or only to his own stream of thoughts and responds less or not at all to outside stimuli. He is then said to be "out of contact" with the examiner. This can exist in all degrees and many variations.
3. Clarity of attention. Clarity of attention may become impaired as during toxic interferences with cerebral functioning. This is often referred to as a clouding of consciousness. Clouding of consciousness is not necessarily a feature of dissociated states. Clouding of consciousness can exist in all degrees from slight impairment to states of severe confusion merging into coma.

Orientation

In the more severe disorders of perception, orientation becomes impaired. However, orientation may be preserved when there are other severe disorders, such as hallucinations and dissociated states. Orientation is usually studied under the following headings:

1. Time—knowledge of the hour, day, date, month, season, and year;
2. Person—knowledge of one's identity;

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3. Place—knowledge of one's location, and spatial orientation. Sometimes, we also consider under orientation

4. Situation—knowledge of why one is in a certain place. This includes correctly identifying the people around one and their functions. Defects of orientation for situation are usually delusions. Sometimes the phrase "paranoid disorientation" is used for them. The patient, for example, knows that he is in a hospital ward but insists that it has secretly been changed into a prison and that the doctors are guards.

¶ The Technique of the Psychiatric Examination

The Approach to the Examination

We cannot and should not sharply separate the psychiatric interview and psychiatric examination. The psychiatric examination begins the moment patient and psychiatrist meet. As the patient talks during the history-taking interview, the psychiatrist should attempt to evaluate his emotional state, his intelligence, his thought contents, or any other function of the patient's personality which may reveal itself. As the psychiatrist's skill in mental examination increases, he will find that he can conduct more and more of his examinations during the history-taking interviews, leaving ever smaller portions for some specific inquiries at the end of the interview or for another occasion. Thus the experienced examiner can often guide a history-taking interview so as to carry out a rather complete survey of the patient's mental state. On the other hand, errors can arise from careless reliance upon the history-taking interview as a substitute for a thorough examination, particularly in the hands of the inexperienced. Such deficiencies may occur if the psychiatrist fails to have the interview range over a broad enough area to provide all the data necessary for an adequate and comprehensive evaluation. The psychiatrist should not think that if he just keeps the patient talking, all the important data will simply fall into his ears. A great deal of essential material may be overlooked unless it is specifically sought, either by skillful direction of the interview or by specific and thoughtful questioning. In the course of such inquiry, the examiner may use the data of an earlier part of the same interview or of another interview to guide his questions so that they will be most appropriate and most tactful.

Any change of emphasis in the interview toward more detailed or specific examination should be made as subtly as possible and preferably without the patient's even being aware of such a transition. The examiner who inadvertently makes the patient feel that he is being "tested" or interrogated as a witness may succeed only in confirming the patient's worst expectations about himself and the nature of psychiatric therapy. A clumsy approach may intensify the patient's anxiety so that he becomes unable to cooperate in the examination to any significant degree. Tactfulness in examination, apart from sparing the patient discomfort and additional anxiety, may therefore add considerably to the information actually obtained.

The transition to more detailed examination of the patient can sometimes be made smoothly by an appearance of investigating the patient's complaints more thoroughly. For example, the psychiatrist can say, "You mentioned a few minutes ago that your memory wasn't working as well as it used to. I'd like to ask you a few questions so we can see just how much trouble you've been having." Abnormal thought contents such as delusions can often be studied ostensibly as part of a more detailed review of the patient's history.

However, some topics of examination do not lend themselves to such exploration, and these the examiner will nearly always need to present with a brief explanatory comment. These should also tactfully attribute maximal function to the patient. The following questions illustrate such introductions.

"I suppose you keep pretty good track of time, don't you?" The patient answers, and then the psychiatrist continues, "Would you know what the date is today?"

"Do you read the newspapers and keep up with the current events?" The patient answers

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and the physician continues, "In that case I am sure you'd know who the President is. Can you tell me?"

"You said you went to the eighth grade, I think. Would you mind if I asked you a few questions in arithmetic? They're quite simple."

"You said your memory was pretty good. Do you mind if I see just how good it is?"

"You've told me a good deal about yourself. Now would you mind if I asked you some more specific questions about yourself and how your mind works?"

If the patient makes no objections to the inquiries, the psychiatrist need volunteer no further explanation. If, on the other hand, the patient seriously hesitates, becomes uncooperative, or asks what is going on, he is entitled to a reasonable explanation. The psychiatrist may explain that, as the patient has evidently had some psychological symptoms (reference being made in passing to these), additional information is needed to find out what can be done to help. The examination should never be presented to the patient as a "test" in which what he does may be compared to what someone else does. Such an analogy may evoke memories of failures in school and anxiety-laden thoughts of inferiority, and such feelings may reduce mental functioning further or destroy cooperation. Instead, the examination should be explained to the patient as an effort to compare what he does now with what he once did, and with what he is believed capable of doing when he is at his best. But it is altogether preferable if the examination can be accomplished with sufficient skill so that elaborate explanations are unnecessary.

The Importance of Not Humiliating or Tiring the Patient.

Anyone can be chagrined by noting an inadequacy of function, especially a mental function, in relation to an assumed standard or to one's previous performance. The examiner should remember this especially with patients who are already somewhat aware of a loss of mental function as, for example, those with arteriosclerotic or other brain diseases. In such instances a few questions may quickly bring out some loss of intellectual capacity. The patient may well have managed to compensate partially for these defects by denial; if he is confronted with them through formal testing or insistent interrogation, however, the defensive denial may be torn from him with catastrophic results. Anxiety so aroused may impair function still further, which can lead to further anxiety in a vicious cycle. Inquiries should therefore be pushed only as long as they reveal information needed for the evaluation and eventual well-being of the patient. As always, the emphasis should be upon the welfare of the patient and not upon the completion of a routine medical form. Although the examination must be complete and eventually recorded in an organized fashion, the data derived from a skillfully conducted interview are seldom obtained in the final written form. Indeed, any attempt to adhere rigidly to a specific outline will often impair the initial relationship between examiner and patient to such a degree as to obviate the very purpose of the psychological examination.

The Importance of Nonverbal Behavior

We wish to emphasize also that the words of the patient often form a relatively small portion of all the data used in evaluating the mental state. Observations of other forms of communication, such as posture, gestures, facial expressions, or other signs of emotions and thoughts, can, in many instances, provide even more significant information than the patient's overt verbalizations. The long-suffering hypochondriac's secret twinkle of enjoyment as she describes the effects of her many illnesses upon her family may supply invaluable clues as to the pathogenesis and meaning of her neurosis. The heavy-lidded, lusterless eye of the depressive frequently bespeaks more sorrow than his words could hope to encompass. The skillful examiner, like the good pediatrician, is exceptionally sensitive to that vast sphere of human interaction known as nonverbal communication. As in all forms of communication, however, specific components may be misleading, in that their function is that of defense, denial, or masking. The smiling depressive who is secretly planning the "perfect" suicide may illustrate the latter all too tragically.

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The Importance of Asking the Patient About His Condition

In our zeal to observe the patient, we can sometimes forget that he has the best opportunity of anyone to observe himself. We should try to enlist him as a collaborative observer. Certainly gaps and distortions will occur in his observations, as in ours, but if we omit to ask him directly what he has noticed, how he feels, and what he thinks, we lose some of the most valuable material we can obtain. The following questions may illustrate ways of inviting the patient's opinion of his condition: "What do you think about your condition?" "What would you say about your mood?" "How do you think your mind works now compared to when you were well (or compared to a year ago)?"

Special Points of Technique

Examining Emotions

The previous chapter included a description of the signals whereby one person communicates emotions to another, which we will not repeat here. As mentioned above, the examiner should always invite the patient to describe his emotions directly. Defensive concealment of emotions may cause discrepancies between what the psychiatrist observes in other signs and what the patient himself reports. Sometimes the patient may not understand the psychiatrist's question. To the question, "How are your spirits?" the patient may reply, "Fine," not because he feels well, but because he does not understand what the word "spirits" means in this connection. Questions about emotions and moods may need to be asked in several different ways before the patient understands.

In making inquiries about depth of depression and suicidal intentions, it is well to begin with the thought content of the depressive mood and work gradually upward toward the possible suicidal thoughts. This gives the patient a chance to volunteer whatever he will about suicidal thoughts and may also produce less of a shock when the psychiatrist finally asks direct questions. The frequency and importance of suicide require us to ask questions bearing on it whenever its possibility arises, as it does in most depressed patients and in many others.

We suggest the following group of questions as one series which can move the inquiry toward the subject of suicide:

"How low do you get when you are depressed?"

"What do you think about when you are depressed?"

"Do you ever think that life is not worth living?"

"Do you ever wish you could die?"

"Have you ever thought of killing yourself?"

"What did you think you would do?"

"What would happen after you died?"

"Why does that seem the only solution?"

In evaluating mood and suicidal intentions, the patient's verbal comments in response to the above questions furnish only a part and sometimes a small part of all the relevant data. The patient's speech, his motor attitudes and movements, his appetite and sleep, and his other verbalizations, for example, of hypochondriacal ideas or ideas of hopelessness, all constitute important information for the evaluation of his mood.

Examining Central Processes

Examining Memory. Skillful guidance of the interview will often permit an accurate evaluation of both recent and remote memory. When it does not, more direct inquiries and examinations are indicated. These can begin with a question such as, "Have you had any trouble with your memory?" This gives the patient a chance to furnish further information. The psychiatrist may then continue with, "Do you mind if I ask you some questions to see just how good your memory is?" The patient assenting, specific questions which test the patient's remote and recent memory can be employed. For example, in testing remote memory, the patient may be asked the year of his birth, of his graduation from school, of his marriage, and of the births of his children. The psychiatrist may then wish to refine his examination by inquiring about items less likely to be well remembered, that is, less im-

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portant events in the patient's life, such as the year of a change of job, or events in the nation's history through which the patient has lived.

Recent memory can be tested by questions pointed toward current situations or events just past. For example, the patient may be asked what he did the day before, where he lives, what he ate for breakfast, or who has visited him. If the examiner thinks the patient's memory markedly impaired, he may ask the patient to tell him his (the physician's) name. Assuming they were introduced at the beginning of the interview, this may test the patient's memory over a period of half an hour or more. Additional tests of recent memory can be accomplished by (1) showing the patient some objects, for example, a key, comb, coin, and watch, and asking him half an hour later to say what these were; (2) telling the patient a simple story and asking him to repeat it with all remembered detail; or (3) speaking a series of random digits to the patient and asking him to repeat them forward and backward. A healthy person of average memory should be able to repeat accurately a series of eight to nine digits forward and six to seven digits backward.

Recognition nearly always exceeds recall in disorders of memory. Consequently, in examining memory the physician may first test the patient's recall for a given item and then, if he fails, offer it to him in a series of other items. For example, the physician can first ask a patient who has visited him. If the patient says he thinks someone visited but he cannot remember who, the physician can next inquire: "Was it your wife, sister, brother, aunt, cousin?" With such assistance from the physician, the patient may remember the correct name.

Examining Thought Processes. Much of the data concerning the patient's thought processes will emerge during the history-taking interviews as the psychiatrist observes the patient's behavior and studies his responses to specific questions. Notwithstanding these ample sources of information, the psychiatrist should often ask the patient himself what he thinks about his thought processes. Suitable questions might include the following: "Does your mind work well, or as well now as it ever has?" "Do you have any difficulty in controlling your thoughts?" "Can you concentrate your thoughts now?"

Where doubt remains after the above observations or where diagnosis requires a more refined understanding of thought processes, the psychiatrist should proceed to more detailed testing. Sometimes he can accomplish this with a few simple questions, but sometimes he will need more elaborate tests administered by himself or a clinical psychologist.

The ability to manipulate mathematical symbols may be tested by asking the patient simple arithmetical problems such as: "Do you remember what 12 times 12 is?" or "Would you subtract 8 from 56 for me?" The subtraction of 7 from 100 serially provides an excellent test of calculation. Upon completing this exercise the patient may be asked to divide 7 into 100 with a view to noting whether the result agrees with that of the test of subtraction and, if not, whether the patient notices this discrepancy. This one test measures attention, the speed of thought processes, and the ability to detect errors and correct them. Moreover, when the test is timed, one patient's performance can be compared with that of another and also with his own performance on later occasions.

Sometimes calculations can be tested by asking the patient questions about his personal life which require him to calculate. For example, the psychiatrist may ask the patient naturally enough during the history for the dates of various important events, such as the patient's marriage or birth of his first child. Later in the interview he can ask the patient how old he was at the time of these events. This method has special value because it can be applied without the patient's being aware of any testing, which can hardly be the case when he is asked to subtract 7 from 100 serially. The subtler method can be used first, the more open method later if the first suggests a need for further examination of this mental function.

The psychiatrist will usually have had occasion during the earlier parts of the interview to evaluate the patient's ability for conceptual thinking. He should note whether the patient

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can form and express concepts clearly. When important impairments in concept formation are suspected, this capacity can be examined more definitively by testing the patient's ability to abstract.

Abstraction may be tested by asking the patient to compare and state the differences or similarities between different paired objects. Pairs commonly used are an orange and an apple, a tree and a fly, a dwarf and a child, a man and a dog, a lie and a mistake, a church and a theater. In offering such objects to test abstraction, the psychiatrist must know that the patient knows them. Otherwise he may test only the patient's range of information. The patient may also be given a series of words such as high, cold, dark, near, etc., and asked to supply their opposites or synonyms.

The ability to generalize may be evaluated by asking the patient to give the meaning of well-known proverbs such as: "The proof of the pudding is in the eating" or "A rolling stone gathers no moss." To these proverbs the patient may reply with several different types of abnormal responses. In a correct response the patient should interpret the proverb as a generalization of human experience. A patient with a disorder of thinking may fail to make the transition from the concrete example of the proverb to its general application to human behavior. Sometimes the patient may "explain" the first proverb by another proverb without interpreting the first proverb, or he may become engrossed in thinking about and discussing the images of the proverb. Thus, to the proverb, "A new broom sweeps clean," a patient may reply, "Well, that's right, when you get a new broom it will sweep cleaner." The patient may also see personal references in the proverb. For example, to the proverb, "It never rains but it pours," he may reply, "That's the way it is with me. Every time I go out in the rain it pours." The intelligence of the patient must always be considered in evaluating the response to such proverbs. A person of low intelligence or poor education, however, usually gives no answer at all to the proverb, whereas a patient showing a schizophrenic reaction is more apt to supply a concrete answer, one having personal reference, or one with bizarre associations mixed in.

Examining Thought Content. In studying thought content, the psychiatrist should always prefer indirect methods of exposure. He should aim at having the patient talk freely and in such a way that he will, without being asked directly, tell the physician all of his important thoughts. This technique does not always succeed, or it may not succeed enough. Sometimes the psychiatrist may need to ask some patients about their central and preoccupying thoughts rather directly. He should not hesitate to do so when necessary. He can say, for example, "Can you give me an idea of the main things you think about?" "What do you think about most?" "What sort of thoughts come into your mind?" "Do you have any thoughts which keep coming back to you?" "Do you have any thoughts you can't get rid of?" "Do you have any special daydreams or fantasies?"

Many patients do not understand the word "fantasy" and may even be unfamiliar with the expression "daydream"; therefore the psychiatrist may find it helpful to ask the patient such questions as: "What things do you imagine yourself doing in the future?" "What would you ask for if you could have three wishes granted?" or "Do you often imagine how you would like things to be in the future?"

If the patient has not exposed his thoughts freely in the course of the history-taking interviews, he may not do so any more readily in response to the direct questions suggested above; the latter certainly do not guarantee a frank answer. On the contrary, direct questions may merely intensify defensiveness. When the psychiatrist does ask direct questions, he will have to judge each time to what extent the patient has been able to expose his thoughts.

The detailed examination of irrational ideas and delusions requires simply an extension of the principles already outlined. The psychiatrist must gradually evoke the patient's trust so that he can confide without fear. The psychiatrist must travel the often narrow path between endorsement of the patient's delusions and rejection of them as totally preposterous or "imaginary."

Note should be taken of the ease with which the patient talks about his irrational ideas or delusions. When a patient holds his beliefs critically and still tries to test them, he may

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be unwilling to confide them in a physician. One does not ordinarily communicate an unusual idea to another person unless he either believes strongly in its truth or feels assured of the other person's acceptance of him. Therefore, delusions which carry strong conviction are usually readily revealed. On the other hand, skillful inquiry may be needed to discover maturing but unripe delusions. Material suspected of delusional elaboration must be approached tactfully and with an assumption of the reasonableness of the patient. If a critical, challenging attitude is adopted, the patient may avoid the subject altogether or at least conceal the existence of any idea, such as an incipient delusion, which he thinks the psychiatrist may doubt.

Some psychiatrists avoid all interrogation of psychotic patients about delusions or hallucinations on the ground that such questions can harmfully crystallize ideas which the patient still holds in solution, as it were. We have already advocated an examination in which the patient is guided to deliver the necessary data in a conversational way, with as much avoidance as possible of direct questions. However, sometimes questions are helpful and essential to the clarification of the patient's symptoms. We believe the manner of questioning is much more important than the questions themselves in promoting the patient's delusions or otherwise injuring him. And certainly the psychiatrist should carefully avoid any suggestion of forcing the patient to talk of what he wants to keep to himself.

When the patient does confide delusional material to the psychiatrist, the latter should also ascertain to what extent he has revealed his thoughts to other people. The psychiatrist should know whether the patient considers him a special person and whether he has delusional ideas about the psychiatrist. Failure to note the latter may seriously impair the validity of the entire examination.

Patients often spontaneously verbalize expressions of insight which have little relevance to a sound understanding or little application in their subsequent behavior. Consequently, it is often helpful and necessary to ask direct questions focusing more sharply on insight. However, as with responses to other direct questions, the patient's answers will take their place with other data which may prove more important in evaluating insight. The physician may ask such questions as: "How do you think you became ill?" "What do you think is the matter?" "What brought all this on?" "What do you think are the causes of your illness?"

Examining Perceptions

Examining Illusions and Hallucinations. When inquiring about illusions and hallucinations, the examiner should start with questions about experiences resembling those anyone can have. Because illusions and hallucinations are unusual experiences, the patient may have difficulty in recognizing what he has experienced or in describing it in everyday language. He may need to be offered a variety of questions before he understands what is being asked.

The following examples of introductory questions may prove useful:

"Have you ever had something like a dream when you thought you were awake?"

"Have you ever had anything you might call a vision, or seen an apparition?"

"Have you ever thought you heard people talking when no one was around?"

"Do you ever seem to confuse your thoughts and someone else's thoughts, as if someone might be putting things into your mind or even saying things to you?"

When the patient answers such questions affirmatively, or when his behavior clearly indicates that he is hallucinating at the time of the examination, the psychiatrist should push the inquiry with further questions designed to learn as much as possible about such experiences. He can ask, for example: "What do you see (hear)?" "Who seems to be doing this (saying these things)?" "What's happening?" "Why are they doing this?"

The patient's complaints will usually include depersonalization and estrangement when these have occurred importantly in the illness. However, when he does not volunteer information about these symptoms which the psychiatrist nevertheless suspects from other data, they should be inquired about directly. One may ask, for example: "Have you ever felt as if

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you were not yourself, or as if you had changed so you couldn't recognize yourself?" "Did you ever think that everything around you seemed different or strange or unfamiliar?"

Examining Attention, Concentration, and Clarity of Consciousness. Important defects of concentration will usually appear in the interviews without special testing. However, it may be desirable to test the patient's ability to hold his attention on some task, and this can be done by asking him to subtract 7 serially from 100. If the patient cannot subtract, he may be asked to repeat groups of digits of increasing length. Ability to subtract serial 7's from 100 provides a useful and semiquantitative index for comparing changes in the patient's condition from day to day as a delirium clears or becomes worse. Performance can be timed and notes made of errors, of whether the patient notices his mistakes and tries to correct them, and of any wandering of his attention from the task. If this test is used often, the patient's speed may improve through learning. Varying the test by asking the patient to start at 101 or 102 can reduce whatever distortion this might bring.

Examining Orientation. Much can be learned about the patient's orientation simply by careful attention to his remarks during the interview. If these do not provide adequate data, the physician should always turn toward more direct questions. Orientation may therefore be evaluated in several different ways:

1. Inferences made from listening to the patient's spontaneous references to people, places, and events during the earlier parts of the interview.

2. Questions designed to test orientation, but not asking directly about this. The patient may be asked where he was before coming to the office (or hospital), and whether he had difficulty finding the office. His reply may reveal whether he is oriented for place. Simple inquiries about recent events demonstrate whether he is oriented for time. Other questions may similarly test orientation for situation and person.

3. Direct questions about orientation. The psychiatrist should use these only after he has tried the other approaches, unless the patient seems obviously disoriented; in such cases he may proceed immediately to direct questioning. However, he should not hesitate to use direct questions when any doubt remains after use of the indirect approaches mentioned above.

The psychiatrist should usually begin with inquiries which suggest less extreme disorders and proceed from these to test for complete disorientation. For example, a first level of inquiry might include the following questions:

"Do you keep track of time fairly well?" "Would you know what day (date, month, year) it is?"

"Where do you live?" "How do you get there from here?"

"Why did you come here?"

A second and potentially more shocking level of questions might include the following:

"Do you know where you are now?" "What place is this?"

"Do you know who I am?" "What is your name?"

"What time of day is it now?"

A partially delirious patient may be disoriented without knowing this. Questions such as the above may alarm him by exposing the severity of his condition. This additional anxiety may actually increase his confusion. After such questions, the psychiatrist should therefore always offer some appropriate reassurance. And if the patient is not oriented, the psychiatrist should attempt to furnish orientation to the patient. He should say who he (the psychiatrist) is, where the patient is, briefly why he is where he is, and what he may expect next, together with any other information which he thinks the patient can usefully assimilate in his condition.

◧ Examination of Inaccessible Patients

Many psychiatric patients are inaccessible for effective verbal communication. This occurs when patients are mute (e.g., in catatonia and severe depression), excessively garrulous (e.g.,

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in manic psychoses and some senile psychoses), or excited (e.g., in schizophrenic excitements). The inaccessibility of different patients of this group varies greatly, and varies in the same patient from time to time. Indeed, few patients are totally uncommunicative with words. The psychiatrist should try to discover under what circumstances the patient becomes more communicative with him or with others. Certain persons or certain remarks of the psychiatrist himself may open up the patient's verbal communications. These successful stimuli should be carefully noted in order to utilize them in further developing contact with the patient.

While waiting for the occurrence and use of such stimuli, the psychiatrist may still learn much from observing a patient who does not talk at all or talk usefully. The patient will signal much about himself with the movements of his face and body or with his gestures or other behavior. A sudden grimace, a single glance, or a series of body movements may reveal more than a thousand words. The following are some of the areas to which the examiner should carefully attend.

Facial Expression

Both the habitual expression of the face and changes in expression should be noted. The hangdog faces of the depressive and the fatuous grin of the hebephrenic communicate immediately to the observant. The eyes, especially, deserve attention. The poets have referred to the eyes as "the doorway to the soul." In a more mundane but practical sense, an awareness of ocular expression can be of immense assistance to the astute clinician. Patients whose life experiences have conditioned them to distrust verbal communication, for example, certain schizophrenic patients, may be quite sensitive and adept in this sphere.

Bodily Activity

Posture, gait, and other motor activity may be quite informative. The despairing slouch of the depressive and the proud, defensive posture of the paranoid vividly communicate important attitudes. The patient may employ such communicative signals as grunts, grimaces, or gestures with his hands. Motor expressions of hostility and anger often tell much about the thoughts of a mute patient. A seemingly disinterested catatonic may revealingly clench his fist or shift his position when his defensive isolation is challenged too aggressively. Semiseductive posturing and unconscious gestures may portray attitudes which could not otherwise be communicated.

Response to Stimulation

The patient's responses to environmental changes, verbal greetings, or direct physical stimulation should be noted and recorded. The examiner may also observe the patient's reactions when personal topics relative to his home or family are discussed within his hearing. Will he cooperate with such routine requests as suggestions that he open his eyes or change his position? Does he disregard noxious stimuli such as glaring sunlight or an obviously uncomfortable posture? Does he let his cigarette burn his hand? Many mute and seemingly unresponsive patients with schizophrenic reactions can be brought into activity by throwing them a ball and engaging in direct motor activity with them. Such stimulation apparently causes them to leave their inner world temporarily and enter into contact with others.

Other Behavior

The spontaneous behavior of the patient should be noted especially with respect to his responses to other persons who approach him. When left alone, what does he do? Does he make any effort to communicate his needs? Does he accept cigarettes or food when offered? Is he incontinent? Does he feed himself? Does he preserve some concern for his appearance or neglect this altogether? The psychiatrist might note, for example, whether a mute female patient continues to comb her hair or use some lipstick, because such behavior usually indicates a degree of self-esteem and some continuing interest in others.

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PART TWO

The Psychoneuroses and Allied Conditions

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CHAPTER 11

AN INTRODUCTION TO MINOR MALADJUSTMENTS

Clara Thompson

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THE LITTLE DIFFICULTIES IN LIVING have always existed, but, until the advent of psychoanalysis, they were not considered problems for the psychiatrist. The old-fashioned family physician heard about them and, consciously or unconsciously, reacted to them as though they were connected with the health of his patients; that is, he listened and gave advice, sympathy, or support, as the situation indicated. Or when the difficulties arose from moral conflicts, the clergyman stepped in, listened to the confessions, and pointed out ways to relief from guilt. Today, the old-fashioned family physician has faded from the scene, and religious absolution is not convincing to many unhappy people, who must now seek a psychiatrist's help.

In entering this field, psychiatry has stepped out of the role of a specialty dealing with obvious disease. The people with these difficulties are not patients in the usual sense; they are usually "going concerns," and are generally considered as normal as one could hope to be in this society. The maladjustments fall into four general categories: There are the difficulties of relationships—interpersonal in the narrowest sense. Then there are difficulties in productiveness—work problems, especially related to those who do not have routine patterns to follow, that is, the creative person. There are value problems, such as conflicts over ways of living in an ethical sense. Finally, there are specific difficulties produced by the society in which we live, and these difficulties often add characteristic color to the other three.

Underlying these four general types of difficulty is the character of the person. Psychoanalysis uses the term "character" in the sense of characteristic, habitual patterns of behavior. These have both constructive and defensive aspects and are formed very early in life in response to the characters of the significant people in childhood. They may be altered by later life experiences, but they tend to be blindly repetitive, and the blindness is reinforced by the fact that a pattern of behavior tends to evoke a companion pattern of be-

havior in others. For example, an aggressive, dominating personality tends to form relationships with people with submissive trends, and to repel or antagonize people similar to himself. Thus, he is left with the impression that his way of life works, although he may sometimes wonder why all his friends seem to be the same kind of people.

Habitual patterns of behavior are not necessarily pathological. To the extent that they are constructive and effective ways of coping with life, they are not the concern of the psychiatrist. For example, an effective, receptive character would be a broad-minded person, open to new ideas and easily adaptable. On the other hand, a nonconstructive receptive type would be a person with no convictions of his own, espousing the ideas of his most recent acquaintances, incapable of integrity. Similarly, an aggressive type may simply be a person who knows what he wants and undertakes to bring it about in an effective way, or he may be a person who ruthlessly exploits others and succeeds in being generally hated. In general, the more effective character types are the products of good early life situations. The significant people who were the means of producing the young personality were not destructive or unnecessarily cramping in their attitudes. They loved the child and did not have to compensate for their own difficulties in the relationship to him. When the parents have greater difficulties, the child may be unloved, or there may be ambivalent feelings toward him. This may result in his being spoiled or overprotected, in compensation for the parents' guilt. This can produce a dependent character or one in need of constant attention in order to assure him of his acceptability. If, on the other hand, the rejection is more overt, the child may grow up in a constant atmosphere of derogation and rejection. He can have no positive self-picture, and although he may always be seeking love, he can have no belief in it when he finds it. As a consequence, he often develops a hostile, defensive attitude, especially when threatened with any form of intimacy. Obviously, these are greatly oversimplified examples, but they will serve to illustrate the way in which character is molded by early interpersonal experience.

Everyone has his own characteristic way of coping with life, evolved from his early life experiences. This is not, in itself, pathological. It is, in fact, the way in which we become human beings. Through early contacts, we learn the rules for living which make us acceptable to our fellow man in the particular society in which we must live. Some rules are more inhibiting of potential development than others; in fact, some societies have more destructive patterns than others, and finally, some parents, because of their own personal difficulties, are more destructive than others.

The psychotherapist comes into the picture when the individual's habitual patterns of behavior create for him difficulties in living in his relation to people, to work, to the sense of his own value, and in response to the cultural pattern. The sufferer is usually partially or wholly unaware of his own contributions to his difficulties. It is therefore the psychiatrist's function, through observing what the patient is doing to and with other people, to lead him to insight into his own behavior, which usually includes coming to an understanding of the way in which the personality difficulties were developed in the first place. This insight becomes all the more convincing when the patient's behavior can be observed directly in the "me-you" situation with the therapist.

Here the analyst can observe the way in which the patient's defensive and manipulative attitudes affect other people, and, by pointing this out to the patient instead of reacting to it, the therapist is able to help the patient see the meaning of his behavior. For example, a person may be habitually very ingratiating, seeking to be liked through flattery or trying in other ways to please. The analyst sees this taking place in relation to himself; he does not respond to it, but, instead, points it out to the patient. Another example is the case of a person who is very competitive. For him, the analyst's position of authority in the therapeutic situation is intolerable, and he is driven to belittle the analyst in some way. He may criticize his technique, or remark that the papers he has written are mediocre, or object to his office furnishings, or try in other ways to humiliate him. The good therapist does not react to this, but sees in it evidence of the pa-

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tient's character pattern. When this is pointed out calmly and without anger, the patient may be able to see for the first time one of the ways in which he makes enemies. These two illustrations are examples of ways of relating to people which do not create good relationships and are defensive attitudes—attempting to cope with an underlying feeling of insecurity and anxiety which was fostered by early life experience.

How do such character patterns create difficulties in living—maladjustments, restlessness, and boredom? I shall discuss this under the four categories already stated, namely—relationships to people, relationship to work, relationship to oneself, and the effect of the cultural patterns in these relationships.

Interpersonal Relationships

Problems of intimacy are among the most disturbing interpersonal difficulties. Marriage counseling has become a subspecialty in itself. People who live together on the most intimate terms suffer most from the rough spots in the mate. In the first place, the choice of mate is usually determined by the character pattern. The aggressive person attracts submissive people, the masochist attracts those who will make him suffer, the "sucker" is fascinated by the exploiter, etc. Freud has pointed out that the victims of unhappy marriages usually choose, in their subsequent attempts at finding mates, people with difficulties similar to the first mate, and the marriage tends to come to grief in the same way. This, he called "the repetition compulsion." Our present knowledge of character patterns makes more clear why this is so.

When a man or woman consults a psychiatrist about marriage difficulties, attention must first be paid to how each is contributing to the situation. There is no such thing as an innocent victim of interpersonal difficulties, except in the case of a very young child. The wife—suffering from a domineering husband, who puts endless obstacles in the way of any personal development on her part, unless he controls it—has asked for it in her way, perhaps by an excessive need for guidance and approval. Unless she can gain sufficient confidence in herself to believe in her own goals, not even divorce will solve her problem, for she will immediately look for someone else to run her life—not deliberately, of course, but driven by her own unconscious needs. The basic marital problem is that mutual neurotic dependency is mistaken for love. Fromm has called these "symbiotic relationships." Only mature people, who are capable of caring for and respecting the needs and interests of the partner as much as they are concerned with their own, are capable of the mutual relatedness of adult love. Marital difficulties flourish in symbiotic relationships because the gratification of personal need is more important than concern for the welfare of the other, and the solution lies in analysis of the personal need.

Fromm has described several types of symbiotic relationships which are confused with love (Fromm, *Escape from Freedom*, Chap. V). There is the "magic helper" situation, in which a relatively benevolent exploitation of the one by the other occurs; that is, the one who appears to be more helpless looks to the other for solution of his difficulties. He has nothing to fear so long as the magic helper is near and gives him support. But the magic helper does not give support because he is strong; he is also dependent on his partner's helplessness for a belief in his own powers. He lacks a strong conviction of his own worth. However, this type of neurotic solution often works very well, because each wishes the other well, and the results of the mutual dependency are not destructive.

The type of symbiosis in which most often one or the other partner seeks psychiatric help is that in which cruelty or suffering is a part of the bond, for example, the tyrant who has the martyr wife, the henpecked man with the nagging mate, or the pathologically jealous man or woman who sees disaster if his partner attempts to make other friends. The partner here, incidentally, often finds a secret satisfaction in the jealousy and, wittingly or unwittingly, keeps the jealous one anxious. These cruelty motivated maladjustments are characteristic of one group who often seek the psychiatrist's help. Advice and guidance are sel-

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dom sufficient help in these cases. Only a probing of the character pattern, effective enough actually to change the way of relating to others, can make for any permanent amelioration of the relationship. As I have already said, changing partners seldom solves the problem as long as the basic pattern of relating remains.

Another form of interpersonal difficulty is that of isolation. The inability to make contact may be due to a hostile or even a destructive attitude. The individual feels so threatened by others that he must either drive them away or destroy them altogether. There are also detached people who are not particularly hostile, who live as onlookers to life. They have an impersonal warmth so long as no closeness is involved, but they fear any entanglement of their emotions. They are lonely people, but unable to remedy their state through their own efforts. Again, the solution must come from a radical exploration and alteration of the character pattern.

I have stressed the aspect of intimacy in interpersonal difficulties. Many of these people get along very well in more superficial relationships. In fact, they may be the "life of the party" or "the hail fellow well met" so long as no permanent warmth or friendliness is demanded. However, some have difficulty in even these tenuous contacts and succeed either in making enemies through their arrogance or hostility, or in withdrawing so completely that no one feels the urge to seek them out. None of these interpersonal difficulties is easily resolved, and when people seek help for them, a thorough character analysis by a trained analyst is indicated.

¶ Relationship to Work

Work difficulties are confined to two general types: one is the person who moves frequently from one job to another or fails to make the advances commensurate with his abilities, and another is the person doing independent creative work who has difficulty producing. The man who drifts from job to job is more apt to be brought to a psychiatrist by his family than to seek help spontaneously. His difficulties may be due to almost anything which comes under the heading of psychiatric diagnosis, for example, a psychopathic state or even an ambulatory psychosis, but they may also be due to a character problem. The man may have grandiose ideas of his ability—no job he has is good enough for him, or he is not appreciated and he must keep seeking in an employer for a parent substitute who will admire and favor him.

A more unusual type of problem is that of a young man who seems afraid to grow up. He did excellent difficult work as long as he could think of the job as temporary, for example, work during summer vacations in college days. As soon as he began work which was to be his life career, he became panicky, and before he sought psychiatric help, he was in danger of failing altogether. He had had similar scholastic difficulties. He did very well in college as long as he was browsing around and had not fully made up his mind what he wanted to become. As soon as he made his decision, his marks went down and he flunked a course. Analysis revealed that he had a deep feeling of worthlessness, and that he could not imagine himself as an adult, responsible person. The casual jobs had been a kind of child's play, and it didn't really matter whether he succeeded at them or not. On further treatment it became apparent that his mother had continued to treat him, far into adolescence, as an irresponsible person. She made his major decisions according to her whim, often depriving him of his own spontaneous interests. It was more important to keep his mother from criticizing him than to follow his own tendencies—except when he could avoid her supervision by being the amateur. In fact, when he came for consultations, it was not clear for some time whether his work difficulties were due to his having been pushed into the wrong career or not. In time this doubt was resolved. He liked the work, but he feared taking his own initiative. It was as if he were always expecting his mother's interference—so why try!

A frequent type of problem in the work field, brought to the psychotherapist chiefly by writers and artists, is the complaint that they cannot produce as they feel they should.

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Here an impossible perfectionism is often a factor. They long to be world-shaking, and all their efforts fall short. They cannot bear to expose themselves to the test of reality to evaluate their actual capacities. Another hazard is that they need approval so much that they cannot risk the possibility of not being loved and admired. There is often a need to be inconspicuous, hoping thereby to avoid disapproval. If no one notices you, you can't be criticized, but it is self-defeating because neither can you be admired. These people are tortured by this conflict and sometimes attempt to solve it by following the reasoning: If you turn out work similar to what everyone else is doing, perhaps it will be praised because it is "in style." But here we encounter a new conflict which is related to our third category—namely, how can you follow the current fashion and, at the same time, be true to yourself.

For example, the objective artist today is not in vogue. If he paints according to his convictions, he will be unpopular and will be called old-fashioned. If he is tempted to imitate the current style, he will be untrue to himself and become depressed. This is a very real dilemma, for the person who goes against the market not only suffers isolation but may be endangering his livelihood. These issues are not always clear to the sufferer. He may simply feel depressed and unproductive. The therapist must help him find the cause. All problems are easier to handle when they are within awareness.

I think it is clear from the above discussion that, even in the case of work inhibitions, relationship to others and the search for approval are very big factors in creating the difficulties. Only those with genuine confidence in their own powers can withstand disapproval and remain true to their own selves.

¶ Relationship to Oneself

This question of integrity really belongs to the third division—the conflict of values. Many people consult an analyst because of a feeling that they are not living the kind of lives they want to live. On the surface, they seem to have achieved much, and yet there is a feeling of emptiness and nonfulfillment. They do not have a pathological depression, but they are unhappy. Fromm has pointed out that the marketing orientation of our present culture has much to do with producing an alienation from the self (Fromm, *The Sane Society*). We have become submissive to an anonymous tyranny. We must be what people desire us to be.

We are subjected to the high-pressure campaigning of advertising. We are advised to follow the crowd. "Everyone smokes . . . . . brand of cigarettes," for instance. So, although no harsh dictator threatens us with extinction if we don't conform, subtle and not so subtle influences exhort us to conform. And many succumb to the lure, hoping for acceptance, perhaps even prestige and fame. But the price is the unlived life, the failure to develop potentialities. This illness of the soul brings many people to analysts today. It is clear that one cannot compromise with one's convictions for expediency's sake without suffering feelings of frustration and guilt. The psychotherapist's job here is to help the patient understand the fears of isolation, loss of status, etc., which led him into the compromise, and to help him, through insight, gain sufficient ego strength to live according to his convictions. It is true that realistic problems may stand in the way for many, but most people can gain some degree of freedom to live their own lives if they understand the situation. The above topic will become clearer after a discussion of the role of cultural factors in difficulties in living.

¶ The Effect of Cultural Patterns

Although the types of problems dealt with in this chapter are certainly, in every case, the result of the impact of interpersonal difficulties beginning with the parents, nevertheless, these people show more clearly than do the more gravely disordered the results of conflicts growing out of a specific cultural pattern, because these people are not so disturbed that they withdraw from some degree of acceptable participation in the life of their social group.

For example, a young girl blossoming into

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adolescence was presented with a problem which seemed to change her whole way of life from one of outgoing friendliness and popularity to one of introversion and withdrawal. She had been brought up under the influence of a Protestant sect which taught the necessity of denial of the pleasures of the flesh. In childhood, this had not particularly affected her, because her companions had similar backgrounds. She was perhaps more serious minded than some of her playmates, but she was a good sport and a leader and enjoyed deserved popularity until she reached the age when sex became a factor in relationships. In high school, she encountered, for the first time, another cultural group, but she still continued to be popular with boys and girls until she came to the first high-school dance.

She had been taught that dancing was wicked, and she had never questioned this teaching. She had not been allowed to take dancing lessons, and she had not been fully aware of how this made her different from others until she went to the party. At the dance, her friends came and asked for dances, and suddenly she found that she was all wrong—different. She had to say, "I don't know how to dance," and "My parents don't want me to dance." That evening, she experienced, with horror, the feeling that she was a wallflower, and from that day she could not regain her old self-confidence. It was not so much that her friends proceeded to drop her as that she lost confidence in her ability to interest them, and she withdrew from their advances. It was, of course, not the simple fact that one evening had been ruined; she saw ahead years of similar parties. She was confronted with a whole reconsideration of her beliefs. Before she would be able again to feel that she belonged, she would have to think through her convictions about attitudes she had accepted without question up to that point.

Here we have a subcultural attitude making a person an outcast. Had she continued to associate only with people with standards similar to her parents', she would not have had this problem and might have reached a healthy, untroubled maturity in a limited milieu. The problem of mixed cultural attitudes is especially characteristic of the great melting pot of American life. I am convinced that many who get confused by it are not basically very emotionally disturbed—their problem rather grows out of positive assets. They are seeking growth in new ways of life, but, in the process, they come into conflict with their earlier cultural patterns.

This has been especially dramatically shown in the rapid movement of the last fifty years toward the "emancipation" of women. In the nineteenth century, women were beginning to show open discontent with their position. Nevertheless, they had a position. They had learned from their mothers the duties of woman and wife. The pattern had not yet radically changed. But in the last sixty years, women have moved far from the patterns of their childhood. In the "roaring twenties," sexual freedom, thought of as equality with men, was advocated. But women had not been psychologically prepared for it. It brought many new problems. In the minds of many a girl, the old-fashioned-wife idea continued to exist, side by side, with the right to be sexually promiscuous. In the same way, the right to a career versus the desire to be a wife and mother stirred new turmoil. This conflict was given additional fuel by the fact that homemaking was no longer a full-time job. Much that once was the province of the woman has been taken over by modern invention, in the form of frozen foods, manufactured clothes, and the many gadgets that make housekeeping easy. Often college-educated, woman found herself, after marriage, relatively unemployed and therefore restless. At the same time, for a few years at least, she had the care of her children which kept her from complete freedom in following her interests. Gradually, she is finding a new place for herself in the world, but the world has not yet sufficiently considered her particular problems of motherhood versus other interests, and she has as yet to make a specifically feminine place—that is, one that considers her particular necessities. Freud saw the beginnings of this revolution and called it "penis envy." Perhaps what he did not realize was that it was a necessary step toward a new orientation. All states in transition are anxiety-

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producing until a new solution has been found. Women will undoubtedly continue to struggle for many years in search of the solution. This problem cannot be ignored in its impact on the interpersonal difficulties of marriage. Men have also been affected by this restlessness in women. With the tradition of being the lord of the household, he may well resent finding himself on the way down—as he experiences it. Although specific marital discord can always be understood in terms of the specific people involved, the cultural background of a relationship in process of change lends its color to the conflict. Undoubtedly, out of the transition state will come a new relationship between the sexes which may be better or worse but, at least, will be different from the old pattern. The therapist, in listening to marital problems, cannot honestly pull out of his card index a prescription for the happy marriage, except in terms of encouraging mutual tolerance and exploration of difficulties. So, among the interpersonal difficulties is that of the changing relationship of men and women to each other. Needless to say, when a man and woman, free from neurotic anxiety, seek the solution to this, they do not need a psychiatrist. But, for the person already burdened with personality difficulties, the failure of the culture to "be a good mother" and tell them dogmatically what is right and proper constitutes an extra hazard.

Another hazard of the culture—that our present society has a marketing orientation—has been treated extensively by Fromm, especially in *The Sane Society*. This must often produce a conflict between the "true" convictions of the individual and expediency, in terms of acceptance by others. If one has subscribed to the importance of being successful, being what is expected of him with the hope of winning power, it is very disrupting to personal integrity and even to sanity if the price of this means denial of valued basic principles. An example is the following: A man believing in the rights of Negroes is in a position of authority in a Southern state. He can belligerently espouse the cause of Negroes and probably, thereby, lose whatever status he has. He thinks maybe he should take a middle-of-the-road course—but then he becomes confused. Is he deciding upon this course because it will produce the best results in the long run, or is he influenced by his personal ambition to be accepted and win a more impressive position in the community? A state of conflict between the two ideas develops, so that he no longer is able to decide what is best for the cause of the Negroes, a cause to which he thought he was dedicated. What got in the way was his marketing need for personal success, and his final choice was determined by his personal ambition. But some part of him could not accept his decision, and presently he consulted a psychiatrist because of depression and suicidal thoughts. In stating his problem, he said, "I cannot understand why I am so unhappy. So far I have accomplished everything I set out to do, and it looks as if I would get the next position I am seeking." Because he was a person unusually honest with himself, the cause of his unhappiness soon was made clear to him. The issue here is not whether the more effective course is to be radical or middle of the road, but the fact that the need to be successful personally was obscuring his judgment. This man might have gone on to the end of his days, pursuing his personal ambitions without realizing their marketing character, if he had not come into conflict with the prejudices of his community, which forced him to face his values. I have chosen this case because this man was not so completely involved in a marketing orientation that he could not relatively easily become aware of the cause of his difficulty. In other words, he was not a full-blown marketing personality. In general, his ambition had followed the lines of his sincere convictions, and it was relatively late in his life when the great temptation to sell out to expediency confronted him.

The much more difficult problem is that of the person who has accepted the marketing orientation as his way of life. Inculcation into how to make his personality of sales value may begin very early in life. One is taught how to sell his personality, how to listen to the market, and so forth, until any spontaneous potential not fitting into the market value becomes completely submerged. These are much more diffi-

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cult cases. Although we are not accustomed to thinking of them as sick in a psychiatric sense, they are certainly unhappy and unfulfilled people. They give the impression of being driven without opportunity for relaxation. *What Makes Sammy Run* is one of the finest literary descriptions of this product of our culture. In dealing with this situation, the psychiatrist needs a real orientation in human values as to "what is good for man," as Fromm expresses it. This does not mean that the circumstance of the individual situation should be ignored; rather, it means that it must be seen in its larger cultural setting.

An important thing to remember in considering the people described in this chapter is that the obviously neurotic person suffers from his failure to adapt, but these people I am discussing suffer from the compromises they have made in order to adapt. Both types suffer more basically from the need of approval, that is, from the need of support from without, and it is just as important for the apparent "going concern" to find his orientation based on his own inner strength as for the obvious neurotic to find his orientation based on the same.

As stated earlier, we are dealing in this chapter with the ordinary everyday problems which confront many of us. This, however, doesn't mean that they can be easily solved by a slap on the back, a "Buck up, you're all right," or a piece of practical advice. Analysis of the defensive attitudes and of the individual values is usually indicated. The goal is the emergence of a self-reliant person, free from restricting dependencies. When this is achieved, the problems of intimacy, work, and personal creativeness can be solved. This is called ego-analysis by the psychoanalysts and is not to be accomplished in a few sessions. It has the drawback of requiring considerable time, as do all analytic procedures. However, the results with this type of problem are often very gratifying, and short cuts are no real substitute. Trying to reform from the outside in will never achieve the type of permanent strength needed for the successful mastery of living.

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CHAPTER 12

TRAUMATIC NEUROSES OF WAR

Abram Kardiner

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The neuroses incidental to war alternate between being the urgent topic of the times and being completely and utterly neglected. Although there is no such thing as a specific neurosis of war, those of a similar character that occur in peacetime are swallowed up in oblivion.

These neuroses are important for several reasons. First, they are of great importance as a practical problem of the conservation of human resources in time of war. We learned a great deal about these neuroses after World War I, and World War II showed vast improvement in our ability to manage them. Secondly, these neuroses contain a syndrome which is of the highest importance for psychodynamics, particularly for psychoanalytic dynamics.

In general, there is a vast store of data available on these neuroses, but it is hard to find a province of psychiatry in which there is less discipline than in this one. There is practically no continuity to be found anywhere, and the literature can only be characterized as anarchic. Every author has his own frame of reference—lengthy bibliographies notwithstanding.

In many cases, war neuroses have been named after the occasion during which they occurred, and the symptomatology has remained the guide to pathology and nosology. This practice has led to the fact that there appear to be hundreds of syndromes produced by war. There is a widespread theory that war neuroses can only be a continuation of a preexisting neurosis and that the war situation acts only as a precipitating agent. Although it is true that a war situation can revive preexisting syndromes heretofore dormant, it can also create new ones.

No one exposed to war experience comes away without some of the symptoms of the traumatic syndrome, however temporary these may be. These symptoms are transient and disappear with rest or withdrawal from the danger situation.

The neuroses that develop in wartime can be considered from the following points of view: (1) the wartime environment; (2) the nature of the self-preservative crisis; (3) types

of reaction to this situation; (4) psychodynamics of the traumatic syndrome; (5) treatment of acute and chronic phases; and (6) forensic issues.

The wartime situation is so complex that there is no facet of the human personality that is not put to the severest stress in it. This includes the whole psychophysical apparatus, the capacity to withstand hardship of infinite variety, the ability to be a member of a team, and the ability to have affection for and cooperate with one's fellows. The soldier-to-be has a preinduction panic, and, after he is in, he lives and functions in a social milieu that has little resemblance to the one from which he came. Whatever protections the soldier had as a civilian, where "allowances" could be made for his weaknesses, all these vanish in military service. These are, therefore, the conditions under which any schizoid types are soon likely to collapse. On the other hand, for many schizoids this is the favored environment. They do better than in civilian life, because they enjoy the protection of a great father and need only to be obedient. Some of them break down after they get home. The same paradox is found in connection with neuroses existing at the time of induction. Each person is, in this regard, a law unto himself.

These, however, are not the neuroses created by the stress situation, that is, by the self-preservative crisis due to the danger of destruction. This reaction to impending threat of destruction is the pathological nucleus around which a new style of adaptation can be organized. It is this new organization and the reactions of the subject to it that constitute the syndrome we call the "traumatic neurosis."

¶ Principles of Evaluation

Notwithstanding a voluminous literature, principles to be used in evaluating this syndrome are rarely explicit. Most of the time there is no evidence of any frame of reference—only circumstantial explanations. The fact is that this syndrome is at the very heart of the psychoanalytic conception of neurosis. Freud used the phenomena of this neurosis as the basis for his study of hysteria (*Unfallsneurosen*) and later employed some of the phenomena as a starting point for the revision of his instinct theory.

There are only a few basic ideas about the pathology of this syndrome. The most obvious thing about this pathology is that it should be related to the apparatus that has to do with the accommodation of the organism to the outer world. It should, therefore, have to do with the whole sensorium and to the neurophysical apparatus for mastery. We could, of course, say that this neurosis is concerned with the instinct for self-preservation, but, however useful it may be to isolate a "sexual" instinct from others, it is quite absurd to attempt to isolate an instinct of self-preservation, which consists of many inborn reflex devices and a great many cultivated and learned devices. Its locus is the entire organism. It is therefore quite difficult to isolate a specific instinct involved.

The ideas about pathology can be described as follows:

The Organic Conception

The "trauma" was thought to have given rise to some specific damage to the central nervous system. This notion was held, especially by neurologists, for a long time. There was much difficulty in establishing the actual damage, and, even when demonstrated, the relation between the damage and the symptoms was never established. During World War I the issue was decided in favor of the so-called "functional" point of view.

The Psychoanalytic Interpretation

A symposium,[3] data for which were gathered in 1918, purported to be a survey of war neuroses from the point of view of the libido theory. It contained some important ideas and was a resumption of a discussion, originated by Freud, concerning the origin of neuroses in traumatic events. Freud revised the whole connotation of the concept of trauma and finally settled upon its definition as an influence that initiated an arrest of development. Subsequent traumata revived the return to the point of original arrest of develop-

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ment (fixation) by a process called "regression."

These four authors all employed this basic idea of psychopathology. The arrest of development was naturally at one of the libidinous stages during ontogenesis—oral or anal.

This little symposium contained a short preface by Freud in which he failed to endorse the views of these four authors with any great enthusiasm.

Perhaps he was not satisfied with these explanations, as he was already engaged in a new approach. This appeared in *Beyond the Pleasure Principle* and is known as the "Reitzschutz theory." Here Freud announced a new definition of trauma as a break-through of the defense against stimuli. This break-through set up a great amount of anxiety identifiable in dreams and was an effort on the part of the organism to free itself of this anxiety by abreacting the anxiety piecemeal by constant repetition. In fact, it was in this tendency to repeat that Freud saw a new principle that lay at the bottom of all instinctive phenomena —the repetition compulsion.

This conception of Freud's, that the pathology was caused by a break-through of a protection against stimuli, was a very powerful one, but it did not describe what the protection against stimuli consisted of, how it was built up, or how it was destroyed. The other idea, that the dreams represented abreactive attempts, is really a revision of an old theory of abreaction that he had long since discarded.

Freud's Reitzschutz theory was the starting point of my own reflections on the subject. My own experiences were with the chronic cases. I had, therefore, a good opportunity to observe the effects of this neurosis on the adaptation of the subjects. Moreover, this neurosis furnished the opportunity for the study of neurosis as a form of adaptation rather than as a form of illness.

The study of the pathology began with the study of the particular personality functions involved, how these functions were integrated into systems of action, what the traumatic experience did to these systems, and what the end products of the reaction were. The dominant pathological device used was akin to repression, the purpose of which was to eliminate the painful environment and to diminish the anxiety created by the curtailment of resources. The neurosis consists of the establishment of a new style of adaptation based upon the truncation of resources. Naturally, it induces a parasitic form of existence compatible with these diminished resources.

Rado, in essence, endorses this basic conception of the pathology, but he is concerned more with the systems of control rather than with the systems for action. Basically, this concept does not alter the pathology. Rado believes that the symptoms of the neurosis have a high demonstrative value to elicit pity and support for the patient's now-diminished resources. In addition, the subject protects himself fiercely against the possibility of a repetition of the trauma—traumatophobia.

The really important issue, stressed by Rado but unrecognized by other authors, is that the existence of a pathological syndrome has an effect on the rest of the personality. The patient may be depressed by this, or he may invoke a long series of other reactions to this syndrome.

The most complete account of war experience in World War II is that of Roy Grinker and John Spiegel. There are only two things in it that are different from the preceding accounts of Kardiner and of Rado. Grinker does not explicitly recognize the traumatic syndrome as such, accounting for the pathology in much the same way as does Kardiner, but he includes in the war neuroses a group of reactions that are no different from those that occur in peacetime, that is, conflicts concerning pride, self-esteem, *esprit de corps*, etc. Secondly, Grinker insists on an explanation that takes into account the neurological paths through which the pathological reactions take place. This really adds nothing to explaining the symptoms, and, for the greater part, this discussion is gratuitous.

¶ The Soldier and His Job

The transition from civilian to military life is a difficult one. The individual becomes a member of a social organization that has no resemblance to the one he left. It is now a nonfamilial hierarchy, in which cooperation is obligatory. He has lost his freedom of choice, for all activity is prescribed. He must carry

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responsibility but also must be subordinate. It is therefore not surprising that he lives in a state of resentment. The difficult physiological stress conditions under which he now lives can only add to the subject's irritability and resentfulness. Since all these factors have to do with the matter of morale, in the American forces absolute democracy in the distribution of risk was of the highest importance, whereas it did not matter so much in the German military forces.

All in all, there are, in this social environment, a vast number of new adaptations, new conflicts, and new stresses—particularly physiological ones—that predispose the individual to decompensations, but the greatest of all stresses is the actual danger of destruction—complete or partial. The regulation of peacetime activities according to physiological tolerance is broken down during war. The soldier lives in an atmosphere of continuous fatigue, anxiety, and boredom, deprived of sex and opportunities for complete relaxation. Moreover, his weaknesses are exposed to public gaze, and his failure to be an effective member of a team may inflict a blow to his self-esteem from which he may never recover.

On the other hand, the soldier is protected by his teammates, by his trust in effective leadership, and by the effectiveness of his weapons. In addition, he is protected by the idea of invulnerability. The latter lasts only as long as no one in his team is injured or killed. This breaks it up.

A soldier's morale will be high if he is well fed, effectively led, rested, on good terms with his teammates, confident in his weapons, and on the winning side; his morale will be low if he is underfed, thirsty, and exhausted, has poor relations with his fellows, is without trust in his leaders and confidence in his weapons, is poorly led, and is on the losing side.

¶ The Acute Phase

The syndromes that are described under war neuroses do not appear on the battlefield. All one sees there are tired, exhausted, and frightened men. In the past the tendency was, on the part of novice field psychiatrists, to send all exhausted and tired men to the rear. They discovered, however, that when the ruling was "no going to the rear," nothing disastrous happened. On the contrary, morale improved. This illustrates the point that the field psychiatrist can improve or worsen his subjects' immediate reaction by his own tacit evaluation of the situation as "what he expects" or that it "is serious." Those on field duty found it to be most advantageous to the soldier, and to the army, to recognize the exhaustion and the fear but not to remove the soldier to the rear. An assignment to kitchen duty, still subject to battalion discipline, not only saved face but often saved a soldier. It is preferable not to retire a useful man beyond earshot of guns, and not prematurely to allow him to get the feel of being away from his unit. This is demoralizing and encourages retreat.

The impending signs of a soldier's approach to a breaking point are poor appetite, carelessness, jumpiness, heedless exposure, freezing to the ground, fear of noise from his own artillery, inability to relax, and characteristic inability to sleep because of perpetual nightmares. The symptoms do not form immediately; they take time to consolidate. How they do this depends on the previous personality of the subject. Thus one person began with tremors and went on to develop a tic and then a profound depression. Another exhibited choreiform movements, stammering, amnesia, irritability, and insomnia.

The symptoms are the outcome of conflict in two areas: (1) the relation of the subject to his own resources and (2) his relatedness to the group. When both are disturbed, the external danger becomes greatly exaggerated, and the attitude of surrender is thus encouraged. Naturally, the relatedness to the group is affected much more severely in a defeated force.

¶ The Chronic Phase

It is my conception that the nuclear condition is a pathological syndrome that becomes incorporated into the personality in different ways; hence, its manifestations differ. This traumatic syndrome consists of the following:

1. An altered conception of oneself in rela-

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tion to the outer world. How this comes about is the task of psychodynamics to explain. This is what is commonly known as a fixation on the trauma. The concept of fixation on a trauma is really a misnomer. It is what happens as a consequence of an altered conception of oneself and of the outer world.

2. Typical dream-life. The catastrophic dream is probably the most universal earmark of the traumatic syndrome. These constant dreams of the failure to consummate successful actions are, in fact, the key to the pathology. It was this phenomenon that gave Freud the idea of a new property of instinct, "the repetition compulsion."

3. Irritability and startle pattern. The irritability is primarily accoustic but spreads over to other forms of stimuli.

4. The proclivity to explosive aggressive reaction patterns. These can be carried out in fugue states, with diminished states of awareness if not states of complete unconsciousness.

5. Contraction of general level of functioning, including intellectual ability. This contraction of interest is a common accompaniment of constant struggle with the fear of annihilation. The individual's affectivity begins to suffer, and his interest in the world generally shrinks. Some of these subjects undergo a kind of deterioration that is not dissimilar to that which occurs in schizophrenia. This diminution of interest in the outer world is generally the result of a long and unsuccessful battle to maintain meaningful contact with the world. In fact, the subject suffers from a kind of delusion that the world has become an unbearably hostile place. The diminution of interest and intelligence is due to the continuous shrinkage of the field of effective functioning and the gratifications derived therefrom.

This syndrome is central to the neurotic style of adaptation. It is elaborated with different end products.

Phobic Elaboration

As a general rule, these neuroses are not subject to much symbolic elaboration. It was this feature that gave me the idea (in 1932) that we were dealing here with a kind of bound energy. This was a way of describing energy involved in physiological functioning. It was presumably in contrast to energy that was mobile and hence capable of symbolization. I no longer believe that this differentiation is necessary or valid. The phobic elaboration makes these cases look as if the traumatic syndrome were merely engrafted on a long-standing neurosis. In fact, some of these cases create the impression that they are actively engaged in a two-fronted neurosis—one pertaining to their relations with people, the other with their relations with the outer world.

Defensive Ceremonials and Tics

These are largely constructed like those above, but they have more resemblance to obsessional characteristics. More commonly, these ceremonials are purely protective in intent, although the subject does not know why. Thus one soldier (Ref. 3, p. 109) spontaneously discovered a cure for his insomnia; if he would lie prone in bed with his hands over his head, he could sleep. This subject had been gassed during World War I; he had been taken by surprise and failed to "take cover." His prone posture was a belated "taking cover," under the influence of which he felt sufficiently protected to fall asleep. This still has the obsessional character of a sleep ceremonial, illustrating the point made about the patient living constantly in the environment of the traumatic experience.

¶ Autonomic and Psychosomatic Disorders

Sometimes the presenting symptoms are largely concerned with the autonomic system, including violent oscillations of cardiac rhythm; spasms of smooth muscle and, occasionally, voluntary muscles; tremors; and stammering. Some of these subjects have every symptom of Graves's disease except increased metabolism. Most of them, in whom the presenting phenomena are largely autonomic, have no awareness of anxiety. These were the cases

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that were most commonly called neurocirculatory asthenia.

During World War I, most of the subjects with spasmodic phenomena of the gastrointestinal tract found themselves in the internal-medicine wards and treated for symptoms of ulcer. This was altered in World War II. There is a wide discrepancy between the psychosomatic disorders in the two wars. Some authorities consider this to be evidence that the symptoms of overt anxiety were less well tolerated in World War II and therefore were driven to express themselves psychosomatically. I do not believe this was the case. All psychosomatic disorders went unrecognized in World War I.

¶ Sensory-Motor Disorders

Sensory skin disturbances were very common, with or without wounds. All sense organs were susceptible to complete or intermittent cessation of function. In some instances all sense organs were temporarily obliterated.

Motor disturbances varied from complete hemiplegia or paraplegias to tremors of every conceivable variety. Head tremors were common, as were disturbances of gait. These latter were less common in World War II.

Some of the sensory disturbances were of a kind that told the entire story of the original trauma. Thus one subject complained of numbness, pain, coldness, and sweating from the chest to the toes, together with other symptoms. When asked to close his eyes, he said, "I feel as if I were in cold water." He was on a raft for eight hours when his ship had been torpedoed. This is another illustration of the conclusion that the subject lives in the environment of the traumatic event.

¶ The Epileptic Symptom Complex

There were very few examples of the epileptic symptom complex in World War II, but a considerable number in the earlier war. This is a recurrent paroxysmal syndrome accompanied by syncope and sometimes preceded by an aura. The unconscious state may last minutes and, occasionally, hours. Most of the cases I saw did not have myoclonic twitchings but, during the state of unconsciousness, executed coordinated movements accompanied by great rage, agitation, and cursing. In twilight states and fugue states, the subject acted out either repetitions of actual traumatic experiences or adventitious, destructive, and quite meaningless activities, such as biting furniture or ripping the sheets and bedding apart. In some instances there was a trigger mechanism such as an odor or the sight of something being cut (a slice of bread or bologna), all of which were reminders of actual battle experience. In many instances the fugue state is an actual repetition of a battle scene or of an actual state of unconsciousness cued off by one of the adventitious accompanying circumstances. Thus one veteran lost consciousness only when it rained and he got his feet wet.

¶ The Problem of Psychodynamics

What we are trying to do with psychodynamics is to unravel the sense behind the symptomatology. What kind of adaptation lies concealed behind these varied manifestations? We are not interested in "explanations"; we are interested only in whether this syndrome can teach us anything we have not already learned about adaptive processes. We have been altogether too absorbed by the medical contrast between sickness and health, so that we tended to lose sight of effective or ineffectual modes of adaptation. For the greater part, those syndromes which we call pathological are really ineffectual or miscarried adaptations. We require a theory that can give us information, act as a guide to intelligent therapy, and be consistent with what we have learned from other syndromes.

The moment we talk of adaptation, we are describing a relationship between an organism and an outer milieu—be it natural or human—in which we are observing what takes place in the organism to the end of continuing favorable conditions or avoiding unfavorable ones. How the organism does this is at the center of our concern.

We start with the inborn equipment of the organism and study how this equipment has

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been molded to meet conditions outside itself. The adaptive equipment is therefore an inborn equipment accustomed to a certain range of adaptive maneuvers in an expected environment. When we speak of trauma, we always mean that some feature of the expected environment has been altered, so that the adaptive maneuvers suitable to the expected environment no longer suffice.

This is really nothing new. The expected environment alters its character when the resources of the organism become diminished. This is the state of affairs that takes place in fatigue, in the ordinary act of attention, in slight accidents, and in organic disease (particularly of the central nervous system). The state of fatigue has as its manifestations some of the features of the traumatic neurosis—irritability, explosive rages, and some features of its dream-life. A sudden pain may cause syncope. Minor accidents will show in the dream-life a transient break in the adaptive apparatus. The same is true of organic disease of the central nervous system. Brain tumors can occasionally be diagnosed on the basis of dream-life resembling that of the traumatic neurosis.

In other words, imbalance between the organism and its adaptive resources is often established in states that seem not to be traumatic in their abruptness but nevertheless create either an unexpected environment or a diminution of adaptive resources to meet the expected environment. Both are traumatic. There is, in other words, a balance between the organism and its adaptive equipment to the expected environment. When this is broken, a new adaptation becomes imperative. The trauma is therefore only the provocation. The neurotic process that becomes consolidated on top of this altered situation is what we call the symptoms. The most noteworthy of these is the wish to avoid the traumatic situation, what Rado has termed "traumatophobia." This urgent wish—to escape from the traumatic environment—and the efforts to construct a new expected environment constitute the new adaptive undertaking. Most of the time it fails, because the subject is completely unaware of the devices he has mobilized to ensure his safety and of the fact that these are incompatible with the goal of recreating a new environment. One adaptive device, generally used, ruins the chances of any such successful solution: The subject usually institutes a series of maneuvers that end in shrinking the ego to a degree that any kind of effective reconstruction becomes impossible. The general course is then to accommodate the organism to its shrunken inner resources.

We are accustomed, in the study of the neuroses, to consider orderly retreats to entrenched positions already established during the course of ontogenesis. However the case may be with the sexual instinct, in this neurosis the methods of adaptation discarded during growth are now of no value as adaptive devices. One does see massive regressions to early childhood, incoordination, inability to speak, and, in rare instances, regression practically to birth. But, on the whole, one sees much more of disorganization rather than regression. This raises the question about what becomes disorganized. One could say that the ego becomes disorganized, but this would not mean very much, because a disorganized or fragmented ego is something that we see only in cases of delirium. There is no such thing in these neuroses. The ego, so to speak, remains organized, all too alert, dedicated to a specific job of ensuring the security of the organism and, particularly, of trying to protect it against recollections of the original trauma. This is a most unsuccessful maneuver, because, for the most part, the entire world has been transformed into a traumatic environment. What therefore becomes disorganized is the whole series of action systems that carry out the intentions of the ego. This takes in the cognitive, coordinative, executive (sensory-motor) apparatus and the autonomic system. The protective process is very closely allied to repression. We cannot quite call it by that name, because repression generally involves the keeping out of awareness of ideas, affects, and memories. In this case, more is involved; whole systems of action are subjected to a similar order of treatment. In the ordinary hysterias and obsessional neuroses, some efforts at substitution for the impounded impulses or ideas are possible. In these traumatic syndromes, no such substitution seems possible.

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The operational schema used in the Freudian system is not as applicable to the traumatic neurosis as to the neuroses of peacetime. We cannot isolate any instinct or component instinct that is disturbed, nor can we account for the pathology on the basis of substitutions. The neurotic syndrome cannot be accounted for on the basis of interference with the instinct of self-preservation or ego-instincts. There is no unitary instinct of self-preservation, and ego-instincts have no standing in pathology. Why talk of instincts in a creature whose adaptability depends not on inherited patterns of behavior but on learned and integrated systems of action? These latter are therefore our effective units of action.

The most useful normal prototype of the traumatic syndrome is the phenomenon of fatigue. Here there is no disturbance in the composition of the action systems, but there is a discrepancy between the available resources of the organism and the demands made upon it. In this state of fatigue there are marked diminution in the accuracy of perceptions, irritability, tendency to outbursts of rage, and the wish to have done with the outer world. The recuperative agent is rest and sleep, a controlled and elastic inhibitory process.

In the traumatic syndrome the breakup of the action systems becomes the starting point for a new adaptive pattern. We can try to follow this new pattern from the situation in which the personality is overwhelmed—the traumatic event.

We have learned that no consistent ego or constant action systems can be built up in an environment that remains persistently traumatic. The ego can only accommodate itself to an expected environment within a limited ambit of variation. The traumatic event breaks up this balance between the ego and the environment by overwhelming the coping devices which the ego has at its disposal. The anxiety is overwhelming, and the ego shrinkage can be so complete that death can ensue. The entire adaptive equipment is thus disintegrated.

This has a specific meaning to the organism: it has now begun a contractile maneuver, that is, it parts with those adaptive devices through whose agency it maintained meaningful contact with the world. Shorn of these protections, the world takes on a hostile meaning. Either consciousness is lost, or its character is so altered that the capacity to derive pleasure from the world is sharply curtailed. The organism becomes occupied with a defensive attitude that chokes off the possibility of further pleasurable outside contact. The contractile device used is ego contraction. No one knows how this is accomplished, but we can identify the fact that it has taken place, be it in the form of loss of sense-organ function, paraplegias, hemiplegias, or other manifestations. The organism itself cannot shrink, but it can withdraw those devices through which it maintains contact with the outer world. The action systems are inhibited and tend to lead independent existences. Meanwhile, the organism tries to maintain contact with the outer world with these truncated resources and has a most uncomfortable time of it.

From this point on, fresh attempts at readaptation are undertaken. Depending on factors we cannot yet identify, some of these cases go on to a spontaneous rehabilitation. In others—in fact, in most cases—there ensues a fruitless struggle to recapture the tools of mastery, lost through this miscarried defensive process, ending in a complete acceptance of defeat, only to live marginally, with diminished resources and a low pleasure return.

From the psychodynamic point of view, the active symptomatology is created by the attempt to satisfy the demands of living with an executive apparatus that is either completely impounded or operating with spastic inelasticity. The effects of this impounding operation are that some parts of the action system are not susceptible to any control or inhibition. This is notably true of the autonomic system. This system therefore goes on creating the intraorganismic conditions for action (increased pulse rate, etc.), but, instead of action, there follow irritability, hyperacusis, and preparedness for flight instead of eagerness or curiosity. The self-confidence is gone. The subject cannot conjure up the image of a completed action and can get no satisfaction from his ineffectual efforts.

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The consequences of the impounding operation are disastrous. No substitution is possible, and regression is of no avail in maintaining satisfactory contact with the outer world. Such is the case with regressive reinstatement of oral mastery. Masochism or passivity to the outer world means destruction.

The consequences of the ego contraction are therefore:

1. Changes in effective adaptation to the outer world. The most important manifestation of this is the lack of interest in activity. The incentive is blunted, because the apparatus is defective. Organized channels of action are broken up, and their place is taken by periodic outbursts of disorganized aggression.

2. The endopsychic conception of oneself has been altered; confidence is lost, and retreat instead of enterprise becomes the objective. The world is now a hostile place, and the subject lives in constant dread of being overwhelmed by it.

3. The altered conception of oneself and the outer world is what lies behind the catastrophic dreams. No action can be completed. Instead, the ego is overwhelmed as it once was. Since the implements for keeping the world at bay (mastery) are now impounded, the world is overwhelming the ego. Hence the hostile world and the impoverished self are two facets of the same pathology. The *Weltuntergangsphantasie* of the schizophrenic is an allied phenomenon. The internal structure of the ego is falling apart, but what the subject perceives is the change that is taking place in the outer world. These dreams were the feature of the pathology on which Freud based his *Reitzschutz* theory. This type of dream attracted Freud's attention because it contradicted the wish-fulfillment theory. Whether or not the dream may be a wish-fulfillment, it is the best indicator of the structure of the personality. In fact, these dreams teach us a new principle in psychopathology: We have the tendency to regard dreams from the point of view of motivation. But the motivation is contingent on the resources available to carry it out. In other words, the dream gives information about motivation and of the structure of the personality *at the time.*

This state of affairs cannot lead to a masochistic adaptation, but the diminution of resources may—and most often does—lead to a parasitic existence.

The autonomic phenomena point, as do all the other manifestations of this traumatic syndrome, to the breakup of the systems for carrying out executive ends of action. The latter are inhibited, but the autonomic phenomena continue to lead an independent existence. Needless to say, the autonomic activity is maintained by a constant undercurrent of anxiety and expectation of disaster.

¶ Treatment

The treatment of this syndrome depends on the length of time that it has had to become consolidated and incorporated into the total adaptive pattern. By and large, the prognosis for the efficacy of treatment varies directly with the time factor. When the subject has had an opportunity to consolidate his adaptation on a parasitic basis, it is extremely difficult to break this up and reinstate a more healthy plan. The great issue in the treatment is not to permit the syndrome to become entrenched in the personality.

The Acute Phase

No one has yet discovered the predisposing factors for this neurosis. It is therefore very difficult to distinguish the malignant conditions from the more benign. Generally speaking, those subject to syncopal attacks have the poorest prognosis.

In the acute phase the therapeutic job is to prevent the soldier from capitulating and taking refuge in escape from duty. The fear and exhaustion states must be admitted by the physician, but the subject must be encouraged to believe that he has not reached a breaking point. Permitting the soldier to admit fear is a policy that has paid off well.

The first requirement is to keep the soldier within his combat unit after his first break. Kitchen duty and rest routine are excellent, combined with sedation at night. There should

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be four or five days of this program, followed by a return to active duty.

Only those already too disturbed at the clearing station should be permitted to go to the evacuation hospital. These include individuals with gross tremors, delirious states, agitated terror states, and stuporous states. Acute "homosexual" panic states also belong in this category.

In this stage the most active therapy is indicated. Its objective is merely to prevent consolidation of the retreat process. The most effective implement is to keep alive the relation between the symptoms and the traumatic event. Any other procedure permits the isolation of the symptoms from the traumatic event. These patients literally try to forget the traumatic event. This amnesia is a protective device, but, unfortunately, the repressive process drags with it all action systems. Whether this connection is kept alive by hypnosis or is done in the conscious state is of little import. Naturally, when the subject is too disturbed for direct approach, the use of drugs or hypnosis is indicated. Hypnosis cuts through a great deal of peripheral resistance that is time-consuming. The demonstrative value of hypnosis can also be very high. On the other hand, the conscious approach is more effective because the ego is not narcotized. The choice is really a matter of taste, but by and large, hypnosis saves time.

The Chronic Phase

Cases that are permitted to become chronic, that is, after six months, have a poor prognosis. The reason is that the subject develops a pattern of existence suitable to his reduced resources. The longer this consolidation is permitted to go on, the harder it is to dissolve. New patterns of gratification become organized and are difficult to break up. The chief obstacle in these chronic cases is the complete collapse of self-esteem. These subjects no longer have any pride in themselves or in their accomplishments. Hence, without being criminal, they expect nothing from themselves, and take from society quite ruthlessly and without even a sense of triumph.

The choice of technique must be decided within a narrow ambit: (1) conscious approach, (2) barbiturates, and (3) hypnosis, or all three in turn. Each has its advantages. One cannot expect an integrative job to be done if one narcotizes the instrument of integration. On the other hand, in the conscious state this integrative instrument is not available, being clogged up with defensive maneuvers. This is the dilemma of treatment. A skilled therapist picks his own combination.

A brief summary of two chronic cases will suffice to indicate both problems and methods.

The first concerns an epileptiform case with fugue states of seven years' duration. There was an old epileptiform anlage from early childhood, dormant for twenty-four years. The subject was thirty-three at time of treatment.

At the initial interview, he showed rigidity of bearing and a Parkinsonian expression. His speech was choppy and monosyllabic.

Initial response to inquiries was disturbing to him. He refused to talk about circumstances of his traumatic experience. His complaint was "spells," which turned out to be fugue states with destructive behavior during these states. Regression to "oral mastery" was a conspicuous feature of the fugue states; that is, he chewed up the furniture, and his teeth, worn down to the gum line, were testimony to this regression.

Seven years of spontaneous recuperative efforts landed the subject in a position where he was engaged in a constant battle with an environment he conceived of as hostile. As a result, he was living in an emotional strait jacket.

My initial probings about the traumatic event only led to reinforcement of his defensive efforts. The traumatic experience was completely fragmented, and it was the subject's spontaneous effort to keep these fragments from reuniting into the total traumatic event.

When finally reconstructed, the "event" was as follows: (1918) "We were to take a line of trenches at seven P.M. The order was revoked and dinner was served—carrot soup. The command was given again. It was dark, stormy, searchlights were playing on us, shadows played. I went over the top, heard someone scream, 'Duck.' I got over the first trench. A shell landed. Everyone was running. I was trampled underfoot. I lost consciousness." The shell did not explode. It was a dud.

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It took seven months of distressing labor and enormous suffering on the part of the patient to reunite these events into their proper sequence and ultimately to enable him to envisage the experience in its totality and to tolerate it.

What he was trying to do before was to keep each item of the experience separated from any other, but he reacted to each item as if it were the whole experience. For example, he would react to twilight, shadows, loud unexpected noises, the word "duck," and several other stimuli. He had lost all power of coordination and had to take work that required less and less skill. It would take him hours to do a task that would ordinarily take minutes. This made him lose job after job. He couldn't hold anything in his hands, and he stumbled all the time.

This case gives a most complete inventory of the traumatic syndrome. His dream-life was typical. His vulnerability to slight pain or a scratch was such that it would reduce him to utter helplessness. A slight automobile accident, in which the taxi he was in collided with another vehicle, landed him in a hospital for several days.

Long before there was any theory about the nature of these neuroses, empirical observations demonstrated the value of abreaction. As a matter of fact, it was not abreaction but the reconstruction of the traumatic event and filling in the amnesias. This is a rather late date to talk about the value of abreaction, since its usefulness has been exploded as far as the ordinary neuroses are concerned. Why should it be of value here?

In the light of recent experience we would now say that, as far as these abreactions are concerned, Freud was a bit mistaken. The phenomenon of amnesia is not purely a matter of memory. It is quite true that amnesia for traumatic events may be one of the features of hysteria, but the amnesia is attached to a system of action. It is the latter that one tries to alter in the neuroses. Recovery of memories does not do this by itself. This is why abreaction, as such, does no good at all if the system of action involved is not altered.

In the traumatic neurosis one sees the relation between amnesia and the total pathological picture. The amnesia is merely an *indication that the action systems involved are broken up*. By reuniting all the fragments of the amnestic picture, one is able to re-establish for the subject the conviction that *he did not die* and was not disintegrated by the experience itself but by the fear of annihilation. Just as a parent guides a child through an experience he regards as fearsome, the patient learns to master the anxiety under the protective aegis of the physician.

In the case of our subject, the reconstruction did take place. His fugues ceased, and the nightmares took on a much more attenuated form.

One other feature of this case is worth noting. During the height of his symptoms, he was much troubled by guilt caused by constant dreams of aggressive activities to those whom he "loved" in so far as he could. There are two ways of accounting for this: (1) in the form that it takes in the obsessional neurosis (it is the currency of aggression instead of affect); and (2) that the decomposition of the patterns of action affects relations to human beings as well as to the outer world.

A second case with a similar syndrome concerned a soldier who fell with a wrecked aeroplane. The phenomena of the illness and of the reactions to treatment were quite the same as the previous case. There were marked diminution of effectiveness and syncopal attacks. One feature of the convalescence cast some light on the pathology of the illness.

The active treatment of this case lasted some six months after his syncopal attacks had ceased. His dream-life became more normal and his compensation was reduced. This led to a flare-up of symptoms, but not the same syncopal attacks he had before. He now had a phobic elaboration of the conflict, namely, a fear of insanity.

The subject was recalled for a routine checkup about six months after discharge. He then observed that he had had one "attack" in the interim, but he exclaimed, "This was the worst one I ever had in my life."

The patient realized, after the attack was over, why he had it. It was the seventh anniversary of his fall. The remarkable feature was that in the last "attack" the patient had a hallucinatory reproduction of the actual fall from the plane in which

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all the amnesias were recovered, down to the finest detail. The subject was himself convinced that he would never have another attack. He did not.

Though several cases have been reported as rehabilitated after neuroses of seven years' duration, by and large the prognosis for chronic cases is very poor. Traumatic neurosis is a disease very closely related to schizophrenia, both from the point of view of central psychodynamics and from the ultimate withdrawal from the world which it set in motion. The deteriorations undergone in both conditions have a striking resemblance to each other. In a manner of speaking, the traumatic neurosis is a kind of persecutory delusion. The persecutor is, however, the outer world. The entire syndrome is produced by what now appears to be a prominent device in the establishment of schizophrenia, namely, ego curtailment.

¶ Some Forensic Issues

Because of the common incidence of traumatic neuroses in wartime, this neurosis is not a private disease. It is a public concern, and its treatment and cure must be a public charge. But this disease entity ought not to be considered a compensation neurosis. The subject does not get the neurosis because he wants compensation; he wants compensation because it is the natural tendency of this neurosis to curtail effectiveness, and, therefore, it secondarily encourages parasitic attitudes.

In this connection it is of considerable importance to note that the handling of this particular veteran's problem was far more successful after World War II than after World War I. This was true of treatment of the acute cases on the battlefield, in the base hospitals, and in clearing stations. The knowledge gained in the interval between the two wars paid high dividends in sparing many a soldier from permanent incapacitation. First, soldiers were better screened in World War II, and the indoctrination included education in permissible forms of fear under stress. This made it possible for soldiers to be more overtly afraid without loss of self-esteem. Secondly, the soldier was not permitted to go to advanced stages of breakdown before recognition and opportunity for recuperation. As a consequence, some of the most dramatic types of World War I were greatly diminished in the second war.

Concerning the problem of public responsibility, there is no question whatever that this is a service-connected disability. It would take the most extraordinary circumstances in civilian life to produce this kind of sustained self-preservative crisis. It is safe to say that no soldier with a traumatic syndrome would ever have developed this condition outside of the conditions prevailing in war.

The prime social consideration is the conservation of man power, with particular emphasis on the return of the intact soldier to his original environment. This syndrome is for the greater part (80 per cent) preventable. This can best be done by preventing the chronic forms from consolidating. The chronic forms create a special problem only because an enormous organization is required to take care of them. The acute form is a clearing-station affair.

The rehabilitation of the traumatic cannot be affected by altering his vocation. The inhibition he suffers is general, and the theory that one task would be easier than another is entirely in error. Traumatics should resume their original vocations.

After World War I the issue of compensation was an exceedingly troublesome one. No compensation should be given except during the time of treatment. Once the traumatic becomes entrenched in a parasitic existence, the idea of rehabilitation excites the most violent opposition. One does not effect a cure—or even the disposition to it—by withholding compensation, but, just as a soldier is inducted with the idea that the community expects him to face danger, he can be made to feel the pressure of public opinion with regard to his rehabilitation—which is treated by the patient as a *danger*.

Perhaps the issue of the method of compensation is a bit out of fashion today, but should it ever arise again, the lump-sum method is the most effective. The continuous-maintenance method is a drag on the govern-

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ment and an encouragement to remain ill. The G.I. bill was a happy compromise and created an incentive for rehabilitation that was absent in World War I.

The issue of compensation is one on which neither the soldier nor the government got a fair deal. I have seen many cases in which government money was squandered in maintaining subjects who could be rehabilitated, and I have seen the government abandon totally disabled veterans simply because they could appear in court with their hair neatly combed. They could convince no one of their disability, except the physician who treated them, and even he was helpless before the court of uninformed and misguided opinion.

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CHAPTER 13

NEURASTHENIA AND HYPOCHONDRIASIS

Gerard Chrzanowski

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IN MODERN PSYCHIATRY there has been an increasing awareness of the fact that technical terms are not merely static entities. The nature of particular terms used in verbal operations plays an important part in interprofessional and therapeutic communication. For instance, when Bleuler introduced the name "schizophrenia" to replace "dementia praecox," he did a great deal more than coin a new term. He opened the way to a new era in clinical psychiatry.

These comments seem in order in introducing the topic of a chapter called "Neurasthenia and Hypochondriasis." We are dealing here with time-honored concepts which have a most undynamic quality. From an operational viewpoint, "neurasthenia" and "hypochondriasis" are awkward, antiquated pieces of furniture, not much good for anything. Nevertheless, both terms have gained a powerful foothold in psychiatric terminology. For the time being, they seem to be here to stay; rather than complain unduly or coin new names, we may as well look into the nature and the implications of the old-fashioned terms as they appear in sundry clinical phenomena.

¶ Neurasthenia and Hypochondriasis: A Single Syndrome

As is well known, the term "neurasthenia," in its original meaning, indicates literally a state of nervous weakness. On the other hand, hypochondriasis once was thought to refer to a topographical localization. The notion was that the soft part of the abdomen below the ribs and above the navel was considered to be the seat of hypochondria. Both terms are used today as indicating conflicts in living. There is still some obsessional preoccupation with the sequence of events—whether organic etiology provides the channel for psychological manifestations, or chronic psychological conflict eventually leads to organicity. The chances are that one chain of events does not present the one and only basis for neurosis or psychosis.

When we come to the nosological classification of neurasthenia and hypochondriasis, we

are confronted with a confusing picture. There is not even complete agreement in regard to the definition of the clinical syndrome. It usually is characterized by a wide variety of symptoms. Ordinarily, there are chronic feelings of weakness and fatigue, various aches and pains, as well as strange physical sensations. Insomnia and irritability may occur in conjunction with a feeling of more or less chronic distress in an organ or organic system of the body. Whereas some patients experience vague, general discomfort, others center their attention upon a particular organ. Any part of the body may be affected. However, there is a high percentage of gastrointestinal symptomatology. The clinician, who is compelled to arrive at a psychiatric diagnosis, does not have an easy task when confronted by a multitude of symptomatic manifestations.

When Freud dealt with the syndrome of neurasthenia, he considered the following symptoms to be characteristic: headache, spinal irritation, and dyspepsia with flatulence and constipation. In regard to hypochondriasis he said, "It is the form favored by true Neurasthenics when they fall victim to anxiety neurosis as they often do."

In "An Attempt at Analysis of the Neurotic Constitution," Adolf Meyer stated that the term "neurasthenia" should be reserved for the cases combining the symptoms of great exhaustibility and irritability, depending largely on the mental attitude of lack of repose and of ready recoverability, frequent head pressures, palpitations and uneasiness of the heart, gastric disorders, phosphaturia and oxaluria, and, in men especially, abnormality of sexual responsiveness. He went on to state:

> Frequently associated with other traits of nervousness, we meet with hypochondriasis, usually built on a feeling of ill-health which leads to self-observation and explanations. These are apt to become the center of thought and interest, are elaborated, or the person merely is troubled with vain fears over trifles, consults quack literature, etc. On the whole, the impressions are apt to become dominating.[22]

Since Bleuler's day there has been an increasing awareness of the clinical observation that neurasthenia and hypochondriasis can serve as a mask for severe mental illness.

Furthermore, it has become clear that, as psychiatrists, we are always dealing with people who suffer from unfortunate life experiences with other people. Disease entities are considered to be more or less durable end states of warped interpersonal interactions from childhood onward. However, classifications of mental disorders are essential for communication in treatment and in research.

In the British Classification of Mental Disorders, as printed in Henderson and Gillespie's *Text-Book of Psychiatry*, we still find neurasthenia listed under the Exhaustion States which are grouped under the heading of Neurosis and Psychoneurosis. In the nomenclature of the American Psychiatric Association, there is no specific diagnosis of neurasthenia or hypochondriasis. Instead, there is a category of Asthenic Reactions and one of Hypochondriacal Reaction. It is possible to classify some neurasthenic and hypochondriacal manifestations under Conversion Reactions or under Anxiety Reactions. The latter diagnosis is described as "anxious expectation frequently associated with somatic symptomatology." Furthermore, there is a group of systematized paranoid hypochondriacal states which are classified as Schizophrenic Reactions, Paranoid Type.

In arriving at a particular diagnosis, there has been increasing emphasis on the premorbid personality. Precursors of neurasthenia and hypochondriasis in children are fairly common. Some of the early complaints are occasionally described as "growing pains." Other children are always tired, have frequent aches and pains, but are wide awake when their bedtime approaches. Gastrointestinal symptoms, paresthesias, and hypesthesias are not unusual in some of these children. Another occurrence in childhood is a disturbed sleep pattern. Some of these children may be lethargic, others are compulsive chatterboxes, some seem to be autistic, others chronically cranky, etc. There are numerous variations of these precursors of neurasthenic and hypochondriacal manifestations.

In other words, neurasthenia and hypochon-

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driasis represent complicated life careers in people, and the terminology frequently distorts particular warpings of long standing.

Regardless of how misleading the terms may be, the fact remains that neurasthenic and hypochondriacal manifestations are almost ubiquitous in all types of psychiatric practice. Furthermore, the phenomena associated with these concepts are widely represented in our culture, without being given much psychopathological significance. Feeling excessively tired as well as being deeply concerned about one's health are relatively conjunctive aspects of our social pattern.

Many people feel righteous about being entitled to a reactive state of weariness as a result of labor and exertion. For instance, it is considered quite respectable for a professional person to feel worn out at the end of the day; for the housewife and mother to be exhausted from her many chores; or the businessman, after a day of pressure at the office, to be very tired. On the other hand, we can frequently observe how certain interpersonal aspects can aggravate the fatigue markedly, whereas others can make the person forget how tired he is. I am not talking here about occasional states of overwork, etc. What matters is the recurrent nature of the syndrome—a state of affairs where feeling exhausted forms a more or less consistent pattern. As far as the reaction of the environment is concerned, it ordinarily does not seem to be practical or in good taste to quarrel with people's justification for being tired, regardless of the circumstances. Furthermore, it is to be understood that special allowances are to be made for the person who is afflicted by debility and potential ill health. The victims of neurasthenic and hypochondriacal symptoms can always claim that they wish it were otherwise, but they just can't help feeling the way they do. Obviously, the more absorbed a person is with his mysterious predicament, the less available is he for personal relatedness to others. The "I don't feel myself" preoccupation impoverishes the nature of all other communication and insulates the person from more direct contact with the environment.

Despite this obvious dilemma, the nature of the insulation is such that it still permits a tenuous relatedness to others at a time when more meaningful contact might not be possible. As long as at least one marginally structured channel of communication is preserved, this may suffice to prevent a disintegration of the personality.

Another significant aspect is demonstrated by the fact that almost every practicing psychiatrist has seen patients who seemingly feel tremendous relief when a "real" organic villain is found. The patient who gets X-ray evidence of duodenal ulceration, kidney stones, herniated disk, etc., may be highly pleased. The point is that he has something which he considers to be beyond his personal control. It exonerates him from a peculiar kind of blame by himself or others. Such people often are hounded with the illusion of imaginary ailments. They frequently believe that they can turn symptoms on or off at will if there is no specific organicity involved. Everything is done to conceal from themselves and others long-standing, unhappy life experiences involving the total personality. The compulsion to negate personal misfortunes is so great that some of these patients readily submit to a surgeon's knife, painful treatments, prolonged use of medication, etc., in situations which therapeutically do not demand drastic steps.

Here is a situation illustrative of the point made. I had seen a sensitive and troubled woman patient in her late thirties, who had suffered a transient psychotic episode. Part of this profound upheaval was triggered off by her belated awareness that her husband had much in common with an older sibling of hers whom she despised. On the surface it all started with an attack of acute abdominal distress on her part. She was admitted to a general hospital and kept for ten days' observation. There was some idea of a gall bladder disorder. The findings, however, were inconclusive, and she was told that she had been severely run down. From the time she returned home things went from bad to worse. Finally she accused her husband of having poisoned her food and similar uncharitable acts. The situation deteriorated to the point where he felt compelled to institutionalize her. Her hos-

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pitalization was relatively short. During her illness it was brought home to her that she owed deep gratitude to her husband's kindness and thoughtfulness. It turned out later that she had never faltered in her conviction that the mental hospital had been a punitive act on his part. At a later point, when my patient had made major strides toward recovery, her husband began to ail. He had always been known as a hypochondriacal person, who suffered from headaches, backaches, gastric ulcers, and neuralgias. Suddenly he developed an excruciating back pain which his wife suspected to be psychogenic in nature. Despite her urging, he refused to consult a psychiatrist. After several weeks of acute misery, he had an orthopedic surgeon operate on him for a dislocated nucleus pulposus. The result of the surgical intervention was miraculous. Now the dragon's tooth which had been bothering him for years had been extracted. His relief was so great that he did not even complain about having to maintain prolonged sexual abstinence. My patient was not unduly affected by this restriction. It soon came out that there had been no sexual relations for more than two years prior to the operation. When my patient became fleetingly interested in sex again, her husband's physical symptoms reappeared temporarily.

As the history unfolded in therapy, several aspects in the situation became clearer. In the past my patient had experienced several spells of depression and ill health, which usually coincided with her husband's feeling on top of the world. There were times when my patient had been highly successful, and her devoted husband almost invariably came down with a physical illness. Furthermore, it became clear that my patient's feelings of well being were usually enhanced by feeling needed. This seesaw pattern had been familiar to the patient within the setting of her own family. In their later years, both of her parents had taken turns in feeling down in the dumps. At such times the low-ebb marital partner was taken to a shock therapist by the solicitous spouse. As a matter of fact, there had been a similar interplay between the patient and her oldest brother. She always came to his help when he was physically ill or in a jam. Once he was well again, she felt all worn out. He would, however, always make her feel she had not done enough for him. On the whole, he led a glamorous life and had always been his parents' favorite. Anyhow, certain aspects of the hostile integration between the siblings had found their way into the marriage. We can see, then, a highly intricate and morbid interplay in a family setting, where alternating hypochondriasis and neurasthenia occur. By the time the husband seemingly blew a spinal fuse, a serious crisis had occurred which threatened to break up the old, familiar pattern. The surgical removal of the man's emotionally exaggerated pain served as a *deus ex machina*. An obvious villain for much obscure difficulty in living had been found. Everybody could point to the tangible intervention and the resulting success. One might add sadly that the patient's psychosis had almost been suffered in vain. Nobody talked, however, of mutual suspicions, resentment, power struggles, and humiliations. A cause had been found that could be reactivated if necessary but which was placed outside of psychological boundaries.

So far the terms "neurasthenia" and "hypochondriasis" have been used together. It is not always easy to draw a line of demarcation between these two conditions. However, when we follow the respective roles these two concepts have played in the evolution of psychiatric theory and practice, the situation is somewhat different.

¶ Neurasthenia and Hypochondriasis as Separate Syndromes

There was a time when the theory of irritability and exhaustion of the nervous system was very much in vogue. In England, John Brown (1735–1788) concerned himself with this concept and attracted some followers. The idea was introduced into American psychiatry by George Miller Beard, who coined the term "neurasthenia" or "nervous exhaustion" in 1869. He described it in terms of exhaustion of the nervous cells through deple-

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tion of their stored nutriment. (There were about one hundred symptoms which Beard ascribed to this cause. The underlying principle was similar to the analogy of a battery running down.)

This conceptual model was largely retained when Freud first studied the vicissitudes of neurosis. In 1894 he stated that neurasthenia as described by Beard covered too much territory; he detached anxiety neurosis as a particular syndrome from neurasthenia.[9]

He grouped neurasthenia, anxiety neurosis, and hypochondriasis together as actual neuroses. In his original formulation Freud thought of an automatic, economic process. His approach was essentially neurophysiological in nature. The symptoms in actual neurosis, according to Freud, were not caused by "mental conflicts." He thought of them as simple physical processes having "no signification in the mind." They arose, in Freud's opinion, through direct toxic affects of dammed-up sexual energy.

Freud placed the problems of actual neuroses outside of the reach of psychoanalysis. However, he formulated the concept of a potential link between actual and psychoneurosis. He observed a connection between neurasthenia and conversion hysteria as well as between hypochondriasis and paranoia. On this basis he conceived of the symptom of the actual neurosis as a core of the psychoneurotic symptom in many instances.

The following illustration of this process was offered: Suppose a person has a hysterical headache. Freud speculated that at one time the pain was real, caused by a sexual toxin. This serves as a focal point of irritation around which psychoneurotic symptom-formation takes place.

In 1908 Ferenczi gave a paper on Actual and Psycho-Neurosis.[6] He elaborated on Freud's investigations by referring to actual neurosis as physioneurosis, in contrast to psychoneurosis. According to Ferenczi, Freud's idea was that sexual excitement withheld from orgasm evokes physiological effects. He stated that Freud was pledged to a chemical explanation of actual neurosis. It was regarded by him as a chronic intoxication by sexual substances.

Ferenczi points out that Freud thought that he could deduce the direct cause of certain neuroses from the nature of the neurotic symptom. A mixture of symptoms was considered to be based on "actiological blending." For instance, masturbation and sudden abstinence from masturbation would lead to neurasthenia and anxiety neurosis simultaneously. Furthermore, he recognized mixtures of actual neurosis and psychoneurosis. In such cases, it was taken for granted that only the psychogenic symptoms could yield to analysis, whereas the physiologically determined symptoms would remain unaffected. The only available treatment for the latter group was in the nature of appropriate sexual-hygienic measures.

In regard to hypochondriasis, Freud was greatly dissatisfied with the obscurity of the concept. He complained to Ferenczi about it in a letter dated March 18, 1912. Freud formulated hypochondriasis as a withdrawal of interest and libido from the objects in the outer world. The relatedness of certain hypochondriacal symptoms to schizophrenia was recognized early. Freud thought that hypochondriasis had the same relation to paranoia as anxiety neurosis has to hysteria.

The concepts of neurasthenia and hypochondriasis have remained relatively unchanged in analytic literature. Fenichel[5] gave a lucid description of these syndromes but stuck closely to the economic concept of libido theory. He affirmed that many an actual neurosis required only adequate sexual outlets. It is interesting that he recognized alterations in the muscular attitudes of people with neurasthenia. He appreciated the inability of such people to concentrate, because they are unconsciously preoccupied with defensive activities. He pointed to the impoverished life activities leading to restriction of the personality, etc. There were many other important insights offered by him, including the appearance of apathy against aggressiveness. However, he still considered an improved sexual technique to be an adequate treatment in some of these patients. The fact that a change in sexual pattern indicates a reorientation in the total personality was not mentioned.

As far as hypochondriasis is concerned, Fen-

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ichel saw it primarily as a transitional state between reactions of a hysterical character and those of a delusional, clearly psychotic one.

¶ Economic Theories of Neurosis

It is of interest that Freud did not follow through with his early studies in the actual neuroses. He did not elaborate on the formulations he made in 1894. Accordingly, he never revised his notion that certain neurotic manifestations result primarily from a toxic effect of undischarged libido. Even after Freud recognized the psychological nature of neurosis and anxiety, he left a loophole for his original neurophysiological theory. As a matter of fact, there is no indication that he ever abandoned his original economic formulation.

The conceptual schism between a neurophysiological and an emotional psychological origin of neurotic manifestations has made it hard to work out theoretically and therapeutically meaningful psychiatric formulations. There is a tendency to see symptoms related to the classic triad of neurasthenia, hypochondriasis, and anxiety neurosis as mechanical in nature without the presence of a mental conflict—the sort of situations where some technical readjustment in attitude, performance, or environment will dissipate the symptom. It could be argued that people with such simple managerial problems do not need the help of a psychiatrist. Needless to say, there are some people in this category. Better living conditions, improved social and sexual habits, various modern pills, etc., will go a long way toward making for a happier and healthier future for some. However, these people are not our main concern. The great number of people we encounter in psychiatric and medical practice are not actual neurotics but people with major difficulties in living. It is for this and other reasons that the dualistic standard in psychiatry (which created the monstrous concept of the neuropsychiatrist) is not helpful. The use of the term "neurosis" to denote mechanical malfunctioning as well as distorted life patterns representing restrictions in the over-all growth of the whole living individual is confusing.

Since Freud, the concept of neurasthenia and hypochondriasis has not been subject to intensive study. Bleuler,[2] a contemporary of Freud, did not go along with the literal meaning of the term and rejected the concept of exhaustion of the nervous system. He observed that overexertion and exhaustion seldom lead to neurosis, and in his opinion never to psychosis. (As a matter of fact, people who work very long hours year in and year out—even those who do not get much opportunity for sleep and rest—seem to be the ones who are relatively immune from neurasthenic and hypochondriacal difficulties.) He thought little of the idea that neurasthenia occurred in people with a weakened health conscience (*geschwaechtes Gesundheitsgewissen Kohnstamm*). Instead, he emphasized the occurrence of neurasthenia as a preschizophrenic symptom.

In regard to hypochondriasis, Bleuler realized that it was no disease entity. He found hypochondriacal phenomena in schizophrenia, in certain depressive states, in neurasthenia, in early organic psychosis, and in all forms of psychopathy.

From a historical viewpoint it seems appropriate to include Janet[10] in a discussion of neurasthenia and hypochondriasis. He introduced the term "psychasthenia" in denoting practically all neurotic manifestations which he did not group as those of hysteria. Janet made particular reference to neurasthenia as a long-lasting feeling of fatigue without physical basis. To him, neurasthenia is a state of psychological depression—a general lowering of mental tension.

A glance at some of our present psychiatric textbooks does not add much to the picture. Henderson and Gillespie[14] make reference to a description of the syndrome by Adolf Meyer. In pure form one expects to find complaints of mental and physical fatigue. These are associated with sensations of pressure in the head, poor memory, inability to concentrate, irritability of temper, increased reflexes, poor sleep, and various aches and pains. It is doubtful that many modern psychiatrists would

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diagnose as neurasthenia this combination of symptoms. The authors of the textbook are alluding to sundry etiological theories—heredity, constitution (asthenia), autointoxication, and prolonged emotional disturbances. Hypochondriasis is depicted as indiscriminately distributed among a host of psychiatric disorders. It is said to occur in depressions, particularly in the involutional variety. Furthermore, it can be found in schizophrenic pictures, in hysteria, in chronic anxiety states, in delusional episodes, and in paranoia.

In another textbook, Noyes's *Modern Clinical Psychiatry*,[24] we find the author dissatisfied with the term "neurasthenia." He would like to group some of the clinical syndromes listed as neurasthenia under the definition of anxiety reactions. Noyes considers the cause to be diffuse nervousness and sustained tension resulting from deep-lying personal maladjustment. In his opinion, neurasthenia does not usually lead to structural, visceral changes. He considers hypochondriasis to be an organ neurosis.

Masserman, in *The Practice of Dynamic Psychiatry*,[21] stresses the principle of multiple factors. He speaks of neurasthenia as an exhaustive-regressive state, which he believes to be due to unrecognized, cumulative, internal tensions.

In *Conceptions of Modern Psychiatry*, Harry Stack Sullivan[29] states that, as a student of personality, he finds no virtue in the conception of neurasthenia. From a psychiatric viewpoint, chronic fatigue and preoccupation with fancied disorders which cannot be explained on an organic basis form merely a panoply obscuring the nature of various interpersonal events. Although Sullivan had no patience with the concept of neurasthenia as such, he described certain interpersonal phenomena connected with the syndrome. The manifestations most applicable in this connection would be fatigue, somnolent detachment, and apathy.

One interpersonal formulation of psychogenetic fatigue alludes to an atmosphere of hostile interaction. A state of mutual insecurity may be assumed in which hurt feelings or a motivation by resentment may be prevalent. Unresolved anger which leads to concealed resentment, out of fear of punishment and disapproval, can become a source of "not feeling well," "being tired," "fatigued," etc. (This is somewhat similar to Rado's concept. He connects the fear of illness with the fear of punishment. He sees beneath the hypochondriacal fear repressed rage and hurt pride.)

There is still a somewhat different type of fatigue. This is conceived to be a regressive act in which the more recently evolved patterns of satisfaction-seeking behavior fall apart (like the child who takes to thumb-sucking just before falling asleep at a phase of development when such infantile behavior no longer normally occurs).

As far as the terms "apathy" and "somnolent detachment" are concerned, they stem from efforts to reconstruct events early in childhood. Both phenomena are considered to be protective devices in response to disturbed significant relationships from infancy onward.

Somnolent detachment is thought to be the result of inescapable and prolonged anxiety. It decreases the vulnerability to excessive interpersonal tension. In apathy, all the tensions of needs are markedly attenuated. It is called out by severe frustration when personal needs have become extremely aggravated.

In contrast to his dislike for the concept of neurasthenia, Sullivan was much interested in hypochondriasis. He considered hypochondriacal preoccupations to be an expression of chronically low self-esteem. It represents a field of substitutive activities which channel anxiety and other disjunctive motivations. The intense concern about malfunctions of the body reflects dissociated interpersonal experiences. Much that belongs in Sullivan's conceptual formulation of *not me* is projected into somatic distress signals. There is emphasis on the social isolation which is so often combined with hypochondriasis. Furthermore, it points to the restriction of meaningful, verbal communication. The main topic of conversation with others is the constant interest in their state of ill health. All other interests are subordinated to their thoughts about infirmities. Accordingly, there is a marked curtailment of intimacy and of any hedonical strivings.

We find in Sullivan another observation. He noticed in some people an interweaving

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and alternation of hypochondriasis and paranoia. The idea is that these patients are hypochrondriacal when they are not overtly paranoid and openly paranoid when they do not show hypochondriacal preoccupation.

¶ Concepts of Human Reality

The terms "neurasthenia" and "hypochondriasis" have been discussed separately only because this has been the prevailing practice. From what has been said, it seems obvious that there are many overlapping phenomena. In the literature there is every indication that hypochondriasis is usually seen as the more ominous condition. Clinical observation would support this concept. However, the dynamic nature of neurasthenia and hypochondriasis is such that one may think more of a difference in degree than in kind. The common descriptive denominator is the somatic preoccupation. This concept brings up the question of methods for the study of human reality. We all know of instances where people have been given a clean bill of health and suddenly come down with illness or even died. Illness cannot always be defined as clearly as we might wish, and a definition or demonstration of absolute health or freedom from disease seems impossible. Among other factors, one could single out the strictly personal reality which consists of a multitude of factors (time as a continuum, discontinuous processes, nature of life experience in social, interpersonal terms, etc.).

Another consideration has to do with the much misunderstood concept of psychosomatic disorders, the unfortunate implication being that what is not organic is psychic, and vice versa. Much confusion can be avoided by showing less interest in dividing man into his dual nature. Instead, we appreciate the fact that psyche and soma complement each other. Our psychiatric interest, then, is focused on the transactions, that is, on how the constant interplay of psychical and physical factors affects the personal mode of living of the individual. So we come to think of symptoms never as purely physical or as purely mental, but always as expressive of personal life patterns; these represent the highly personalistic* responses to various and variant experiences in the course of a total human life span. The line of demarcation between the living system and the environment cannot any longer be drawn with precision. Consideration of what is inside a person and what is outside of him is often time-bound. Conceptual notions of entities and essential qualities have given way to more relativistic and transactional models. We have come to think in terms of a continuum, a process with multiple factors (at play) *having an effect* often at the same time.

It has proved helpful to study human personalities on the basis of mutual activities in a field. By stressing the operational aspects, our interest has turned toward how people affect each other and what impact the social and cultural setting has upon them. This has largely taken the place of being preoccupied with intrinsic factors. There has been less need to think in terms of strict causality alone. Today, it does not suffice to diagnose an organic disorder or rule out overt somatic involvement. Even in the predominantly organic disorder there are involved some sociocultural as well as some interpersonal components. The individual and his environment are an interdependent system at all times. Any effort to isolate one or the other produces major artifacts. Every disorder tells something about the person in terms of specific life experiences. It points to potential vulnerabilities or sensitivities in the total life history. The area which is of interest to the psychiatrist is always of a strictly personal nature. It has to do with personalistic, experiential data which can become communicable in increasingly more meaningful terms.

When we encounter neurasthenic and hypochondriacal manifestations in our patients, we have to think largely in terms of symbol processes. They tell something about what the

* "Personalistic" or "psychiatric" is used in terms of a definition by Edward Sapir ("Why Cultural Anthropology Needs The Psychiatrist," in Mullahy[23]). It refers to a transformation of form or meaning which is capable of communication effected by a lone individual to other individuals. This is considered to be in contrast with those aspects of behavior which various people share and which provide data for social science.

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patient thinks of himself and of his personal world in his communal existence. There has been increasing interest in denial of illness[32] and bodily feelings in general.[31] The nature of people's self-image ("I and my body," visual, tactile, auditory modes of perception) is a wide-open field for study. As a conceptual scheme, the notion of a nexus (as used by Whitehead)—a central relay station, where all sorts of things get together—is a fascinating concept.

The clinical study of neurasthenia and hypochondriasis brings another consideration to mind. It is as if the person were attempting to cling to some reality when the world seems in danger of slipping away. There seems to be a focusing on that which is closest as a means of warding off interpersonal tension or losing oneself. Much of the bodily preoccupation has the appearance of a miscarried effort at finding oneself. The more intrapersonal fear is experienced, the less attention will be paid to interpersonal difficulties. Some of the symptoms found in neurasthenia and hypochondriasis can best be understood in terms of the patient's role in his family constellation, in addition to sociocultural and other factors. It is of interest that certain somatic preoccupations are widely fostered in our culture. The interest in weight for reasons of health is highly acceptable. To climb on a bathroom scale twice a day is not an unusual occurrence in the American family. For women, the intense interest in the surface measurements and contours of legs, breasts, waist, etc., is encouraged; the way eyelashes are curled, hairdo's are fussed about—all these are deeply rooted in the culture. For this reason it may be more difficult to detect severe personality disorders in women where there is a camouflage of socially acceptable preoccupations. Some people are aspirin, laxative, patent-medicine, or Christian Science addicts. It may be possible to get by on this basis without showing overt symptoms of hypochondriasis or neurasthenia.

There has been an increasing awareness of the interdependence of environmental factors and personal, adaptational aspects in the continuum of an individual's life space. We have a great number of variables to consider, and the conceptualization of static units closes the door to meaningful new insights.

We have long been aware that fashions are not confined to the outer wrappings of the distaff side, but that neurosis and psychosis, in all their diversity, have something of "a latest look of their own." The modern way of life in the atomic age will undoubtedly produce relatively novel aspects of human aberrations which are not yet in vogue. It is that much more remarkable how durable the phenomena called neurasthenia and hypochondriasis have remained.

¶ Considerations of Social Psychiatry

We still have a great deal to learn about the intricate relationship between culture and symptomatology. However, several pilot studies by social psychologists and allied scientists have thrown light on possible connections between the gestalt of psychopathological phenomena and cultural determinants. Epidemiological investigations have been used to focus attention on the occurrence of certain psychiatric manifestations in various cultural and social settings. Much interest has been shown in the part which the tradition of an ethnical group, sex, age, level of social achievement, etc., play in the particular shape and form of mental illness. With it there has been increasing understanding of the degree to which the definition of mental disorder constitutes a social phenomen.

Opler, in *Culture, Psychiatry and Human Values*,[25] has alluded to how certain ethnological groups tend more toward some symptoms than do others. For instance, he points to the difference in attitude toward illness of Italians and "Yankees."

Then we have the New Haven study by Hollingshead and Redlich, published in *Social Class and Mental Illness*.[15] This study is limited to people under psychiatric treatment and, accordingly, is not a study of the community at large. It stresses the influence of social and cultural conditions on the development of sundry deviations in behavior. Particular interest is shown in the impact of

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different class levels of a given society on the type of disorder which can be observed. In the New Haven study the percentage of patients who tended toward somatizing their complaints was highest among the lowest two classes in the group studied. These two groups consisted mainly of the people whose educational and economic level was at the bottom of the scale. Although the tendency toward somatization is not synonymous with the existence of neurasthenia and hypochondriasis, it seems to be a factor worthy of consideration.

In private psychoanalytic office practice, where patients from middle- and upper-middle-class groups are prevalent, I have encountered a fairly large number of hypochondriacal patients. However, the great majority of these patients suffered from recurrent episodes of preoccupation with their health. There were some patients in whom the symptoms of concern over ill health were more or less constant. These people invariably showed severe pathology and were classed with the tortoise as far as speed of recovery is concerned. Despite grave distortions in the personality, these patients usually did not create an impenetrable wall by means of their somatic complaints. Similar observations were made in supervising the work of some of my colleagues.

The situation was quite different in consultation work in a community clinic located in a low-income borough of Greater New York. There the incidence of somatic preoccupation as a primary complaint was much higher. In several instances it seemed most difficult to get beyond the level of neurasthenic and hypochondriacal preoccupation. Many of these patients had been referred by general practitioners, who prescribed psychiatric treatment. Not infrequently, the patient insisted on side-stepping any interpersonal complications and expected to be magically liberated from physical distress.

¶ Management and Therapy

Earlier in this chapter reference was made to the frequent occurrence of neurasthenia and hypochondriasis in psychiatric and medical practice as well as in the culture in general. In some communities patients with this symptomatology constitute a large number of referrals to the psychiatrist. Others go around and change physicians frequently, or they become more or less permanent fixtures in a doctor's practice. Some of these patients show up in a psychiatrist's office with the challenge, "I have tried everything else, this is my last resort!" The urgent question arises as to what to do with these patients. Should they all be analyzed or tranquilized? Would it be in their best interest to receive mild reassurance by the medical practitioner, or would they do better with expert psychiatric help? Is it helpful to distract them, help them change their environment if possible, stimulate other interests, etc.?

I need not state specifically here that it is not possible to devise one formula for all cases. The management or method of therapy depends on a multitude of factors.

Generally speaking, I have not found tranquilizers given in moderate amounts to be very helpful. Most patients today have tried one kind or another by the time they come to the psychiatrist's attention. It seems that relief is usually not adequate or lasting. There is undeniable merit, however, in having the psychiatrist attempt chemotherapy which does not make the patient unduly drowsy. Great care must be taken not to offer the medication as a miracle pill. I am opposed to all forms of shock treatments in these conditions. In hospital, clinic and private work I have seen no indication of even minor improvement in hypochondriasis and neurasthenia, as a result of various shock methods. On the other hand, I have encountered distinct difficulties in psychiatric and psychoanalytic treatment with patients who had undergone this procedure. Every neurasthenic and hypochondriacal patient requires individual consideration. In a somewhat schematic evaluation, we might distinguish between the following possibilities: Neurasthenia and hypochondriasis may occur in connection with structural visceral changes. Regardless of whether the organic or the psychic malfunction comes first, by the time there is a demonstrable preorganic or organic

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situation, we do not have a primary psychiatric problem at hand.

Occasionally there can be considerable relief, or even cure, as a result of straight medical treatment. In a great many people, however, there is a concomitant disturbance of the personality. This may require attention in its own right.

We may find neurasthenic and hypochondriacal phenomena in conjunction with character disorders, neurotic difficulties, etc. Here we have a different situation. Not all patients have the motivation to change; not all patients have the opportunity to rearrange their lives. There are people who would have to undergo tremendous changes of the personality. Their patterns of relating to others would have to be grossly modified if they were to become less neurasthenic and less hypochondriacal. The decision as to whether the patient is amenable to treatment should be left to highly experienced psychiatrists. Doubtful cases should be worked up carefully, including projective psychological tests, whenever possible. There is grave responsibility involved in arriving at a thoughtful and adequate conclusion.

Some patients can be found to be preschizophrenic; others to be full-blown schizophrenics, some with delusional ideation. The latter group frequently is markedly paranoid, and some offer a poor prognosis. Among the preschizophrenic or schizophrenic patients (without a fixed delusional system), treatment by a highly skilled analyst in office practice may be successful. Occasionally, a patient has to be hospitalized when all communication is broken off as a result of suicidal tendencies, preternatural preoccupations with somatic symptoms, etc.

We may also encounter people with neurasthenic and hypochondriacal complaints who develop the characteristic symptoms after experiencing an acute existential predicament—that is, a state of affairs where professional, marital, or other difficulties have been prominent. Once the crisis is over, these people are apt to suffer from neurasthenic and hypochondriacal symptoms. In other words, it can be observed that pressing reality problems are capable of obscuring the existence of neurasthenia and hypochondriasis. At the end of an emergency situation, we may find a flare-up of difficulties which, at times, had been subclinical until then.

Some people are prone to have a chain reaction of highly unfortunate life experience. Once the external pressures subside and life seems to offer more satisfaction and happiness, that is the time when long-standing personal insecurities come to the fore. As long as there is a powerful distraction by more or less constant, external misfortunes, there is less opportunity for coming in contact with unfortunate aspects of the person's self-image. The low self-esteem inculcated early in childhood was always there, but the patient did not suspect his grave personal vulnerabilities and hypersensitivities until actual living conditions became much more promising.

We have to appreciate that there can be actual, current conflicts largely beyond the individual's control. People cannot be expected to undergo excessive existential stress and strain without showing some aftereffects. It should be kept in mind, however, that many situational factors have to be understood in terms of people's character patterns. The vicissitudes of life which call for change of environment if possible, for less strenuous activity, more rest, and other managerial rearrangements, etc., are not in the realm of psychiatric practice. More often, history tends to repeat itself, and personal difficulties have to be analyzed so that there will not be just a shift of symptoms.

I should like to add here that some people in our culture are bored, find their living conditions dull, and entertain themselves with interesting physical symptoms. To some of these patients the psychiatrist has little or nothing to offer. They often go on and on, without improving or deteriorating much.

In closing, it should be emphasized that the distinction between so-called real and so-called imaginary illness is unfortunate. All symptoms are real, whether or not our methods are adequate in explaining them. We seldom find hypochondriasis and neurasthenia among peo-

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ple who are just plain fakers. Whatever a person feels is based on some perception and some experience. We do not have the right to suggest figments of the mind, precisely because our over-all understanding of the nature of the complaint may be lacking. The assumption that a complaint without demonstrable organic basis is a senseless complaint needs to be dispelled.

In summing up therapeutic considerations, I must repeat once more that neurasthenia and hypochondriasis are indicative of particular warps in the personality. It is doubtful that the formation of either syndrome is connected with any standard set of circumstances responsible for the syndrome's existence. There seem to be variable traumatic events which manifest themselves in more or less circumscribed patterns. As is common with syndromes and symptoms in medicine and in psychiatry, they cannot ordinarily be cured as such. In psychiatry the elucidation of particular, personal life experiences is a highly skillful and time-consuming procedure. When Mr. Jones complains of always feeling tired, and Mrs. Smith of never enjoying good health, we must assume that common-sense approaches have been tried in most instances. Patients should not be expected to waste good money and time just to be told the obvious. It is not advantageous to be told that the trouble is in the head and not in the body. We have to realize that patients frequently cannot hear us when they are highly defensive about the nature of their actual difficulty. Standard clichés of our common language are often sterile channels precluding mutually meaningful understanding. The patient who says "fatigue" and the psychiatrist who hears "neurotic syndrome" obviously are not talking in the same tongue. Any attempt to exchange the word "fatigue" for "neurosis," or vice versa, will do nothing to improve communication. As long as there is no common meeting ground, it does not even matter whether the patient nods his head in approval or shakes it in disbelief.

In discussing therapy, I object strongly to any kind of do-it-yourself manual in psychiatry. At the same time, I recognize the necessity for formulating technical procedure. It seems to me that illustrations are best offered in terms of a particular approach without creating a model for direct imitation.

Suppose Mrs. Smith consults you with the following story: She has been to many medical doctors for pain around her heart, headaches, backaches, and thyroid trouble; she had been treated for gastric ulcers, but she has always feared it might be cancer. Nobody so far had been able to help her. A chiropractor offers her occasional relief, but it is never for very long. Her family physician has prescribed tranquilizers and barbiturates but they do absolutely nothing for her. Another physician had recommended a different medication, which helped only in the very beginning. Finally she had come to see a psychiatrist. She repeats her complaints to him, but the quality of her voice is such that she sounds as if she did not actually expect to be believed. After taking in her recital, with an occasional query here and there, the psychiatrist deliberately changes the focus of the interview. He comments something to the effect, "I hear that you have not been well for some time. Suppose you tell me how it all started." If there is a more-or-less definable starting point, he may go on to inquire what life was like at that time. Was fate smiling, or were there hardships or misfortunes? If all goes well, interest may be stimulated in relating experiences of stress and strain of a familial, social, economic, or other nature. The emphasis is not on a single traumatizing event, but on repeated experiences of unhappiness, friction, disappointment, etc. Then a brief glance is attempted into the past, with such nonthreatening questions as, "How happy a childhood did you have?" If you get a rigidly defensive answer, then, "I suppose there were at least some fleeting moments of unhappiness, as we find in the life of all children?" Should all answers point to a Hollywood Class C movie with a happy ending, it would be appropriate to say so. Anyhow, the attempt is made from all directions to get the patient interested in talking about himself in areas which present potential difficulties in living. You may find that you have gently and

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skillfully helped point to the way in which the patient may eventually find help. Almost invariably, however, such a patient will counter with some sundry version of, "That is all very well and very interesting but how about my various ailments?" Then it seems appropriate to explain that psychiatrists do not know how to cure tangible or intangible physical disorders as such. They do know, however, something about frustrations, tensions, and anxieties. It is often possible to get a new slant on what gets in a person's way. There can be no promise of the disappearance of the physical symptoms, but it has been found that in some instances discomfort has been greatly reduced when certain difficulties in living are better understood. Under no circumstances can we afford to have the patient sit back while the psychiatrist is expected to do his stuff and melt the patient's complaints away. If there is to be any measure of success, the principle of collaboration has to be stressed from the very beginning.

It is most important that we do not offer things to patients which we cannot deliver. The reassurance is much more profound when it is made clear that direct verbal communication may lead to a better understanding of one's life situation, but that one cannot assume that bodily complaints will fall by the wayside as soon as insight is gained. The psychiatric facts are often otherwise, and it is our duty to inform our patients honestly and knowledgeably.

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CHAPTER 14

HYSTERIA

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Conversion hysteria and dissociative reactions display dramatic somatic symptoms and personality disturbances: gross paralytic, spasmodic, and convulsive motor disturbances; exaggeration, diminution, or perversion of sensation; dumbness, deafness, or blindness. Amnesias, fugues, and somnambulisms may attract first attention. Any of these symptoms may occur together, though there are characteristic ensembles; or a symptom may present separately or in alternation with another or others. Such flamboyant symptoms may subside temporarily in response to equally striking modalities of treatment, magical or magico-religious. Historically, the "cure" of such symptoms has been exploited both consciously and unconsciously by the power of the magician, the priest, the king, and the quack, or by this nostrum or that god.

¶ Introduction: A Brief Historical Perspective

The word "hysteria" means "wandering of the uterus" and was used by the Greeks at the time of Pericles, who recognized the relation of the disorder to sexual disturbance. In Plato's *Timaeus* it is stated:

> In men the organ of generation—becoming rebellious and masterful, like an animal disobedient to reason, and maddened with the sting of lust—seeks to gain absolute sway; and the same is the case with the womb of women; the animal within them is desirous of procreating children, and when remaining unfruitful long beyond its proper time, gets discontented and angry, and wandering in every direction through the body, closes up the passages of the breath, and by obstructing respiration, drives them to extremity, causing all varieties of disease.

Hippocrates held a similar view of those priestesses afflicted with the sacred disease who chanted their oracles after convulsing. In many cases the sacred disease was not epilepsy but hysteria. However, Hippocrates, like many a modern physician, found it difficult to distinguish convulsive hysteria from idiopathic epilepsy.

During the Middle Ages the naturalistic viewpoint of the ancient Greeks was rejected. In the medieval witch trials, for example, the stigmata of hysteria were relied upon as a

method of ascertaining possession by the devil. In Europe, this belief in the demoniacal origin of hysteria dominated such a large proportion of the population that it became, clinically, an epidemic of delusion—and led to an outbreak of persecution. Only in recent times, since mass communication media have created the possibility of rapid, wide diffusion of popular delusions, has society witnessed parallel epidemics and results.

With the resurgence of an age of reason, the more educated and influential rejected these medieval notions. In the eighteenth and nineteenth centuries, though the womb theory of Hippocrates could no longer be maintained in its crude form, many observers continued to find a connection between hysteria and the sexual emotions. According to Ellis,[14] Villermay asserted in 1816 that the most frequent causes of hysteria are deprivation of the pleasures of love, griefs connected with this passion, and disorders of menstruation.

The development of the sciences of anatomy and physiology in the nineteenth century created a tendency in medical circles to interpret all mental phenomena in terms of diseased structure of the brain. The main current of opinion agreed with Briquet,[8] who denied any connection between hysteria and sexuality. In short, after 2,000 years of discussion, hysteria came to be regarded as an organic disease rather than as primarily a mental ailment, and the role of sexual disorder in its pathogenesis was minimized. However, this narrow conception of the disease was soon challenged by the work of Jean Martin Charcot. The traumatic power of emotional disturbance in provoking the manifestations of the disease, and elimination of the manifestations through suggestion under hypnosis were clearly demonstrated by Charcot's work. Thus the ground was laid for renewed investigation of the psyche of the patient suffering from hysteria.

Pierre Janet, a pupil of Charcot, proceeded to investigate the psychological aspects of hysteria with great care. As a pertinent example of his case studies,[32] an abridgement of the report he gives of his patient Irene may be selected.

This girl nursed her mother during terminal illness, at which time she toiled away also at a sewing machine in order to earn a livelihood. The mother died, and Irene attempted to revive the corpse. The body slipped to the floor and she desperately attempted to drag it back into the bed. Shortly after these events, Irene commenced to have somnambulistic attacks. Janet writes of these attacks:

> The young girl has the singular habit of acting again all the events that took place at her mother's death, without forgetting the least detail. Sometimes she only speaks, relating all that happened with great volubility, putting questions and answers in turn, or asking questions only, and seeming to listen to the answers; sometimes she only sees the sight, looking with frightened face and staring at the various scenes, and acting accordingly. At other times she combines hallucinations, words and acts and seems to play a singular drama. [Janet writes of his patient between such attacks]: We shall soon notice that even in these periods she is different from what she was before. Her relatives who had conveyed her to the hospital stated: "She has grown callous and insensible, she has soon forgotten her mother's death, and does not remember her attacks." That remark seems amazing; it is, however, true that this young girl is unable to tell us what brought about her illness, for the good reason that she has quite forgotten the dramatic events that took place three months ago.[32]

Janet concluded from cases of this kind that one series of ideas had become isolated from consciousness generally, in a process of dissociation. Thus, in the case of Irene in the periods between attacks, she knew nothing of what had happened at the time immediately prior to her mother's death. There was a gap between the idea of her mother's death (and associated ideas) and the larger system of ideas she evinced in the intervening periods.

Janet concluded that hysteria may be defined as "a malady of the personal synthesis." He emphasized the factors of retraction and of dissociation of consciousness evident in the disease. These he thought to be due essentially to a "preliminary ailing tendency." In postulating this inherited ailing tendency, he followed the view of his master, Charcot, who

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had insisted upon the hereditary predisposition of the nervous system of sufferers from conversion hysteria, both convulsive and nonconvulsive forms, and forms of the disease now designated as dissociative reactions. Janet, however, connected this inherited predisposition with an inadequacy of mental tension to hold together under conditions of stress (toxic, exhaustive, or psychological) partial systems of thought which thus separated from the main body of consciousness.

In 1893 Josef Breuer and Sigmund Freud published an account of their experiences concerning a new method of investigation and treatment of hysterical phenomena. This preliminary communication, entitled "The Psychic Mechanism of Hysterical Phenomena," was followed by a series of case histories and theoretical explanations constituting the *Studies in Hysteria* published originally in 1895.[1] These studies presented the evidence for their view that disturbance of sexuality, as a source of psychic traumas and as a motive of defense in the repression of ideas from consciousness, was of outstanding importance in the pathogenesis of hysteria.

Breuer and Freud, in 1893, found that individual hysterical symptoms subsided when, in hypnotherapy, they had succeeded in thoroughly awakening the memories of the causal process with its accompanying affect, and the patient circumstantially discussed the emotionally exciting situations in the most detailed manner and gave verbal expression to the affect. It was necessary that the original emotionally exciting memories be reproduced as vividly as possible, so as to bring them back into the *statum nascendi*, and then they could be thoroughly "talked out." Recollections without affects were of little therapeutic value. In other words, they found that "the hysteric suffers mostly from reminiscences." Very often these were found to be experiences dating back to childhood—experiences that had established the soil out of which further emotional excitation in later years could yield more or less intensive morbid phenomena.

It is apparent that, in their joint work on the problem of hysteria, Breuer and Freud were opening up a path to the crepuscular light of psychoanalysis, a path that Freud later energetically took alone. They had found that their method of treatment worked through abrogating the pathogenic efficacy of the original nonabreacted ideas by affording an outlet for their strangulated affects through speech and bringing them to "associative correction by drawing them into normal consciousness."

¶ Clinical Manifestations

Hysteria is manifest in many different forms, some of which are readily confused with the patterns of organic disease. Because of its inner nature, hysteria is a great imitator; in order to avoid confusion between it and organic disease, it is necessary not only to comprehend its characteristics but also to be familiar with the patterns of organic disease. The protean forms assumed by hysterical disease have given rise to a carnival of literary expansiveness, whereas the problems of diagnosis have been largely neglected. For this reason, only the more common and some of the more dramatic forms that it assumes are dealt with briefly here; the more important topics of psychopathology and diagnosis will occupy our attention later. In any case, the possible symptoms are so numerous that it would be impossible to discuss them all without making the text encyclopedic. It often happens that the disease is not seen in pure culture; though predominantly hysterical, an illness may contemporaneously present features of other neuroses, of psychosis, or of organic disease. This serves only to increase the need for accurate diagnosis. Typically, the clinical features are:

1. A group of physical symptoms without an ascertainable structural lesion.
2. Complacency in the presence of gross objective disability (*la belle indifférence* of Janet).
3. Episodic disturbances in the stream of consciousness when an ego-alien homogeneous constellation of ideas and emotions occupies the field of consciousness. This may exclude the normative stream of consciousness in the individual so affected.

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It is characteristic of hysteria that, whatever the result of dissociation, be it a localized muscular paralysis or an alternate personality, the operative mental function is a homogeneous whole—affect and idcation are not utterly incongruous, and there is no primary thought disorder, as in schizophrenia. In hysteria the splitting of the personality is molar—not, as in schizophrenia, molecular. Some cases evince a transition from hysterical disorder to schizophrenia, and in transitional phases it may be difficult to predict the movement, whether in a reaching back to reality accompanied by a consolidation of hysterical symptoms[3] or in a deepening withdrawal accompanied by molecular disintegration. The direction of change often depends largely upon management and psychotherapy.

This diagnostic problem of the differentiation of hysteria from organic disease on the one hand and from schizophrenia on the other will be apparent as a crucial concern, to which we will return later. With this general orientation as a background, specific symptoms are discussed below.

Amnesia and Multiple Personality

The simplest form of dissociation is shown in the absence of recall of a circumscribed series of events in the patient's life, events which later investigation reveals as associated with strong emotion. In some cases the amnesia includes the total existence of the patient up to a recent point of time. Amnesia is sometimes the sequel of a fugue (that is, a restriction of the field of consciousness which becomes dominated by a homogeneous series of ideas and emotions hitherto excluded from awareness). At this time a patient may leave his usual abode and way of life for a journey which has no immediate connection with his former activity. The patient later typically evinces a complete amnesia for this episode. Under the stress of military conditions, such cases occur not infrequently; here is one example:

A soldier was found wandering at a seaside resort by the military police and was unable to give a satisfactory account of himself. Psychiatric investigation revealed that one day he had suddenly left his unit and boarded a train, presumably for his home in another part of the country. However, he changed trains at a junction and made for the seaside resort. This resort had many pleasant associations for him. He had spent his honeymoon there, and he and his wife were in the habit of going there for their annual holiday. In the Army he had become preoccupied with the impulse to leave, to the exclusion of all other considerations. His activity in making for the resort could only be made meaningful to him as an attempt to recapture the palmiest of palmy days of peace and security. Before the psychiatric intervention, he could give no adequate account of himself to the police, for he could not recall how he had got into the situation with them.

This example demonstrates the usual findings in dissociative reactions limited to a hysterical level. The reaction is not aimless, as the wandering might at first appear, but purposive. Moreover, the present is exchanged for the past and is met as though indeed it were the past. The patient sought to return to a time and place when—and where—gratification was maximal, and to escape from the frustrational current situation in his life. Janet's somnambulic Irene, discussed in the previous section, combined hallucinations, words, and acts in a dramatic reliving of the traumatic situation which precipitated her illness. This demonstrates also the exchange of the present for a remembered situation, in this case in an effort to master it. When these somnambulic episodes are not spontaneous, they can be evoked in hypnotherapy for the purpose of helping the patient to abreact the strangulated affects and to bring the memories to associative correction by drawing them into the normative stream of consciousness.

A more complex and extravagant clinical manifestation of severe dissociation than that exhibited in fugue state with amnesia is multiple alternating personality. Stevenson's *Dr. Jekyll and Mr. Hyde* is the literary fictional model of this type of severe dissociation. The rare actual cases, when reported, often achieve a fame comparable to that of the novel. William James, in his *Principles of Psychology*,

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has given an account of double personality which has become famous.

The Reverend Ansell Bourne disappeared from a town in Rhode Island. Two months later a man calling himself A. J. Brown woke up in a fright asking where he was. This was in Pennsylvania, where six weeks earlier he had rented a confectionery shop. A. J. Brown the confectioner then started to claim that his name was Bourne, that he was a clergyman, and that he knew nothing of the shop or Brown. Subsequently, he was identified as the Reverend Ansell Bourne by his relatives. He remained unable to explain this episode in his life which seemed to him uncanny.

Morton Prince, who introduced into medical literature the concept of multiple alternating personality, investigated such a case in the person of Miss Beauchamp.[38] This lady exhibited at various times three separate fragmentary personalities. A self-righteous moralistic and masochistic personality was usually dominant but alternated with a strongly ambitious, aggressive, distinctive character, creating a perplexing cleavage in the life and personality of Miss Beauchamp. In working with this patient, Prince used hypnotherapy. Under hypnosis, a third personality fragment, calling herself "Sally," came to occupy the field of consciousness. Sally was aware of the saintly personality, though the saintly Miss Beauchamp was unaware of Sally, the impish child. Prince, over a period of six years' work, was able to achieve an integration in the character of Miss Beauchamp.

A recent example, presenting the problem of a housewife reminiscent of Prince's Miss Beauchamp, is provided by the study of Thigpen and Cleckley.[50] Masserman[41] has also recently reported a case of alternating personality.

Convulsive Hysteria

Charcot categorized hysteria into two types —convulsive and nonconvulsive.[9] This is an indication of the high incidence of hysterical convulsions in the patients who came to his notice in Paris in the last decades of the nineteenth century. Briquet,[8] in his statistics, showed that nearly three quarters of his patients suffered convulsive attacks. Nowadays, in Western Europe and the United States, convulsive attacks are relatively infrequent manifestations of hysteria. Convulsive attacks were found by the present writer, from 1942 to 1945, to be a frequent manifestation of conversion hysteria in Indian soldiers, in contrast to their occasional incidence as a manifestation of hysteria in British soldiers during the same time.[1] Janet traced the connection between convulsive attacks and somnambulisms, showing that convulsive attacks were merely degraded forms of somnambulism where the outer expression of the somnambulic idea in physiognomy, attitude, and act was no longer clear. He showed, too, in his case studies that hysterical convulsive attacks have the same "moral causes" as somnambulisms or other expressions of hysteria, and that these hysterical accidents, like others, "begin on the occasion of particularly affecting events, genital perturbations, sorrows, fears, etc."

Convulsive hysteria may simulate idiopathic or symptomatic epilepsy. Sometimes, hysteria may be suspected on the following grounds: during the attack, the patient is not completely unconscious; the attack occurs only in the presence of onlookers; the patient does not fall in a dangerous situation; the corneal, pupillary, and deep reflexes are present; the patient does not bite his tongue nor micturate; he becomes red in the face rather than blue or white; attempts to open the eyes are resisted; pressure on the supraorbital notch causes withdrawal of the head. However, it must be stated that hysteria is manifest in so many forms, some of which so closely imitate organic disease of the nervous and other systems, that, without the distinctive marks of its etiology and psychopathology (see later), symptomatology alone can be misleading. Where epilepsy is associated with the development of abnormal rhythms in the cerebral cortex, the electroencephalograph can be helpful in making a differentiation.

It is often clear, on investigation, that the hysterical fit partly represents a rage reaction or temper tantrum due to frustration or fear of genital sexual wishes. Often, too, one can

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find evidence of erotic discharge in the form that the attack takes (*attitudes passionelles*, ecstatic poses, etc.). The case of a young woman of nineteen years who suffered frequent "fits" provides an illustration:

The fits occurred about 6:30 P.M. every evening when she was listening to the radio. The attacks had commenced following the dissolution of a love affair. The young man, it was ascertained, had formerly appeared at her house regularly at this time and had listened in with her. The fit was preceded by painful sensations in the right side of her body. Here she had formerly experienced pleasurable sensation, for her boy friend had sat closely at her side. In conversation, this patient at first expressed the view that she did not care at all about her friend's defection. This defense against her affective disturbance had proved adequate during the day when she was at work. Returning home in the evening, she was assailed by her memories of the young man, and the convulsive attack provided the outlet she required for her outraged feelings.

Kretschmer[37] points out that in living beings the "tantrum violent-motor-reaction" is a typical reaction to situations which menace or impede the course of life. He sees its purpose as enabling the organism to make a rapid selection of that motion, among the many at its disposal, which will meet the situation. Should one of the many irregular motions by chance separate the animal from the zone of danger, this single motion will be continued, with a speedy resumption of quietness. Being an instinctive reaction which expires quite schematically, it may either aimlessly disappear or become directly harmful. In the course of evolution, the violent-motor-reaction as a biological defense reaction retires more and more into the background. More recent and more expedient formations cover the older reaction type. In adult human beings, selective voluntary action is the chief reaction type to new situations. In panic, shocking experiences momentarily paralyze the higher psychic functions, and, being a phylogenetically older adaptive mechanism, the violent-motor-reaction comes once more into activity by stepping automatically into their place. In an earthquake or other catastrophe, a crowd will display "headless" hyperkinesias—screaming, trembling, convulsions, twitchings, running this way and that. If among the many motions initiated there is one which by chance takes the person away from the sphere of tumbling houses or the zone of danger, quiet ensues; the violent-motor-reaction has attained its regulative aim. In children's response to painful stimuli, the violent-motor-reaction—pushing, screaming, sprawling, striking—is often evident instead of the deliberative speech and deportment of adults.

Between these two groups, panic and childish behavior, are inserted the hysterical hyperkinesias—the twilightlike running away, the tremors, and the convulsive paroxysms. The hysterical attack, Kretschmer insists, represents an atavistic violent-motor-reaction. He points out that, in general, such psychogenic reaction forms are hysterical where psychic aims in man avail themselves of reflex, instinctive, or otherwise biologically preformed mechanisms.

Paralysis, Involuntary Movements

Many varieties of hysterical paralysis occur. In some varieties the paralysis is more or less complete. Sometimes it is associated with tremor of the affected limbs; sometimes contractures may be present. Often, paralysis takes the form of astasia-abasia. In this condition, movements may be carried out when lying down or even when sitting down, though standing and walking cannot be performed. Such a symptom as astasia-abasia provides clear evidence of a dissociation characteristic of hysteria. In other cases a number of signs which occur in organic paralysis are absent in conversion reactions; of these signs, those elicited by testing the tendon reflexes may be mentioned. Often, dyskinesias such as tremor, as mentioned above, may accompany paralysis or paresis, and there may be an accompanying bizarre gait. Tics and muscular spasms may accompany a paresis or may occur alone. Another common type of hysterical motor disturbance consists in disturbance of speech. Sometimes this is limited to one language, whereas another language (usually the mother

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tongue) is spoken without difficulty. In such a case a dissociation characteristic of hysteria is already evident on the basis of symptom observation. Usually, however, the certain diagnosis of hysteria requires closer investigation than is afforded by the mere observation of symptoms. On the one hand, most symptoms are readily confused with the manifestations of other diseases; on the other hand, hysteria frequently occurs in concert with other diseases and its contribution to the manifestations of disease has to be determined.

Kretschmer points out how widely spread in nature is the immobilization, or sham-death-reflex—the occurrence in animals, that is, of motor rigidity in response to threatening danger. As previously stated, he groups convulsive hysteria around the biological radical of the primitive violent-motor-reaction. Immobilization, in one form or another, he groups around the biological radical of the phylogenetically important sham-death-reflex. Hysterical paralysis is often accompanied by an obvious restriction of the field of consciousness. Sometimes this reaches the degree of stupor. These hypnoid-stuporose hysterical states, together with paralytic conversion reactions, Kretschmer thinks are anchored in the old, general, animalistic reflex mechanism of sham death. Thus he considers that hysterical reactions group themselves around these two fundamental animal reactions to danger. He considers, too, that in human beings the danger may be external and/or may be bound up with the emotions and conflicts which accompany the sexual life. He states: "Wishes, struggles and disappointments of an erotic nature form the large main group of experiences which produce hysteria in ordinary civil life, especially in women; the war neuroses, and a part of the accident neuroses, contribute the other very large half of hysterical reactions."

In order to illustrate characteristic findings in a case of conversion paralysis, the following summary shows how the diagnosis may be established on positive grounds from the point of view of symptom observation and etiology as well as psychopathology (for which see later).

The patient, a married man, aged fifty-nine years, complained of paralysis of the left leg and weakness of the left arm. On examination, the left upper and lower limbs were slightly spastic. When the patient was encouraged to flex the left thigh at the hip joint, the antagonistic muscles went into increased spasm. The patient was next required to raise himself into the sitting position in bed, his arms being folded and his legs separated. Under these conditions the paralyzed left leg remained firmly on the bed. (The paralyzed leg rises higher than the other under these conditions in organic disease of upper motor neurone type—"Babinski's second sign.") The plantar reflex was flexor (Babinski's sign negative), and the tendon reflexes were present and equal on both sides.

In discussion it was ascertained that the patient's illness commenced during the bombing of London, at which time he had become acutely fearful. Moreover, the illness required giving up work just as he was approaching the time for retirement on full pension. The only other noteworthy item of information in this discussion was that his father had died in his eighties, of cerebral thrombosis with left-sided paralysis. This patient was later given Sodium Amytal intravenously for the purpose of further psychological exploration. Under narcosis he prayed for the forgiveness of his sins, giving an account of the use of contraceptives since the birth of his second son (twenty-five years of age). The doctors had then advised against further children on account of his wife's ill-health, and he had since used contraceptive techniques, though this was against his religious convictions and those of his father. He also spoke of his struggles against masturbation prior to marriage, and wept bitterly. He felt he had committed grave errors and was not entitled to enjoy retirement as his father had before him. During the bombing he had felt convinced that retribution was at hand. In further discussions without narcosis, the patient at first denied any sense of having done wrong and defended his conduct during marriage on the grounds that he had to think of his wife's health, and that in any case she was quite satisfied with her two boys, etc. He appeared quite reasonable in his attitude toward his sexual problem, though he admitted he had always spoken in public against any form of contraception, and went on to talk of moral dangers.

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Interview with his wife disclosed his great dependence upon her in all respects, including an incapacity for decision without her. Moreover, she gave an account of her honeymoon thirty years before which was marred by her husband's worry lest he had cancer.

In this case the signs were characteristic of hysteria. We may also note the following features: There was a temporal connection between the onset of his paralysis and the dangerous situation of bombing. A conflict of a sexual nature evoked by this stress was uncovered, and the meaning of the symptoms became clear. Moreover, his personality background showed evidence of overdependence and neurotic traits, the latter presenting chiefly in the form of hypochondriasis at the time of his marriage, which, incidentally, he had delayed for a considerable time. We will later elucidate the diagnostic importance of the chronological correlation of stress and conflict with the onset of symptoms in the setting of hysterical character background.

Further Notes on Involuntary Movements

As has been emphasized above, observation of symptoms may not in itself be sufficient to diagnose hysteria; for this purpose further investigation along both psychologic and physical lines may be requisite. For example, in a child, the diagnosis between a relapse of Sydenham's Chorea and a hysterical mimesis is sometimes extremely difficult and quite impossible on the basis of symptom observation alone. Not uncommonly, hysteria is responsible for evanescent hyperkinesis definitely choreiform in type in young children. In such children, an impression of choreiform movements may have been previously produced by an attack of rheumatic chorea, or the child may have observed such an attack, usually in hysterical cases in another member of the family. Sensitivity of the physician to the underlying psychodynamics of the neurosis is essential in arriving at such difficult differentiations, and the psychopathology of conversion reactions is discussed below. It should also be mentioned here that nonchoreiform movements, that is, typical movements which might be performed normatively but which are performed excessively and inappropriately, may also of course be part of hysterical disorder. When such movements are circumscribed, single, or few in number and have become stereotyped by repetition, the terms *tic* and *habit spasm* are often synonymously applied. In older children and adults, systematized tics are usually found in the setting of obsessive-compulsive neurosis or of severe obsessive character disorder. It seems in such cases of persistent tics that the original hysterical symptom has become assimilated within the deeper regression of compulsive disorder. Tics frequently involve the head and neck; spasm of some of the facial muscles or rotation of the head are often observed. The latter symptom may present in full flower as *spasmodic torticollis*. Frequently this is a symptom of conversion hysteria as revealed in intensive investigative psychotherapy (see Ref. 1, pp. 25–27, 30, 40). In such cases, however, obsessive-compulsive features are usually also prominent, and one is obliged to use in diagnosis the inelegant term "mixed neurosis," or some synonym. Similar considerations apply frequently to *occupational cramp*. This is a progressively severe disability due to spasm of the muscles employed in finely co-ordinated movements essential to the fundamental skills of the particular occupation of the patient. *Writer's cramp* is but one example. Occupational cramp often yields to psychotherapeutic intervention when the hysterical nature of the symptoms becomes apparent. Sometimes such cramps also yield in response to favorable shifts in the life situation of the patient when the progressive course is dramatically interrupted.

Sensory Disturbances

Somatic conversion symptoms often include subjective and objective sensory disturbances. Pain is the most common and persistent complaint, occurring anywhere in the head, body, or limbs, and described sometimes in quite horrific terms, though the patient may at the same time evince a complacent attitude. At other times, florid histrionic behavior accom-

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panies the complaint of pain. Severe pain and hyperesthesia of the scalp may be localized in the temporal or parietal regions and described as a sensation of a nail being driven into the head (clavus). Pain in the back is common, sometimes accompanied by rigidity of the muscles and curvature of the spine as in bent back (camptocormia). This often follows minor trauma to the spine. Abdominal pains may simulate organic disease, leading to erroneous diagnoses and useless surgical interventions. Localized hysterical tenderness gave rise to the concept of hysterogenic zones, formerly utilized alternatively to stimulate or terminate a hysterical attack. These tender spots are sometimes found over the breasts, the inguinal regions (ovarian), the head, or the spine. Allochiria, the perception of sensation on the opposite side of the body corresponding to that stimulated, is sometimes elicited.

Diminution of sensation is common, sometimes amounting to more or less complete anesthesia. These anesthesias do not follow typical neural distributions but involve, for example, a limb or part of it (glove and stocking) or may be sharply limited by the midline to one half of the body.

The so-called "stigmata" sometimes accompany other symptoms of hysteria. These consist mainly of sensory disturbances and so are mentioned here. Localized reduction of cutaneous sensation or pharyngeal anesthesia may be discovered. Hyperesthetic spots over the ovaries and absence of reflex closure of the eye on touching the cornea have often been described. Concentric contraction of the field of vision and the feeling of a lump in the throat (globus hystericus) are other anomalies. Traditionally, these anomalies were held to be characteristic of hysteria and, on this account, were designated stigmata. They came to form the positive grounds for the diagnosis of hysteria. Babinski,[4] however, weakened this base for diagnosis when he showed that they often arose as a result of iatrogenic suggestion (pithiatism). Sometimes one or more of the stigmata do occur independently of the physician's examination, and accompany other symptoms of hysteria. Ferenczi[17] has shown that the body sites where they occur are peculiarly adapted for the representation of unconscious fantasies, and it is for this reason that they may occur, or readily arise, on suggestion.

Affective Disturbance

Patients suffering from conversion reaction are often quite complacent in the presence of gross objective disability, a proverbially puzzling paradox encountered in the early phase of psychotherapy. Usually, if pain is prominent, much anxious concern is focused upon this, though a complacent attitude about the accompanying disability, or the possibilities of organic disease which the patient suggests himself, may remain. *La belle indifférence* simulates, sometimes, the flattened affect of some forms and phases of schizophrenia. Janet noted the disposition to "equivalences" in hysteria; when, for example, by means of suggestion, a somatic conversion symptom was dissipated, anxiety or depression or, in some cases, confusion appeared in its place, shattering the façade of striking indifference which had formerly accompanied the somatic symptom. Seitz[49] has recently investigated the conditions of replacement of one symptom by another. Somatic symptoms may be replaced wholly or in part by the expression of anxiety or depression, or in some cases by feelings of victimization. As will be discussed later, symptom-formation in hysteria represents the unconscious solution, or attempted solution, of emotional conflict. The symptoms serve more or less as a protection against the perception of anxiety and depression associated with this conflict. When the somatic conversion reaction is incompletely protective, anxiety and/or depression are then also apparent. It is to be noted, too, that anxiety which arises on recession of somatic conversion symptoms, or that which accompanies such symptoms, is usually displaced from its source in the conflict and may be displayed in phobic reactions. Freud termed such displaced anxiety, specifically connected with a special situation, anxiety hysteria.

Anxiety may be exhibited as a vague fear of

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impending disaster, or, more specifically, of death, heart failure, or insanity. In such cases the somatic accompaniments of anxiety, such as dilated pupils, sweating, palpitations, and digital tremor, may be apparent in addition to the conversion symptoms. Other patients exhibit their martyrdom and resignation with a keen sense of the dramatic value of pathos expressing feelings of sadness and self-pity.

¶ The Nature of the Symptoms

Hysteria and Freud's Discovery of Psychoanalysis

Psychoanalysis connotes the techniques devised and evolved by Sigmund Freud for investigating the human psyche and the body of theory that has emerged from the data thus collected. Its beginnings can readily be traced to the working association of Breuer and Freud at the close of the nineteenth century when, together, they worked out a method of treating hysterical phenomena. It was found that, if instead of hypnotizing a patient and then making direct suggestions of cure the patient was simply encouraged to talk while under hypnosis, hysterical symptoms were often relieved more effectively. It was found, too, that this talking out under hypnosis was laden with emotional charge, whereas under waking conditions the same patient would be lacking in affective expression. More than this, it was discovered that important events connected with the emotional life of the patient, which were otherwise forgotten, were recalled and expressed under hypnosis. This method of talking out of emotionally charged and otherwise forgotten events was called "mental catharsis," as it operated to eliminate sources of disturbance from the psychic system which would, without this, result in symptoms. The process of affording an outlet for emotion in talking was called "abreaction."

The fact that a patient suffering from hysteria was unable to recall significant and emotionally charged events in the waking state, whereas under hypnosis such material would, with encouragement, make its appearance gave rise to the psychoanalytic concept of resistance which opposed such recall, and which was lessened by the hypnotic procedure. The fact that the patient came to develop an intense emotional relationship to the physician was one component of the concept of transference. Freud found that this development in the patient-physician relationship was due to emotion becoming transferred from earlier objects of the patient's feelings to the personality of the physician. Later, Freud used the technique of "free association" to replace hypnosis as a method of lessening, or attempting to lessen, resistance, and thus psychoanalysis emerged. Though, in general, the method of free association accomplishes less than hypnosis in factual recall of early events and experiences even when the resistances are unveiled, emotional revival is, in the long run, facilitated. This emotional revival involved in transference became the prime means of success in Freud's later psychoanalytic work. The technique of psychoanalysis has encompassed ways and means of developing and utilizing transference, of effecting its dissolution, and of unveiling resistances in resolving emotional difficulties out of the range of the patient's awareness. This technique has emerged from the mental-catharsis method of treating patients suffering from hysteria.

In the foregoing brief genetic account of the formulation of the concepts of resistance and transference as these became apprehended from the clinical findings in working with patients suffering from hysteria, it will be noticed that these same findings have additional implications. Thus, the fact that certain events of the past were recalled, under hypnosis or as a result of analytical work, indicates that such events were somehow and somewhere recorded and stored within the psyche, though not immediately available to consciousness. Access to consciousness was at first barred by resistance. Such exclusion from consciousness as a result of the operation of an inner resistance is known as repression and is an important manifestation of resistance.

With Freud's theory of dreams,[27] psychoanalysis was enlarged from a psychotherapeutic

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method to a psychology of the depth of human nature. Freud showed that dreams were meaningful, that each one represented the disguised expression of an attempted wish-fulfillment. He contrasted the manifest content, that is, the dream as related directly, with the latent dream thoughts, reached by the techniques he devised to deal with resistance. In the young child the manifest and latent content may be identical, the dream plainly representing the imaginary fulfillment of an ungratified wish. Usually, in adults, the wish is a repressed one, disguised in the manifest dream because of resistance. Freud showed that human life was dominated by conflict between conscious appraisal of reality plus ethical values (including the unconscious conscience) and the repressed unconscious. In sleep, a temporary withdrawal from the external world, the energy of repression-resistance is diminished so that the unconscious forces obtain some degree of hallucinatory satisfaction. This is "safer" during sleep, since the avenues to motor expression are then blocked; in any case, some degree of repression-resistance persists, so that even in hallucination the latent thoughts are disguised. In this way, disturbance emanating from ungratified unconscious conative processes is drained off, and sleep is safeguarded. Of course, this function of the dream sometimes fails; the disguise is not sufficiently heavy, and the watcher awakes in anxiety. On the other hand, when the disguises have worn too thin, there can be the comforting thought, in sleep, "After all, this is only a dream." Thus sleep is permitted to continue despite the threat of revelation.

The following is a clinical example to illustrate some of the foregoing points and their connection with the psychopathology of hysteria:

A middle-aged male patient was brought to psychiatric interview on account of total paralysis of his legs. Seated in a wheel chair, he explained calmly that two weeks previously he had awakened in the morning to find himself paralyzed. In view of the prevalence of an epidemic of poliomyelitis, he assumed that he had the disease and summoned his physician. He now understood that the diagnosis was in considerable doubt, and that, following intensive organic investigation, no definite organic basis was discoverable. The patient expressed this situation in his own way, and at the same time expressed his doubt concerning the opinion of the physicians. During the further course of interview, the patient explained that he had had considerable difficulty in getting to sleep since his wife had left him three months previously. He also expressed the view that he did not care very much about this, and spoke with bitterness about the faithlessness of women. The events of the day before the paralysis were recounted as routine, but a dream had occurred during the night. In this dream, the patient went away from his house and found himself struggling with two people in a strange neighborhood; shots were fired, he had a gun in his hands, and then he woke up in anxiety to find himself paralyzed.

During the course of further treatment, this dream was further investigated and was found to represent his wish to pursue his wife and wreak revenge upon her and her lover. Consciously, he was very much against any such course of action. It was, indeed, found that his paralysis was a massive defense against any possibility of his moving to kill his wife and her lover, and the massive nature of the defense was partly a measure of the intensity of his vengeful wishes. The "strange" neighborhood turned out, in fact, to be the old familiar neighborhood of his childhood at a time when the patient thought himself to be an unwanted child because his father had been released from the Army, and his mother had given over all her attention to the soldier on his return.

This fragmentary account illustrates that a forceful repressed wish found hallucinatory satisfaction in his dream, and that, the disguise being too thin, he awakened in anxiety. His inability to get to sleep showed his need for inner vigilance to ward off these dangerous wishes, which were being repressed with increasing difficulty. Later, the repression partially failing, it needed to be supplemented in the waking state by the conversion reaction of paralysis. There was much self-punishment in this paralysis, too, as became apparent from the patient's associations in the process of

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psychotherapy. Notice here that the dream is the first member of a series that includes among its members the hysterical symptom, the obsession, and the delusion. As Freud states, it is differentiated from the others by its transitory nature and by the fact that it occurs under conditions that are part of normal life. In this pathological case, the connecting link with a hysterical conversion symptom is clear.

It is also clear in this case that the dream was related not only to current events in the life of the patient but also to childhood experience. The patient in his childhood had found his passionate wish for exclusive possession of his mother's love threatened by the return of his father from a lengthy absence in the Army, and this threat turned out to be wellgrounded in reality. In later years this experience led to his very reserved attitude toward women, and it was only in middle life that he had found his way to marriage with a much younger woman who later deserted him for a younger man. This had revived all the emotions constellated around his childhood oedipal-phase experiences, the murderous wishes being transferred from his "faithless" mother and his father to his wife and her lover. Sleep became difficult because he was afraid to relax lest these ego-alien wishes should succeed in breaking through from repression. In the dream the disguise was not sufficiently heavy to safeguard his sleep adequately, and he woke in anxiety. The succeeding hysterical symptom was a compromise formation compounded of the repressed wishes and the repressive forces, including those of unconscious conscience. In this case some of the repressed wishes are more obvious in the dream, and the defense against them and the self-punishment in the symptom of conversion paralysis. It is also to be noted, in this particular case, that the symptoms of paralysis defend against the expression of hostile wishes which result from the frustration contingent upon the disruption of his marital life. In many cases the symptom has a more clearly evident sexual-symbolic reference. In this case too, however, the paralysis symbolically represents castration—loss of the power to satisfy genital-sexual needs through their unconscious acquisition of a forbidden character by association with earlier incestuous wishes.

Psychopathology of Hysteria

It will be apparent from the above discussion that in conversion reaction the symptomatic changes in physical function unconsciously give distorted expression to the instinctual strivings that previously had been more fully repressed. The symptoms are substitutes for ideational representation of these strivings and can be translated into word language from their body-language with accompanying affective expression. At the same time, the symptoms indirectly represent the defensive force in conflict with the derivatives of instinctual impulses and the retribution or punishment for forbidden wishes.

When traced to its roots, hysteria in all its forms is predominantly related to the climax of infantile sexuality, the oedipus situation, with its struggle to surmount incestuous genital-sexual and hostile strivings.[25] Some conversion symptoms represent a materialization of unconscious fantasies concerned with forbidden genital-sexual wishes. Genitalization may consist in tissue changes including hyperemia and swelling, representing erection, or of muscle spasms, representing the movements of coitus, or of sensations resembling genital sensations, although these are often complicated by the perception of pain. On the other hand, as in the case described above, the symptoms may represent the reactive hostility to frustration of genital-sexual wishes, and in such cases anal-sadistic fantasies may find expression. Sometimes, pregenital expression of predominantly genital wishes may also occur; bed-wetting, a frequent masturbation equivalent in children, is a common example of this. Often interpolated between the original oedipal experiences and fantasies and the symptoms of the adult are daydreams connected with masturbatory activities.

The symptoms consist of an autoplastic attempt to discharge the tension created by

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intrapsychic conflict, and express drive and defense simultaneously, short-circuiting conscious perception of conflict related to the oedipus complex. This last statement covers the primary gain. Secondary gain is involved in the alloplastic ego-endeavor to utilize the symptoms for manipulating other people and the current life situation. Often the attention-attracting function is conspicuous: by physical symbolic exhibition of conflict, the patient indirectly attracts sympathy for his plight. The flight into illness may provide escape from an intolerable job or family situation or from military service. In other words, some gain is attempted from the suffering in which the patient is caught up, and this gain might sometimes be related to a precipitating factor. In the latter event, a passive mastery might ensue, with later recession of the symptoms. Following injury, hysterical perpetuation or exaggeration of symptoms may have a conspicuous secondary gain factor motivated by the wish for compensation. In some cases the secondary gain persists only as long as the symptoms persist, and in such a situation the disease may become chronic, presenting an additional important resistance in treatment, as will be shown later.

Further elucidation of the psychopathology of hysteria follows.

Recent Concepts

ORALITY AND HYSTERIA

As indicated earlier, in the study and treatment of hysterical phenomena, Freud invented the method of psychoanalysis and developed the basic concepts of this science. The concepts of fixation and regression also grew out of these early studies, and the formulation arose that the personality of those liable to exhibit hysterical symptoms when frustrated was one with fixation at the phallic or early genital phase. In the onset of neurosis, regression took place to this point of fixation with its infantile object-relationships and its attendant castration anxiety. The anxiety motivated repression, which, however, failed to be effective, and symptom-formation ensued. Marmor[40] has recently emphasized that, in many cases of hysteria, fixations in the oedipal phase of development are themselves the outgrowth of pre-oedipal fixations, chiefly of an oral nature. He writes:

> The kind of parent whose behavior keeps a child at an "oral" level is apt to be the kind of parent whose behavior favors the development of a strong oedipus complex. The pre-oedipal history of most of the hysterias I have seen has revealed one of two things—either intense frustration of their oral-receptive needs as a consequence of early defection or rejection by one or both parent figures, or excessive gratification of these needs by one or both parent figures.

Similarly, Fitzgerald emphasizes early "love deprivation" and consequent "love craving" as a basic character trait of the hysterical personality.

The concept of multiple points of fixation, and, in particular, in hysteria, of the importance of oral fixation, serves to explain psychodynamically the clinical associations noted in many cases between hysteria and schizophrenia,[42] hysteria and depressive disorder, and hysteria and addiction, especially alcoholism. There is often a narrow margin between hysterical introversion or dissociative reactions and schizophrenic autism, or between hysterical materialization and schizophrenic hallucination; under certain circumstances, as already noted, the transition from classical conversion hysteria to florid schizophrenic psychosis takes place. Where the oral fixation factor is of greater importance, the egointegrative capacity is weaker, and psychotic regression occurs more easily.

It is to be noted too, in the opinion of this writer, that secondary gain factors are often underestimated as to their importance in the psycho-economy of the patient on account of inadequate realization of the quantitative loading of pregenital fixation. For attention-attracting and sympathy-gaining, the compensation-managing and the acquisition of dominance are related, in the complex stratification of psychic life, to the frustrated oral-dependency and anal-manipulative needs for narcissistic supplies and mastery.

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Hysterical Personality

In 1892 Charcot wrote of hysteria:[10]

> The dominant idea for us in the etiology is, in the widest sense, its hereditary predisposition. The greater number of those suffering from this affection are simply born "hystérisables," and on them the occasional cause acts directly, either through autosuggestion, or by causing derangement of general nutrition, and more particularly of the nutrition of the nervous system.

He demonstrated that morbid ideas could act as the "occasional cause," and that symptoms could be influenced by suggestion under hypnosis. Emphasizing as he did heredoconstitutional factors, however, he was more interested in the classification of symptoms and the differentiation of hysteria from other neurological disease than in the personality characteristics of the patients. At this time the known etiological field consisted of constitutional factors and of environmental factors largely unrelated to the early emotional transactions within the parent-infant relationship. The important role of the early personal environment was largely hidden from view before Freud's investigations. Without depreciating the importance of heredoconstitutional factors, Freud, in unraveling the meaning of symptoms in terms of the patient's experience, penetrated the amnesia for events in the early infantile period of life, and recognized its crucial formative importance in personality development. More attention thus came to be paid to the personality characteristics of patients suffering from symptom neuroses.

The first psychoanalytic contribution to characterology was Freud's paper in 1908 on the anal character.[21] As it became apparent that the optimal goal of therapy went beyond the relief of symptoms to resolving the need for symptom-formation, increasingly psychoanalytic characterology assumed clinical importance. Reich,[45] in his book on character analysis, attempted to depict the character structures in symptom neuroses, including hysteria. He described the behavior of the hysterical character as obviously sexualized, including coquetry in women and softness and effeminacy in men. Even locomotion, he considered, was sexualized so that movements are soft, graceful, and sensually provocative. As the sexual behavior came closer to attaining its apparent goal, apprehensiveness became evident. Reich also described unpredictability, strong suggestibility, sharp disappointment reactions, imaginativeness, lack of conviction, compliance readily giving way to depreciation and disparagement, compulsive need to be loved, overdependency on others for approval, powerful capacity for dramatization, and somatic compliance. Wittels[52] had already stressed the infantile and feminine, and the liability to confuse fantasy and reality. Reich attempted to explain these features as being determined by fixation in the early genital phase of infantile development with incestuous attachment, but as we have seen, Marmor has, with more cogency, related some of these features to pronounced orality in the hysterical personality. Abse[1] also stressed the dependence aspects of the personality background, especially in peacetime neurosis when the emphasis is on unsettled infantile situations; in war neurosis, in general, the emphasis is on the role of the actual or current conflict induced by stress.

Chodoff and Lyons,[12] in a recent paper, challenge the close relationship adduced by others between conversion phenomena and the hysterical personality. Of 17 patients with unequivocal conversion reactions, only 5 satisfied the criteria (similar to those of Reich's description above) they laid down for the diagnosis of the hysterical personality. They therefore concur with Kretschmer[37] and Bowlby[6] in the opinion that conversion reactions do not occur solely, by any means, in patients who present the characteristics of the hysterical personality.

Two comments seem appropriate: In the first place, as already stated, some of the features of the hysterical personality belong to derivatives of pregenital points of fixation, and, where these are absent, it might be expected that the etiological role of the actual conflict would be more emphatic. Secondly, while the predisposition to acquire hysteria is built up very largely from undue emotional attachment

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to one or both parents with difficulty of later displacement of this attachment, the dependent and other correlative patterns of personality are often not so simple and obvious. To understand deviations from such a pattern, it is necessary to study the total repertoire of unconscious defenses and to take into account that the evident achievements in external adjustments and independence may show the character of overcompensation. Basically, such patients remain unconsciously dependently fixated on the infantile object (in fact or in fantasy) and are vigorously defending themselves against this state of affairs. An example from military psychiatric experience is briefly outlined below.

Following enlistment in the Army, the patient, aged thirty, developed pains in the stomach. Later he began to suffer trouble with his eyes, especially when riding his motorcycle. He could not keep them open and complained they kept "screwing up," which, indeed, they did. He was of a very aggressive character type. Prior to enlistment he often performed in fairgrounds on the "wall of death," demonstrating his skill and daring on a motorcycle, and was proud to be earning much more money than his father. He had always been a daredevil, amateur motorcycling being his hobby from an early age. His usual employment was that of a butcher, and he was the mainstay of the home. He had never taken up a sustained relationship with any woman other than his mother, to whom he remained very attached. In discussions he made it clear that he was ready for anything in the Army and could perform wonders on his motorcycle—were it not for the spasms of his eyes.

In this case both the unconscious underlying overdependency and passive homosexual strivings were vigorously countermanded by character defenses. These gave an appearance of remarkable and heroic virility and independence, with others depending upon him, prior to his separation from his mother and the onset of symptoms, including conversion reaction.

THE DECREASED INCIDENCE OF CLASSICAL HYSTERIA IN URBAN WESTERN SOCIETY

Chodoff[11] writes, of the decreased psychiatric interest in conversion hysteria in recent decades, "This is undoubtedly partly the result of an actual diminution in the occurrence of conversion hysteria due to such changes in the cultural climate as a wider dissemination of education with an increase in sophistication, a less authoritarian social structure, and a decrease in sexual prudery and inhibition." He mentions, too, that Freud's work was itself a very significant influence in bringing about cultural changes, such as decrease in secrecy and prudery about sex and an increase in understanding of the fact that physical symptoms can result from emotional disturbance. Laughlin[39] adds that decreased social acceptability of classical forms of neurosis might account for somatic and physiological expressions of emotional conflict seeking deeper and more disguised avenues of discharge. Where the attempted symbolic resolution of an emotional conflict in body-language begins to communicate as much, or nearly as much, as word language to the patient and to those in his particular life space, the attempt may immediately become abortive, for repression is signaled to increased efficacy.* The unresolved tension may then result in discharge through the autonomic nervous system, with excessive stimulation of innervated visceral structures. A vegetative neurosis[2] may yet again acquire a psychoneurotic superstructure of hysterical type, but in any case, the form of the neurosis departs from the classical forms prevalent in the time of Charcot and Freud.

In this connection, it must be emphasized that conversion symptoms are not limited to the voluntary muscular system but also occur in the vegetative system. Fenichel[16] states: "The urge to express unconscious sexual wishes in a distorted physical way has at its disposal a far more extensive area than has conscious will." It can similarly be shown that commands given to a patient under hypnosis can influence many more physical functions than can conscious will in the same individual. Vegetative functions are also utilized in conversion defense, especially if a condition of somatic com-

* Instead of more effective repression, further defense may be engaged against the symptoms themselves. In some cases, denial may occur, with an intensified form of *la belle indifférence* as the ensuing clinical manifestation, or manifest anxiety may paradoxically be used defensively.

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pliance has already been established by unresolved tension resulting in autonomic discharge. However, the regression in hysteria may also include a change in ego-state analogous to that obtaining in early childhood. The archaic ego has access to more of the body functions than occurs later after the repressive barrier is established.

It is evident that, for the reasons advanced by Chodoff, there may be an actual decrease in the incidence of hysteria in some centers of modern civilization. On the other hand, this decrease may not be so substantial as it at first sight appears, because the ancient Proteus may take many shapes and thus elude even some of the refinements in modern diagnosis.

Classical forms of hysteria are common in the more outlying rural areas in this country, as is evident, for example, in some regions of North Carolina. Examination of such instances of classical hysteria, in the experience of this writer, reveals that the familial style of life, including sleeping arrangements, results in the relatively frequent early observation by the children of sexual scenes between the adults. This "primal scene" exposure may be of more direct significance than other elements in the cultural mode in lending a special coloring to the oedipus complex with a later increased incidence of major classical hysterical attacks.

Identification in Hysteria

Hysteria is a great imitator, and this depends largely upon the fact that the sensations or movements evinced in the conversion symptoms may relate to the observations the patient has made of others. For example, Freud's patient Dora[22] developed a cough which was found to be traceable to her observations of Mrs. K's coughing attacks. She unconsciously wished to put herself in Mrs. K's position as the wife of Mr. K, but felt guilty about her rivalry. She selected Mrs. K's affliction as the point of identification, thus caricaturing her envy in the service of self-punishment. Oedipal wishes may, however, result also in an identification with the significant person of opposite sex. Forced to relinquish the forbidden and desired object, a partial identification with the object may ensue. Identification frequently occurs with some aspect of another person with whom the patient has little relationship. Freud used a hysterical epidemic in a girl's school as an example.[26] One girl who received a love letter fainted, whereupon other girls fainted too. The purpose of the identification in this instance was that the girls wished for the same experience and thus dramatized their forbidden wishes, accepting the punishment too. Anyone who, as a prototype, offers some libido-economic advantage at a time of heightened inner conflict and tension may thus be imitated. Multiple identifications often occur, the classical example of which is Freud's patient who tried to take her clothes off with one hand while trying to keep them on with the other.[23] She identified herself as a woman being sexually assaulted at the same time as she identified herself with the sexual aggressor. Bonnard,[5] in a recent paper, described children who had witnessed the quarreling of their parents, and she interpreted their gestures as an identification with both the aggressor and the victim. Multiple identifications may assume dimensions of partial personality systems in more severe dissociative reactions, as described previously in the section on amnesia and multiple personality.

The important role of identification in the sociology of the body-image is discussed by Schilder.[48] He has emphasized that the postural model of the body is not static but in constant flux, changing according to reactions to circumstances. There is a continuous process, underlying the evident changes, of construction, dissolution, and reconstruction of the body-image. Processes of identification and projection are of considerable importance in bringing about such changes. In hysteria the mechanism of identification expresses the close relation of the patient to different postural models of different persons. Innumerable condensations of object-relations may be expressed in a hysterical change in one organ of the body. Schilder also draws attention to Freud's patient Dora (see above). Her coughing attacks also expressed genital wishes to be infected and to take the place of her mother who had vaginal catarrh.

Fenichel[16] states that "identification is the very first type of reaction to an object. All

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later object relationships may under certain circumstances regress to identification. The hysterical identification is characterized by the fact that it does not involve the full amount of cathexis available." A recent important discussion by Jacobson[21] attempts to show the relation between less and more regressive forms of identification. Foulkes[19] also attempted to show these relations. In the opinion of this writer, it is often by study of the type of identifications the patient has made and the correlative fate of the object-relationships involved that it is possible to obtain a better notion of how far from psychosis is a particular case of hysteria. Identifications may, however, elude understanding, especially in short-contact work with a patient or when psychotherapy is of a "repressive-inspirational" type, utilizing, perhaps unwittingly, primitive forms of identification in the suppression of symptoms.

¶ Diagnosis

Glover[28] sums up the pathogenesis of symptom-formation in hysteria by citing, roughly in sequence, the major factors usually involved. These are: (1) somatic compliance; (2) frustration; (3) introversion; (4) regression; (5) reactivation of oedipus strivings; (6) failure of repression; (7) displacement, symbolization, and/or identification with the incestuous object; (8) breakthrough of innervations; (9) inhibition or exaggeration of somatic function, giving rise to crippling or painful symptoms; and (10) somatic dramatization of unconscious fantasy formations, including repetition of some elements actually associated with oedipus-phase development.

Examples of somatic compliance are the localization of symptoms in accordance with fixation of body-libido (erotogenic zones) and localization due to libido-disturbance, the result of organic disease. Thus conversion symptoms of an oral kind may readily occur in a patient of constitutionally strong oral libido with oral fixation. On the other hand, an organ affected by organic disorder is readily chosen to express symbolically a reactivated oedipal conflict. This last is an important warning to the clinician not to adopt an "either-or" frame of reference in the differential diagnosis of hysteria from organic disease.

Conflict induced by frustration results in the reactivation of an oedipus complex which has been held in faulty repression and of which the negative (homosexual aspects) are strongly emphasized.

With these major points in mind, it can be stated that the positive grounds upon which a diagnosis of hysteria is established consist in the distinctive marks of its etiology and psychopathology which psychiatric investigation of the patient and his symptoms affords. The disorder is the result of mental conflict, and there are connections between the conflict and the symptoms. Hysteria is manifest in so many forms, some of which closely imitate organic disease of the nervous and other systems, that, without the distinctive marks of its etiology and psychopathology, symptoms may be misleading. It often happens that the symptoms themselves are no more characteristic of hysteria than of other diseases. In some cases, however, where there are characteristic symptoms such as astasia-abasia, anesthesia *en manchon*, clavus, globus hystericus, or the changing of one to another symptom, it is necessary to consider the extent to which hysteria is responsible for the illness of the patient. The stigmata only occasionally accompany other symptoms of hysteria. Rarely, pharyngeal anesthesia may be discovered, and cutaneous anesthesia is sometimes demonstrable, for example, in cases of hysterical convulsive attacks.

The occurrence of mental conflict prior to the manifestations of the disease, or of its exacerbation, may be revealed by a painstaking history of the present illness. Such conflict is provoked by changes in the life situation of the patient. It is necessary to determine the temporal connections of periods of stress with the conflicts and symptoms. Following this chronological correlation, which is positive in cases of hysteria, the nature of the conflict and its possible symbolic relation to the symptoms needs to be more closely studied. In hysteria the meaning of the symptoms thus becomes evident, for they express regressively (and often in a body-language) both the repressing forces and the repressed oedipus strivings in the field

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of conflict. Next, the personality characteristics of the patient need to be evaluated. Dependence aspects may disclose attitudes derived from the persisting, albeit unconscious, strong emotional attachments to the parents or their surrogates. The repressed oedipus complex of early childhood may express itself in the record of events of later life which the patient is able to recall. Overdependence in the spheres of occupational, social, and sexual adjustment is often clear. In some cases this is masked by a reactive insistence upon independence, which, however, betrays the character of overcompensation and shows the marks of unresolved aggression toward the parent (or parent-figures).

It is also possible in diagnostic interviews to increase understanding of the patient and his illness by a consideration of the neurotic traits which he has evinced during the process of growth and development. These are prominent and, in cases of hysteria, often persist into adult life. In some instances, too, there is a history of previous frank neurosis which can be correlated with the life situation and the conflicts evoked at that time. Table 1 summarizes the requirements in history-taking for the diagnosis of hysteria. No scheme should be rigidly followed, but the data are all required. It may be necessary to have more than one distributive discussion, in which the patient is helped to talk freely in his own way and at his own pace, in order to elicit the information.

As repeatedly stated above, hysteria and organic disease may be contemporaneously present. Organic disease may follow hysteria, as for example, when refusal of food proceeds to anorexia nervosa and subsequent physiological derangement. In other cases, physical disease is primary, with disturbances of the body-image and an induced regressive ego-orientation—a state of affairs conducive to conflict in many people with symptoms comprising, perhaps, an overlay of hysteria.

It is sometimes difficult to differentiate hysteria from organic nervous disorder. In general, an organic lesion of lower-motor-neurone type is one of individual muscle elements, whereas hysterical paralysis is usually a paralysis en masse.[24] An upper-motor-neurone lesion, however, often results in a paralysis which superficially resembles that which occurs in conversion reaction, but there usually are important symptomatic differences. Thus, lower-face paresis, hemianopsia, and circumduction of the leg at the hip are common in an upper-motor-neurone lesion. Pronounced changes in the tendon reflexes, sustained ankle clonus, and the sign of Babinski usually point toward organic involvement of the nervous system. Hysteria has to be diagnosed, however, on its own characteristics and not merely by the exclusion of organic disease, which, at times, it may accompany.

TABLE 1. **Directive Scheme for History Taking in Diagnostic Interview***

1. *Present Illness:*
   a. Consideration of chronological correlations of onset and exacerbation of symptoms with changes in life-situation (or traumatic experiences).
   b. Consideration of conflicts evoked by such changes in life-situation. The connections of these conflicts with particular symptoms as far as can be consciously disclosed in discussions by the patient when his attention is directed thereto.
2. *Personality Background:*
   a. Dependence aspects:
      i. Nature of current interpersonal relationships, especially family and affiance.
      ii. Current occupational, social, and sexual adjustment, including recreational and cultural interests.
      iii. Employment and school record and achievement.
   b. Neurotic traits:
      Predominant type, time of appearance, disappearance, or persistence.
   c. Previous nervous breakdown: type, correlation with life-situation at that time.
3. *Family and Hereditary History*, and the patient's view of it.

* Reproduced from Abse, D. W., *The Diagnosis of Hysteria*, 1950, by permission of the publishers, John Wright & Sons, Ltd., Bristol, England.

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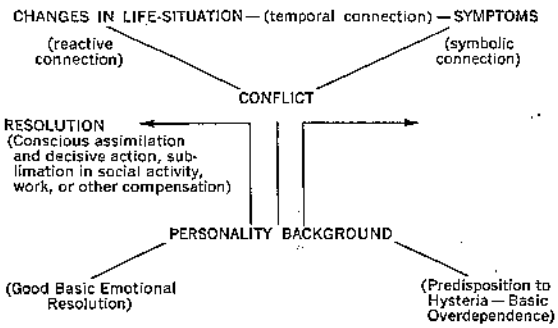

In certain forms and phases of schizophrenia, with delusions, hallucinations, disfigurements of speech, and the generalization of automatization, the disease is readily distinguished from hysteria. Incipient schizophrenia may occasion difficulty in differentiation, especially because the resemblances depend upon an initial similarity of psychological mechanism.[34] The difficulty is enhanced by the fact that, occasionally, hysteria ushers in a schizophrenic psychosis; that hysterical phenomena may cover, or occur with, schizophrenic disease; and by certain forms of hysteria including dissociative reactions such as fugue, Ganser's syndrome, pseudodementia, pueriliism, and stupor. These last are sometimes part of a transient psychotic disturbance, but there is usually no march to fixed schizophrenic disorganization. Hypochondriasis in schizophrenia is usually of a bizarre nature, which may be accompanied by a subjective experience of a change or duality of sex, perplexity, and a peculiar overidcation. If any of these symptoms accompany somatic conversion symptoms, schizophrenia should be suspected.

Depressive or paranoid episodes may punctuate the course of a predominantly hysterical illness. In this case the diagnosis may more properly be designated as "borderline state," and the treatment may be modified accordingly.[36]

¶ Prognosis and Treatment

Conversion hysteria is often best treated by psychoanalysis, and the prognosis is generally favorable. Psychoanalytic psychotherapy imparts the potential for the treatment to reach beyond the goal of relieving symptoms to that of minimizing the need for symptom-formation in response to frustrational life situations. Various conditions however, may indicate the suggestive methods of psychotherapy for relief of symptoms, and others may contraindicate psychoanalysis. Immediate help may be mandatory, as, for example, in such acute conditions as anorexia with bodily emaciation, or when anxiety and confusion dominate the clinical picture. Consideration of such cases for psychoanalysis must wait until symptoms have been relieved and the patient is calmer. Advanced age, exceptionally great secondary gain, or feeble-mindedness are contraindications to analysis. In instances of conversion reaction or dissociative reaction which follow a severely stressful precipitating situation, the simpler supportive methods of psychotherapy may suffice for recovery to the *status quo ante*. The question of psychoanalysis may, in such cases, be raised by the patient himself and may be best left to his own consideration and decision.

In cases complicated by the exhibition of psychotic mechanisms, psychoanalytically oriented psychotherapy, with modification of the usual techniques of psychoanalysis, may be indicated.[36] This is frequently the case in the more severe dissociative reactions. In selected instances of conversion hysteria, following adequate investigation, hypnotherapy continues to find a place, and some therapists utilize hypnosis for "uncovering" types of psychotherapy.[52]

There are some cases of conversion reaction with an unfavorable prognosis, no matter what treatment is attempted. The conversion reaction may be the only possible emotional solution for the patient because of the real-life situation which excludes healthier possibilities of gratification. Such cases may not ever recover from valetudinarianism attended by a "favorite" physician who is apt to be changed from time to time. Other cases, which used to be designated "chronic degenerative hysteria," deteriorate into a massive form of emotional dependence, even parasitism, upon others. When the victim or victims separate or are separated, institutionalization may be-

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come necessary, sometimes because of a supervening psychotic disorder of depressive or paranoid type.

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CHAPTER 15

THE PHOBIAS

Paul Friedman

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THE TERM "PHOBIA" is derived from the Greek word *phobos*, meaning flight, dread, panic, or fear. When a fear becomes attached to objects or situations which objectively are not a source of danger—or, more precisely, are known by the individual not to be a source of danger—we designate it as a phobia. The patient, as a rule, realizes the irrationality of his behavior but feels compelled to avoid those specific situations which expose him to overpowering anxiety.

The concomitant physiological symptoms usually present in anxiety states and reactions of fear and panic, such as tachycardia, rapid breathing, tremor, sweating, etc., may likewise accompany acute phobic reactions.

¶ Historical Remarks

The earliest case history of a phobic patient is recorded in one of the books attributed to Hippocrates.[37] One of the first attempts to deal systematically with the origin of phobic reactions was made by John Locke.[55] * "Antipathies" and fears, Locke reasoned, often arise from an association of ideas, and, if such "antipathies" were acquired in childhood, their causes may later be forgotten:

> The ideas of goblins and sprites have really no more to do with darkness than light; yet let but a foolish maid inculcate these often on the mind of a child, and raise them there together, possibly he shall never be able to separate them again so long as he lives; but darkness shall ever afterwards bring with it those frightful ideas, and they shall be so joined, that he can no more bear the one than the other.

Locke recognized that it is not within the power of reason to relieve the "antipathies" thus acquired, but added that they could sometimes be cured by time. (Incidentally, he was quite explicit in stating that besides the acquired "antipathies," there are some which depend on constitution.)

More than two hundred years later, Watson[75] formulated a view of acquired fears similar in its essentials to Locke's, although stated in terms of conditioned responses. A more sophisticated theory was recently formulated by Dollard and Miller;[16] they describe phobias as learned responses to painful experiences.

* In the chapter "Of the Association of Ideas," included for the first time in the fourth edition of *An Essay Concerning Human Understanding*, 1700.

Within the field of psychiatry proper, phobic phenomena began to receive increasing attention during the second half of the nineteenth century. One of the historically important papers was published in 1871 by Westphal[78] who first introduced the use of the term "agoraphobia" to describe fear of wide streets, squares, or open spaces, and presented data on three agoraphobic patients.* Westphal described the agoraphobic reaction as determined by a fear that is "psychologically unmotivated"; that is, by an idea of danger which appears irrational and strange to the individual, but which dominates his behavior as he approaches the feared area. He also argued against some earlier theories that ascribed such fears to attacks of dizziness or to epilepsy.

The phenomenological similarity between phobias and obsessions led the descriptive psychiatry of the late nineteenth and early twentieth century, as represented in the writings of Oppenheim,[60] of Kraepelin,[49] and (to a lesser extent) of Pitres and Régis,[62] to lump them together, a tendency already implicit in Westphal's discussion of agoraphobia. The phobias as well as obsessions and "impulsions" were regarded as being, to a large extent, constitutionally determined, although Pitres and Régis placed considerable stress on the importance of the precipitating incident and on the emotional aspects of both the phobic and the obsessive reactions. In the early editions of Kraepelin's *Lehrbuch*, these conditions were classified under the neurasthenias; later they were reclassified under "compulsive insanity" which, in its turn, was designated as a psychopathic state. Although he considered these states to be a form of degeneration of the nervous system, Kraepelin admitted that such "degenerative" symptoms could occur in persons of superior intelligence whose intellectual capacity appeared otherwise unimpaired. Kraepelin, as well as Oppenheim, regarded the prognosis of phobias as unfavorable, although both mentioned that recoveries occasionally took place. The therapeutic measures recommended by Oppenheim included exercises aiming to accustom the patient to the phobic situation; in the case of agoraphobia, he suggested that the physician accompany the patient in walking across the feared open places. However, he also advised various somatic measures, such as washing the head in cold water and removal of nasal polypi.

A study utilizing the questionnaire method was carried out by G. Stanley Hall[36] and published in 1897. His statistical analysis of fears, based essentially on a classification of the feared objects, led Hall to advance the view that some fears represent vestigial traces of ancestral experiences, perhaps antedating limbs and visual space perception. According to him, the best evidence for the phylogenetic antiquity of the predisposition for fear rests on "the proportional strength of different fear elements and tendencies. Their relative intensity fits past conditions better than it does present ones."

Pierre Janet[39] submitted the phobic reactions to a more thorough psychological examination, relating them closely to hysterical paralyses, since both have the function of preventing the individual from carrying out some task he does not want to perform. In this conception the fear aspect is a secondary phenomenon rather than a cause of the phobia. Janet was the first to present a massive amount of observational data on the phobic and obsessional syndromes which had never before been exhaustively studied.*

However, it was Freud who introduced the truly dynamic conception of phobia. As early as 1895, in his paper "Obsessions and Phobias: Their Psychical Mechanisms and Their Actiology,"[32] he sharply delimited these two conditions from one another, designating the phobia at that time as a part of anxiety neurosis. But the fundamental psychoanalytic formulation of the mechanisms underlying the phobias is contained in his clinical study "Analysis of a Phobia in a Five-Year-Old Boy,"[27] published in 1909, which remains a classic exposition of the subject. It will serve as a basis here for the detailed discussion of these mechanisms.

* The term "claustrophobia" was introduced in the same year by Raggi.[64]

* Limitation of space prevents a more detailed exposition of Janet's hypotheses which originated in Charcot's theory of the hypnoid states of hysterical patients.

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Differential Considerations

First, however, it is necessary to introduce some distinctions whereby the phobias can be more carefully delimited from other types of fear reactions.*

Today we distinguish sharply between anxiety neurosis and anxiety hysteria (phobia). The clinical forms of anxiety neurosis may range all the way from acute kakon-crisis,† characterized by sudden onset and by violent excitation, to milder states of generalized anxiety. The anxiety neurotic suffers from a general fear of dying rather than from fear of a specific object. His anxieties are of a floating form, whereas the phobic's thoughts center on a specific object and subside when this object is removed. This is why phobic patients carefully avoid the anxiety-arousing object or situation.

Moreover, phobic fears must be differentiated not only from fears based upon realistic danger but also from those primarily involving an intellectual belief in the dangerous character of certain objects or situations. For example, a person is not necessarily manifesting a phobic reaction if he hesitates to travel by air because of his knowledge that plane accidents do sometimes happen. It is true that this rational consideration, which is based on statistical facts, may occasionally be overdetermined by a genuine phobia of flying. But then, the phobic component is precisely that part of the fear reaction which is independent of the intellectual estimate of danger and whose intensity is disproportionate to such intellectual judgment. An excellent description of these relationships can be found in *The Love and Fear of Flying* by Bond.[6]

On the other hand, a distinction must be drawn between the true phobias and the so-called panophobic reactions. The latter are usually pseudophobias, in which the fear is not attached to a particular object, although the patients seem to be afraid of many objects and situations. Indeed, such individuals fear anything and everything, especially any change. The phobias proper may be broadly grouped, according to their content, into those relating to objects and those relating to situations. Among the former we may cite the animal phobias; among the latter, stage fright, the fears of blushing in public (erythrophobia), of going out into the street, etc.

Another important distinction among the phobic reactions, which has proved the most practical of all classifications, was originally formulated by Freud[32] when he divided them into "(1) common phobias, an exaggerated fear of all those things that everyone detests or fears to some extent: such as night, solitude, death, illness, dangers in general, snakes, etc.; and (2) specific phobias, the fear of special circumstances that inspire no fear in the normal man; for example, agoraphobia and the other phobias of locomotion." The common—or, as Freud later designated them, universal—phobias thus are fears inherent in all human beings, but which have become intensified and have assumed neurotic proportions. Any normal person might experience fear at the sight of a snake, for instance, or when caught unprotected in a thunderstorm.

There is a wide range of variation with respect to the objects of phobic fears. Some of the more frequently encountered phobias involve fear of animals, of open or closed spaces (agoraphobia or claustrophobia), or of heights. But virtually any object may become the object of a phobia. Hence Hall's[36] idea simply to classify phobias according to the feared objects or situations, endowing each one with a special Greek name (gynophobia, peccatiphobia, botophobia, photophobia, etc.), is no longer considered useful, as one would have to add an infinite number of names to the list.

While cultural factors appear to have some influence on the choice of specific phobic objects, the incidence of some phobic fears seems to be much less subject to fluctuations.*

* Problems of differential diagnosis of phobias by means of the Rorschach test are discussed by Schafer[67] and by Klopfer and Spiegelman.[48]

† von Monakow[57] derived the appellation of this acute anxiety state from the Greek *kakon* = evil.

* Laughlin[50] aptly notes that syphilophobia, common in the 1920's, has become increasingly rare and in recent years was encountered only in association with schizophrenia; by contrast, the frequency of phobic fears of cancer appears to have risen. These changes, as he points out, seem to parallel changes in the rea-

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These are essentially the ones that correspond to the more universal experiences of space, darkness, water, etc., experiences which, in large measure, extend to early infancy. Indeed, as Freud[28] observed, such phobias are rooted in childhood, whereas others most often are acquired later in life.

¶ Pathogenesis

The processes involved in the formation of phobic symptoms are especially well illustrated in Freud's "Analysis of a Phobia in a Five-Year-Old Boy,"[27] commonly known as the case of "Little Hans." Usually, the origin of a neurosis can be traced only through a reconstruction of remote events, but in this instance the phobia came under study almost as soon as its manifestations appeared, and the boy's father, who conducted the treatment under Freud's guidance, was in a much better position than are most therapists to supplement the patient's statements with his own knowledge of certain relevant events.

Freud's classic case study deals with a child who refused to go out into the street for fear that a horse might bite him. At the root of the phobia, as the analysis revealed, was a conflict between the boy's instinctual strivings and his ego demands. His oedipal conflict and strong hostility toward his father gave rise to intense fears of punishment, that is, to castration fears, which became transformed into the phobic fear of being bitten by a horse. In other words, the horse was substituted for the father; an internal danger was changed into an external one, and the fear was displaced onto the substitute. It is easier to avoid an external danger than to cope with an inner danger that cannot be avoided.

These processes are characteristic of the phobic structure in general.

listic danger from the two diseases and also to reflect the greater publicity recently given to cancer. On the other hand, according to Laughlin, the popularity of some phobic objects—water, height, closed spaces, open spaces—apparently remained unchanged during the same period. In this connection, however, it should be noted that any intensified fear of disease is more likely to be hypochondriacal-narcissistic than phobic.

¶ Repression and Displacement

In phobia the original object of the fear is typically replaced by some other object, and the original source of the fear reaction becomes repressed. In the case of "Little Hans," death wishes against the father and fear of punishment for such wishes were repressed, because consciously they were unacceptable to the boy who also had strong positive feelings toward his father. However, his death wishes and fear of punishment (as well as still other psychic components) re-emerged in the form of a phobia consisting of fears that a horse would fall down and that a horse would bite him. The choice of a horse as object of the phobia appeared to have been overdetermined by various factors, including the fact that prior to the onset of the phobia Hans once had actually seen a horse fall.

The child was unaware of the symbolic meaning of his fear, thus the displacement provided a double advantage: he could go on loving his father, while the fear could be concentrated on an object more easily avoided.

As already indicated, his choice of the horse as the phobic object was by no means accidental. Before the outbreak of the phobia, Hans had shown a lively interest in horses. He had observed that they (and other large animals) had large "widdlers" (penises). This item of information led him to conclude that his father likewise had a large "widdler," and, as yet unfamiliar with the facts of sexual differentiation, he reached a similar conclusion about his mother. Such observations, moreover, served to reassure the little boy that his own "widdler" would grow larger as he grew older. But it is noteworthy that, after the phobic symptom had emerged, the work of repression extended also to the recollection of his observations of the "widdlers" of large animals, that is, of observations that undoubtedly had played a role in the choice of the horse as the substitute object in his phobic symptom.

In fact, the repression not only caused this substitution to be made but also encompassed the original affects. As Freud points out, the

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child's *hostile feelings* toward the father were replaced by a *fear* of the horse, so that the aggression was displaced (projected) to the outside. Nor were his sexual feelings toward the mother manifestly present in the phobic symptom, although the castration fear, symbolized by the fear of the horse, was in part derived from a fear of punishment for these feelings.

Even though a transformation of affect takes place in phobia, it is not as pronounced as in conversion hysteria where the original affect is more thoroughly repressed.

The degree of displacement in phobia may vary. Fenichel[21] mentions several categories, such as "sex phobia," eating phobias, fighting phobias, which primarily involve fear of temptation and where relatively little displacement occurs. In other types the degree of displacement is much greater, so that the symbolic meaning of the phobia is more effectively concealed and can be discovered only through prolonged analytic work. Thus the agoraphobic symptom may have a variety of remote meanings, including: (1) the idea of an open street as an opportunity for sexual adventure; (2) the idea of leaving home; (3) the idea that on an open street one may be seen and caught;[21] (4) the idea that some other person (usually a parent or sibling) may die while one is away from home; or (5) the idea of being born. In a less symbolic sense, agoraphobia also may represent a reaction to "equilibrium eroticism," that is, to a sexualized pleasure in the sensations of equilibrium while walking.[1]

Displacement is likewise conspicuous in claustrophobia, a symptom often traceable to intrauterine fantasies. According to Ferenczi,[23,24] there is a close association between claustrophobia and the idea of being inside the mother; the fear of being buried alive is often a transformation of the wish to return to the womb. He cites a case where claustrophobia and fear of being alone in any enclosed space acted as a defense against masturbatory temptation. Observing that skin and chest sensations are particularly prominent in claustrophobic anxiety, Lewin[51] attributes this fact to the fantasy of being inside the mother and to ideas concerning the tactile sensations and breathing of the fetus. This fantasy is also described by him as one of partial identification through oral incorporation.

These are but a few examples where displacement is prominent. It is actually a characteristic feature of most phobias. The assumption that the choice of the phobic object is determined by displacement is consistent with the theory that fears of early infancy affect the subsequent choice of the phobic object.

¶ Projection

Concomitantly with displacement, projection plays an important role in the phobic symptom formation. "Little Hans," as already indicated, harbored aggressive impulses against his father. These impulses he projected onto the object of his hostility, the father, thence displacing them onto the horse by which he feared to be bitten.

One might say that the general human tendency to create the outer world in the image of the inner world is especially intensified in the phobic's defense against anxiety. According to Fenichel,[21] even "the physical state of sexual or aggressive excitement" may be projected and experienced in sensations of equilibrium and space. (Whether this kind of projection can still be characterized as anxiety hysteria seems doubtful.) However, although in phobia the ego structure is more severely impaired than in conversion hysteria, the projection here is far less extensive than it is in psychosis. Unlike the paranoiac, the phobic remains capable of reality testing; most usually he is aware that his anxiety is subjective rather than based on objective danger.[59]

¶ Identification and Regression

The role of identification in phobia has been described by many authors. Deutsch[14] showed that the phobic fear of going out alone in the street is closely bound up with ambivalences which frequently can be traced back to the oedipal situation. In some instances of animal

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phobia (for example, the case of hen phobia described by Deutsch), analysis revealed the existence of an earlier identification with the animal which subsequently became the phobic object.[56]

In the case of "Little Hans," the realization that large animals had large "widdlers" became fused with his own wish for a larger "widdler." This occurred by way of identification, thus paving the way for the replacement of the father by the horse in the phobic symptom.

The process of identification may take a more primitive form. Thus the idea of being devoured by animals, a common phobic fear in childhood, is based upon a regression to the oral stage of development. The classical illustration is the fear of being eaten by the wolf, described in Freud's paper "From the History of an Infantile Neurosis."[29] Moreover, oral incorporation also characterizes many phobias of adults. For instance, a male patient related his phobic fear of bridges to a fantasy of crossing into a dangerous country where he might be devoured by prehistoric animals. Since phobic reactions are indicative of regressive processes in the same measure as they place the person in a situation of infantile dependency, this regression is especially marked in phobic syndromes which restrict the patient's locomotion and make him continuously dependent upon a companion.[3, 14, 21]* But to some extent it is inherent in all phobias; they all impose some restriction of action not caused by objective reality. Viewed from this standpoint alone, regression would seem to be minimal where the phobic object is quite remote and easily avoidable, as in a phobia of some rare or exotic animal. This general consideration, however, is not the only criterion for the existence of regression in phobic reactions.

* It may be relevant, in this connection, to note Abraham's[2] comment that the fear of walking in the street usually occurs in persons who are also afraid of being left alone indoors. The common feature of the two feared situations is seen in the fact that "the unconscious of such patients does not permit them to be away from those on whom their libido is fixated," and that "any attempt by the sufferer to defy the prohibitions set up by his unconscious is visited by an anxiety state." Thus, in the cases covered by Abraham's generalization, the term "agoraphobia" describes only one aspect of the manifest phobic picture.

Evidence of regressive features is frequently found in the symbolism utilized by the phobia. For example, in the case of "Little Hans," the repressed impulses themselves—sexual wishes toward the mother, death wishes toward the father—were predominantly of an oedipal kind, in keeping with the child's developmental stage. But his idea of being bitten by a horse contained, along with the castration symbolism, a strong oral-sadistic component characteristic of an earlier age.

◧ Symbolism in Phobias

To understand the meaning of a phobic symptom, we must delve into the complex and multifaceted structure of its symbolic content. Only thus can we uncover the real source of the patient's fear.

Coming back to the case of "Little Hans," we find that his fear was a result of a combination of many elements. He was not simply afraid of horses as such or of the street as such. He was afraid, on the one hand, that a specific kind of horse would bite him and that a horse would fall down on the street. But, on the other hand, his phobia also included heavily loaded furniture vans and other vehicles that might cause the horse to fall; and at one point he was afraid, moreover, that a horse would come into the room and bite him.

Freud showed that this diffuseness of the boy's phobia was "derived from the circumstance that the anxiety had originally no reference at all to horses but was transposed onto them secondarily and had now become fixed upon those elements of the horse-complex which showed themselves well adapted for certain transferences." The idea of the falling horse represented a death wish against his father, while the idea of being bitten by a horse having some specified characteristics represented a punishment for this wish. On another level, which emerged only later, the heavy furniture vans represented pregnancy and the falling horse represented his mother having a baby.

These ideas found their clear formulation in Freud's *Introductory Lectures*,[28] where he

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compared the content of the phobia to the manifest part of the dream: "it is a façade." Lewin, using this as a point of departure for his illuminating study on "Phobic Symptoms and Dream Interpretation,"[32] showed that the overdetermination of the phobic symptom is the work of the primary process, as is also true of the dream fabric. He treats the façade of the phobia as we are used to treat the manifest content of the dream. Indeed, as the case of "Little Hans" exemplifies, true phobias frequently consist of a condensation of various symbols which seem to be interrelated in a meaningful way. Moreover, as I have shown elsewhere,[33] and as Jones[42] had previously observed in his paper on symbolism, in the phobia—as in the dream—there is a certain affinity between the person and the symbols he chooses to express his unconscious imagery.

The following example is an illustration of phobic symbolism. An unmarried woman of twenty-six sought psychoanalytic treatment because of a fear of walking down a flight of stairs, an affliction from which she had suffered since adolescence. The clinical picture could be described as follows. When approaching the first step on her way downstairs she became frightened, and her legs stiffened as though paralyzed. She could not move her feet. Clinging to the bannister, she would move her left leg with great effort by lifting it first to the left, then to the right, before she could finally put her foot down on the step. Exactly the same procedure was then performed by the right foot, etc. Throughout her descent the patient's eyes were centered on her movements, as though she were a child learning to walk.

Her phobia had first appeared at about sixteen, in high school, when a teacher had warned the class to be careful in walking downstairs, as the stairs were rickety and had caused some minor accidents. Since then the phobia had persisted continuously for more than ten years.

The patient had an only brother three years her junior, who apparently was favored by the mother. When he was very small, the patient had hated him, teased him, and often threatened to leave him in the woods at night. She also used to frighten him by telling him that he was not the real child of their parents, but a foundling, and she felt gratified when the little boy would run crying and complaining to the mother about it. She remembered being scolded and punished by her mother, whom she had feared and disliked since early childhood.

Nevertheless, she felt pity for the mother, who, she believed, was being cruelly attacked by the father. When she was about eight or nine she used to overhear conversations between her parents and would not fall asleep until all noise had stopped completely. Many times she became frightened, felt anxious, wanted to scream, and wished her father would die.

At about six she had once walked into the bathroom and surprised the piano tuner while urinating. The man then showed his erect penis to her, and she told him that she had seen the same thing before on her father. It is significant that, in the early stages of her analysis, the patient found it difficult to remember having seen her father nude or having observed him in the bathroom; nor could she remember having indulged in masturbation before the age of ten or eleven, when she had started to masturbate regularly. However, she remembered an incident at the age of about nine. She had been playing with some other girls and boys in an empty carriage that stood abandoned in the back yard of their house. A boy slightly older than she tried to put his hand under her skirt. She became frightened, wanted to jump down from the carriage, and for some reason felt unable to do so. However, in her state of fright she somehow did leave her companions and went to complain to her mother.

When she was eighteen she worked as a secretary for a much older man who once attacked her from behind while she was standing near the files. She became frightened and left the office.

From that time on, there were several unsuccessful love affairs. One, with a young intern in medicine, lasted about two years. She hoped to marry him, but when he suggested a separation she accepted it without any protest or ill feeling; she understood, she said, that he could not afford to marry a poor

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girl because he needed money to establish himself in practice. She then had an affair with a much older man who likewise left her with some rationalization, which again she accepted. A third affair followed, with precisely the same pattern and the same outcome. In all these relationships she was completely frigid. As she put it, most of the time she would comply with the man's insistent desire to have intercourse and then consent to go on with the affair only because she was very much afraid of being blackmailed.

The patient's early jealousy of her brother persisted during adolescence; it became further increased when he was allowed to go to engineering school, whereas she had to renounce her own aspirations to study medicine. When he enlisted in the Air Force at the outbreak of World War II, she wanted to join the WAAC's or some other military women's auxiliary, but she was forced to give up this project because of a sudden increase of phobic symptoms.

The conflict about her femininity and her identification with the brother was brought out in many revealing dreams during the analysis. Very often she dreamed of being pursued by men who threatened to kill her; she would flee from the man in fright, then gloat as he ran into a mortal danger, but she would finally rescue him from this plight.

At a certain phase of the transference situation, the patient had a dream in which she stood on a small, round platform at the top of a long, narrow, endless flight of stairs. The entire structure was suspended in mid-air in a vast, arenalike space. As she stood on top, she became frightened, nervous, heard a voice telling her to go down the stairs. She felt unable to move and, looking down, thought that nobody could walk down these stairs. But the voice was telling her to go down, to move. Finally, she figured out that by sitting down she would gain more security: "If I were closer to the stairs, I would feel surer of myself." She then imagined that there were railings, and very cautiously somehow she began to descend. She kept her eyes closed until she had moved down some distance. Opening them, she saw that the stairs were beginning to close up at the bottom and were growing nearer and nearer to her. Then she heard another voice, telling her to turn around and go back. She felt paralyzed and unable to release her hold on the rails. With great effort she managed to take her right hand off the rail and to grasp the other rail with both hands, attempting to turn around. She did not remember going up, but thought that somehow she had done so, for she remembered then lying on the platform at the top of the stairs and sobbing. At the same moment the stairs seemed to twist like a snake, but they were stationary the rest of the time.

This dream, in which the patient's phobic experience was minutely enacted, became fully understandable only through the analysis of another anxiety dream soon thereafter. This time no stairs appeared in her dream; the dilemma consisted in having to cross a bridge, but of being threatened with death if she did so.* Her associations to this dream led to hitherto inaccessible childhood memories, including the recall of two decisive experiences at the age of five or six:

1. The patient remembered that she had slept in the same bed with her parents. Half awake, she had witnessed intercourse between them. She remembered exactly how her mother had pushed her father away, saying to him: "Turn your back, it's enough." The father then had turned toward herself, put his arms around her, and touched her with his wet penis. She had been frightened, as if paralyzed, wanting to jump out of bed, to scream and holler at her parents, but unable to do so. This was all she could remember about this incident. But she immediately related the words spoken by her mother, "Turn your back," to the dream in which an invisible voice told her to "turn around and go back." She was as paralyzed in the dream as she had been when lying in bed with her parents. It became clear that the movement of the stairs and the trembling of the platform represented the shaking of the bed during the parents' intercourse.

* This dream and its interpretation were previously reported by the author in a paper on bridge symbolism.[35]

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2. The second memory concerned an incestuous game with her brother, which had taken place on several occasions near a window overlooking a bridge. While engaged in this forbidden sexual activity, the little girl had guiltily looked through the window, watching lest someone should come.

Thus the analysis of these two dreams showed that the bridge and the stairs were really interchangeable. Both were symbols crystallizing the conflict at the base of the phobia: desire and punishment for incestuous sexual pleasure.

This brief fragment from the patient's history and analysis has served to demonstrate the sadistic and self-punitive trends underlying the structure of her phobia. From a tender age she had harbored hostile and aggressive impulses, and the analysis revealed intense murderous wishes toward the brother whom she had used in her incestuous play. Her guilt feelings and self-punishment were at the basis of her masochistic behavior. It is not intended to elaborate further on this case, which was reported mainly as an illustration of the interrelation between symbol and phobic symptom.

The symbolism of the stairs, so often used by Freud, is especially transparent in the staircase dream supplied by Rank (and included only in the latest edition of *The Interpretation of Dreams*).[30] It is interesting to note that the connotation of this symbol here is not static but kinetic, a concept described in my aforementioned paper.[35] There, too, the bridge symbolism represents a dynamic process of crossing.*

Stairways and bridges seem to be closely connected and often used interchangeably. Both represent links (one vertical, one horizontal) between one place or condition and another.

There are other sets of symbols presenting similar affinities; for example, all vehicles or all animals, respectively, are interchangeable. By the same token, an original monophobia may progressively spread to other objects belonging to the same associative constellation.

* Gerhart Hauptmann, in his book *Griselda*, makes use of the symbolism of stairs, giving it also a sexual meaning. This was cited by Reik in *The Secret Self*.[66]

If we noted before that virtually any object can become the object of a phobia, we may now add that any symbol can be used to express a variety of meanings. Taking the phobia of the elevator as an example, it may stand for a fear of the *claustrum*; it may stand for a fear of height; or it may, like any phobias involving vehicles of locomotion, stand for a fear of sexualized sensations of equilibrium and space.[21]

The foregoing considerations are of importance because they shed light on the obscurities behind the façade of the phobic symptom.

While the psychoanalytic theory places considerable emphasis on symbolic substitution in phobic symptom formation, some authors, notably Rado[63] and Lief,[53] stress the role of the "sensory context" in the acquisition of phobias. Indeed, phobic reactions may become attached to the "sensory context" of a traumatic experience, but upon closer scrutiny the latter may prove to be a precipitating rather than a causative factor. Phobic reactions which are largely a result of sensory conditioning, and in which symbolic substitution plays a less prominent role, might correspond roughly to the processes described by Dollard and Miller.[16] In their view, phobias are essentially avoidance responses acquired as a result of painful experiences.*

¶ Phobia in Children

Phobias "are *par excellence* the neuroses of childhood."[27] Indeed, there is scarcely a human being who has not, at some time in early life, experienced fear of a phobic nature.

The classical case history of "Little Hans" is especially illuminating also because it demonstrates a typical causative factor which often

* In a recent paper, Dixon *et al.*[15] maintain that it is "both incorrect and misleading" to consider phobias as isolated symptoms and that "any apparent specificity of the complaint may in fact be due to an unconscious displacement." While the statistical analysis presented by these authors is highly interesting and instructive, exception must be taken to their conclusion that the phobia is not a distinct entity. The fears dealt with in this study seem to be symptoms of various clinical conditions.

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gives rise to infantile phobias—the little boy's castration fear. In girls we may find a corresponding factor in fantasies of previous injury to the genitals. Bornstein[8] reports a case of this kind, where the child's belief that her genital had been injured produced a phobia as early as the third year of life.

Castration anxiety and its feminine counterpart, however, are by no means the only major source of childhood phobias. Symbolic threat of sexual attack plays an important pathogenic role in girls[70] and in boys with passive homosexual tendencies. Moreover, phobic reactions in both sexes frequently originate in separation anxiety. Thus, Abraham[2] reported a case of childhood agoraphobia that could easily be traced to the child's desire to be with the mother, an observation which is corroborated by interpretations of agoraphobia by Weiss,[76] Deutsch,[14] and other psychoanalytic authors.*

Separation anxiety seems to be responsible for a variety of phobic reactions which in recent years have received a great deal of attention under the general description of "school phobia." As suggested by Johnson *et al.*[41] and corroborated by more recent studies, school phobia is a syndrome occurring under very definite circumstances which include: (1) "a history of a poorly resolved dependency relationship between a child and its mother"; (2) an acute anxiety in the child "produced either by organic disease or some external situation . . . and manifested in hysterical or compulsive symptoms"; and (3) a recent frustration or threat suffered by the mother, increasing her need to exploit the child's dependency relationship, with the result that separation from her when going to school becomes a traumatic experience.[41] However, separation anxiety is certainly not the only causal factor in school phobia.†

Because of the young child's identification with the important persons of his environment, we often find a predisposition to phobia in children of phobic parents. Hence the child psychiatrist may find it necessary to recommend treatment for his patient's parents in order to remove such pathogenic influences. A more exhaustive discussion of childhood phobias would exceed the frame of this chapter.

A childhood phobia may be a transitory disturbance or may continue into adult life. However, not all phobias start in childhood. In treating adult patients, we are often confronted with the question whether the development of a phobic symptom actually represents a new disturbance or a reactivation of an earlier neurosis, a point that may be important in the choice of therapeutic procedures.

¶ Some Remarks on Therapy

In dealing with phobic disturbances the therapist will be guided by the same general principles as in the treatment of other psychoneuroses. As we know, however, there is always some fluctuation and haziness in the manifest content of a phobia, and considerable probing may be needed before this manifest content can be accurately described. Sometimes, symptoms can be eliminated by supportive measures alone. In childhood phobias, for instance, this will essentially consist in accustoming the child to the feared situation. Thus it has been found that a child's fear of school* often can

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* Katan[45] has suggested that a mild form of agoraphobia may be considered a normal phenomenon in the development of the adolescent girl.

† An interesting manifestation which at one level might be regarded as a school phobia, but which in reality was merely a reactivation of an earlier and more idiosyncratic phobic structure, is reported in Freud's case history of the "Wolf Man."[29] This patient, while in school, developed a fear of a teacher who was quite critical of him and whose name happened to be Wolf. As the patient had had a wolf phobia (or, more precisely, a fear of a picture of a wolf drawn in a particular position) in early childhood, the teacher's name apparently reactivated some of those early fears. (Even much later in life the patient reacted with panic when he consulted a dentist named Wolf. Reported in R. Mack-Brunswick's "A Supplement to Freud's 'History of an Infantile Neurosis,'" in *The Psychoanalytic Reader* [R. Fliess, Ed.], Vol. 1, pp. 86–126. Published by International Universities Press, New York, 1948.)

* It may be interesting to cite here the following passage by Locke:[55] "Many children, imputing the pain they endured at school to their books they were corrected for, so join these ideas together, that a book becomes their aversion, and they are never reconciled to the study and use of them all their lives after; and thus reading becomes a torment to them which otherwise possibly they might have made the great pleasure of their lives."

be gradually overcome if he is brought to the school every day but not forced to attend classes or to participate in any prescribed activities.[46] Under these conditions, "going to school," as such, becomes less threatening, and this decrease of the child's fear may then be extended to the specific object or situation (teacher, classroom, etc.) on which the phobia really centers.

In some cases of early childhood phobia, it may be necessary for the therapist to include certain educational measures, such as explanation of the anatomical differences between the sexes, reassurance to the little girl that her sexual organ is intact, to the young boy that he is in no real danger of being castrated. In dealing with such infantile anxieties, the educational and analytical part of the work cannot be rigidly separated. The cases reported by Bornstein[7,8] and by Sterba[70] illustrate that some initial analytic work is indispensable to determine precisely what the child fears or to establish the pattern of communication best designed to convey the needed reassurance.

In children, as well as in adult patients, genuine phobias marked by a high degree of symbolic displacement require systematic psychoanalytic treatment. This method aims to uncover the symbolic meanings of the symptom and to interpret changes of these meanings in terms of the changing transference situation.

In his paper "Turnings in the Ways of Psycho-Analytic Therapy," Freud[34] stressed the necessity of exposing the phobic patient to the dreaded situation or object, and he warned that "one can hardly ever master a phobia if one waits till the patient lets the analysis influence him to give it up. He will never in that case bring for the analysis the material indispensable for a convincing solution of the phobia."

Hence it is very often necessary for the analyst to intervene more actively and to insist that the patient brave the phobic situation. In this way the full strength of the underlying conflict can be evoked in the associative material. Evidently, the analyst will await a propitious phase when the patient's positive transference may help to reduce the phobic fear. This more active intervention in the analysis of phobias constitutes an exception to the standard psychoanalytic procedure.

To give an example: An agoraphobic patient was referred to me after having been treated by several other therapists over a period of seven years. She had always been accompanied to their offices by her husband, and for a short time I permitted this arrangement to continue. But as soon as the transference situation appeared propitious, the patient was requested to come alone. She complied readily, but had to telephone me before each session in order to assure herself that I was expecting her. After a few months she became able even to go unaccompanied to her place of work, although she still had to call me very frequently to feel secure.* Her evident dependency needs and defensive devices, as well as the strong hostility underlying her dependency, could then be analyzed in the light of the transference situation. It thus transpired that the phone calls served to reassure the patient that her death wishes against the analyst as a transference object had not materialized. Her transference manifestations revealed the characteristic ambivalence toward identification figures which has been described by Deutsch,[14] Katan,[45] and other authors as among the basic factors in agoraphobia. I may add that this patient's feelings of dependence displayed, in rather transparent form, a "linkage fantasy"[61] whereby an identity between herself and the analyst (as a symbolic parent figure) was asserted by magical means.

To repeat, psychoanalysis is the treatment of choice; it is the method best designed to yield insight into the meaning of the phobic symptom and the underlying psychic conflicts. However, the psychiatrist, in his daily work, is called upon to deal with situations where regular analytic treatment is not feasible and where early relief of the symptomatology seems imperative. There are, of course, numerous methods by which such relief may be achieved.

* In a somewhat similar vein, Deutsch[14] mentions an agoraphobic patient who, in a state of positive transference, was able to go unaccompanied to the analyst's office, and whose fear of walking alone was considerably attenuated with respect to the analyst's neighborhood.

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Unfortunately, limitations of space make a detailed discussion impossible here. A psychotherapy based on dynamic principles is certainly the most appropriate method, especially in cases where deep repression and symbolic substitution are not too marked.

Hypnosis has been used with some success in the treatment of phobic disturbances. But however spectacular and immediate the results may appear, they by no means reach the goal of a truly dynamic therapy. As long as the underlying conflicts remain untouched and unconscious, the patient is prone to develop a new phobic symptom in place of the one removed.

Since phobic patients realize the irrationality of their fears, direct suggestive therapy is not effective. Sometimes it may even strengthen the patient's guilt feelings or intensify his hostility toward the therapist and resistance to the treatment. And when such attempts at rational persuasion seem successful, it is usually due to rapport rather than to logical reasoning.

The phobic patient, more than any other neurotic, can become a faithful ally of his therapist in the struggle against his ego-alien and tormenting symptom. His need for dependency and protection and his will to recover offer excellent chances for successful treatment, if it is undertaken in the early stages of the illness. But only the therapist's skill and understanding of the dynamics will enable the patient to overcome his resistance and to give up his neurotic defenses.

The ambivalent struggle of an agoraphobic patient, as she anticipated her first unaccompanied visit to her therapist's office, was expressed in the following verses:

Which Epitaph Shall Be Mine?

She couldn't try
For fear she'd die;
She never tried
And so she died.

or

She couldn't try
For fear she'd die;
But once she tried
Her fears—they died.

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CHAPTER 16

THE ANXIETY STATES

Isidore Portnoy

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IT IS CLEARLY EVIDENT that awareness of anxiety as a painful affect is increasing in the Western world. Rennie *et al.*,[47] in a study of a compact central residential area in New York City, found anxiety in 75.5 per cent of the study population. While such a finding no doubt depends on the criteria used, it gives some idea of the extent of the problem. The movement toward ataractic philosophies and drugs, sharply accelerated in recent years, supports the statistical studies. It is clear that anxiety and this movement toward peace of mind must have the most far-reaching consequences for the growth of the individual and the development of the social structure.

Anxiety-producing factors in our culture grow progressively more numerous and intense, while anxiety-relieving agencies have become sharply and increasingly less effective. The cold war and the threat of atomic annihilation are recent additions to the long list of factors that make this the age of anxiety. Perhaps more fundamental are the increasing strains and pressures experienced by individuals living in a period characterized by great complexity, cultural disunity and instability, rapid change, and the mingling of varied and differing cultures. Group identifications, including those of family and community, are weak. In an atmosphere of hostile tension, deriving largely from the competitive character of our society, man's isolation has increased. The particular character of "the search for glory" (Horney,[20] p. 17) in our culture, with its emphasis on status, success, superiority, and perfectionism, has shaped man's view of himself, so that his sense of identity depends on the degree to which he can fulfill the requirements of this particular religion. This is a period characterized further by the undermining of many of the basic values, definitions, standards, beliefs, and illusions which previously provided the foundation for man's orientation to himself, to others, and to life. The passing of the age of the powerful "fathers" has left the "sons" free to make their own way. As the period of angry rebellion subsides, man increasingly faces the difficulties involved in responsibility, choice, and freedom, as he moves with doubt and uncertainty on a road on which the directional signs are at best unclear, at worst, conflicting. Kelman[26] (p. 140) has noted that disintegration can lead to healthier as well as to sicker reintegration.

This is the possibility and the challenge that man faces. His anxiety is an expression of the cultural disintegration in our time.

¶ Basis of Definition and Classification

Although considerable progress has been made toward a deeper understanding of the psychodynamics of healthy and sick personality, psychiatric nosology continues to be based on presenting symptomatology. The various schools of psychiatric thought have dealt with the problem of diagnosis and classification in terms of their own particular theory of human motivation, but none of these classifications has gained widespread acceptance. Retaining the descriptive diagnostic category of anxiety states has value for the psychiatrist because it does not fix his thinking in any rigid mold of theory. It has the further advantage of keeping open avenues of communication by providing a language that all can use, however limited its symbols may be in conveying the essence of the underlying pathology. Furthermore, anxiety is more than a symptom complex. It has its own dynamisms, so that the term "anxiety states" has psychodynamic as well as descriptive value.

The anxiety states are defined as neurotic syndromes characterized by more or less chronic apprehensiveness with recurring episodes of acute anxiety. These states are to be distinguished from the condition of pervasive anxious concern which may be considered normal for our times. Not included in this classification are the transitory episodes of acute anxiety occurring in more or less healthy individuals under overwhelming stress. Phobic, conversion, dissociative, obsessive-compulsive, depressive, and psychosomatic phenomena are invariably present to some degree. Where they dominate the picture, the appropriate diagnosis is made. The difference between these conditions may be viewed as expressions of the particular ways in which the individual deals with his anxiety and conflicts. As Martin[84] has indicated, awareness of imminent total involvement in conflict is what threatens in anxiety. In this view, it is the anxiety state which the phobic, compulsive, etc., individual is attempting to avoid. The particular psychosomatic, conversion, or phobic symptom is a symbolic expression of the underlying anxiety and conflict.

While clinical anxiety may be manifested in a great variety of symptoms,[2] each person has his own characteristic way of feeling anxious. The most typical picture is that of subjectively experienced uneasiness, apprehension, anticipation of danger, doom, disintegration, and going to pieces, the source of which is unknown by the individual and toward which he feels helpless, with a characteristic somatic pattern. This somatic pattern shows evidence of increased tension in the skeletal muscles (stiffness, tremors, weakness, unsteadiness of voice, etc.); the cardiovascular system (palpitation, flushing or pallor, faintness, rapid pulse, increased blood pressure, etc.); and the gastrointestinal system (nausea, vomiting, diarrhea, etc.). There may also be other manifestations such as cold wet extremities, rapid or irregular breathing, frequency of urination, and sleep disturbances. Subjective awareness of anxiety may be slight or absent, though physiologic evidence may be readily noted by the observer. The many devices for lessening awareness of anxiety include rationalization, denial, narcotization by alcohol, drugs, sleep, sex, work, activity, and avoidance of any feelings, thoughts, and experiences which could evoke the anxiety response (Horney,[21] p. 49). The question of unconscious anxiety is an important theoretical and practical one (Reid,[46] discussion by Kelman).

¶ The Nature and Meaning of Anxiety

Comprehension of the phenomenon of anxiety is essential to an understanding of healthy growth as well as neurotic development. Our present understanding is the product of theoretical concepts and experimental research to which many have contributed. Which contributions are given the greater weight will be determined by one's particular frame of reference. For me, the works of Kierkegaard,[28, 29] Freud,[5, 6, 7] Goldstein,[15, 16, 17] Cannon,[3] Sulli-

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van,[54,55] Simpson,[52] Kelman,[25,26,27] and above all Horney[20,21,22,23] have constituted essential elements in understanding for the following reasons: Kierkegaard saw "the sickness unto death" as the despair resulting from the loss of self and laid the groundwork for the view that anxiety is an inevitable aspect of being alive and neurotic anxiety the experience of dissolution of the self, nonbeing, and meaninglessness. Freud pioneered explorations into man's inner life, discovered the role of unconscious phenomena (most particularly inner conflicts) in determining the sources of neurotic anxiety, and recognized the crucial significance of anxiety for the development of the individual and the elaboration of his neurotic and psychotic states. Goldstein brought the holistic view of the organism into the field and recognized that "anxiety may be produced by a variety of events, which have one common element—there is always a discrepancy between the individual's capacities and the demands made on him which makes self-realization impossible"[15] (p. 90). Cannon did pioneering work in the field of homeostasis, so that the phenomena in anxiety may be viewed biologically as expressions of threats to, temporary failure of, and attempts to restore homeostatic equilibrium on a new level. Sullivan viewed the human being as an integral part of culture, so that anxiety is seen as arising from a threat to the individual's security in interpersonal relationships. Simpson, with his view of human evolution, provides a biologic base for thinking about man's values which are threatened in anxiety. Kelman brings unitary-process thinking into the field of psychiatry, his basic premise being that "organism-environment is a single, integral reality" and ". . . the patterns of this reality can better be formulated in a language of process. Tension manifested in physical and psychological patterns is one attribute of this hierarchical system. When the mean level of tension in this unitary system is exceeded, anxiety becomes manifest"[26] (p. 151). "Anxiety is cued off when tension develops beyond the mean due to the organism's attempts to integrate in an environment for which it is not adequate and which is not adequate for it. Anxiety appears in the phase of disintegration of the natural cycle, disintegrating-reintegrating as aspects of integrating"[26] (p. 143). Horney's concept of self-realization, anxiety as the dynamic core of neurosis, and acquired conflict and solutions to conflict as the body of the neurotic structure will be elaborated in later sections of this chapter and in Chap. 71, Vol. II ("The Holistic Approach," Kelman).

May[41] has provided a definitive summary and synthesis of the dominant anxiety theories, in addition to contributing his own important emphasis on the crucial role of man's valuating capacity in the phenomenon of anxiety. In the field of present experimental research, the works of Funkenstein,[10] Grinker,[18] Liddell,[31] Masserman,[37,38] Rioch,[48] Selye,[49] Wolff,[57] and others have contributed to the movement in the direction of a holistic biologic approach to the phenomenon of anxiety.

Any attempt to define the nature and meaning of anxiety must begin with the statement that anxiety is a natural phenomenon which the individual experiences when values essential to his existence, his sense of being, and his identity are threatened. It is to be distinguished from fear in which the threat is peripheral, the intactness of the sense of being is not being threatened, the danger is objective, and the individual can evaluate it and can act either in terms of fight or flight in coping with it. Goldstein[17] (p. 296) believes that fear is the experience we have when we anticipate the possibility of the onset of anxiety. Sheiner,[51] stressing the significance of the individual's fear of anxiety, feels that the essential difference between fear and anxiety is that in fear the individual is able to act, ". . . is conscious of himself, his resources, and his surroundings. He is still an integrated personality."

Even more essential is it to distinguish normal anxiety and healthy involvement in anxiety from neurotic anxiety and neurotic involvement in anxiety. When we speak of normal anxiety, what we mean, essentially, is that it is man's nature to have anxiety in the face of certain kinds and degrees of threat. In brief, it is the ultimate expression of our being human rather than gods. (This constitutes one

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of the reasons why anxiety is so unbearable, particularly for the neurotic individual who has the need to feel omnipotent.) In normal anxiety we face the limitation of our powers, the degree of our vulnerability—limitations and vulnerability which are not expressions of illness but are inherent in the nature of man. What gives human anxiety its particular quality is man's ability to be *aware* of his finiteness. We experience normal anxiety in the face of such realities as death, old age, and illness, as we recognize our factual helplessness. The anxiety of an infant is similarly based. We experience normal anxiety whenever we move from the old, the sheltered, the known, the tested, and the certain into the new, the unknown, untested, and uncertain; that is, whenever we "stretch," expand, move forward. In this view, normal anxiety is an inevitable accompaniment of healthy growth and change in the direction of greater freedom, autonomy, and creativity as we move toward increasing fulfillment of our innate constructive potentialities. We may assume that no individual's striving toward self-realization is ever so completely crushed that he does not experience such anxiety to some degree. We experience normal anxiety in the uniquely human endeavor to find a meaning in existence. We experience it when we are involved in healthy conflict or the clash between opposing convictions and genuine values. In our culture, love, freedom, equality, respect, prestige, and success, when not compulsive, may constitute more or less normal values, any threat to which may evoke anxiety.

We can speak of healthy involvement in anxiety in terms of the individual's response to these threats and challenges. To the extent that the individual is able to respond with courage, that is, to call on still more of his resources to meet, master, or, at least, endure the threat, we may speak of a healthy involvement in anxiety. Here the individual responds to the anticipation of impending self-disintegration by asserting, at the decisive moment, "I am." In this process of owning, facing, and meeting the experience of anxiety in its anticipatory phase is involved an assertion of selfhood of such significance that the experience of psychic annihilation, which is such an inevitable component of neurotic anxiety, is greatly diminished or is absent. Instead of the characteristic neurotic response in anxiety, which is neither to fight nor to flee but rather to shrink, to vanish as a self, in healthy anxiety, when the threat to selfhood has been perceived, consciously or unconsciously, and the possibility of ultimate disintegration accepted, the human being responds with an affirmative assertion of his being. It must be emphasized that this is not a response *to* anxiety but is actually an aspect of healthy involvement *in* anxiety. Two of the main results of such healthy involvement are an increment of growth and a significant change in the quantity and quality of the anxiety experienced, symbolized in flushing and body heat, as contrasted with blanching and body coldness in neurotic anxiety.

What makes it possible for an individual to have this courage to be, so that the anxiety experienced is a constructive spur to healthy growth rather than a paralyzing, disintegrating block? What, in other words, are the dynamics of courage? It is not within the scope of this chapter to explore at length this most fundamental question. Briefly, courage is an expression of the healthy state, the process of self-realization which is the unfolding and developing of the constructive potentialities of the real self (Horney,[20] p. 364). To the extent that the human organism is genetically and physically intact, and providing that his personal milieu, particularly in infancy and childhood, is favorable, self-realization will naturally occur. In this process, the following conditions evolve: (1) healthy character structure, manifested chiefly by wholeness—the owning by the individual of all aspects of his being, more or less; (2) spontaneity, the capacity for genuine, as differing from compulsive- and anxiety-dictated feeling and behavior; (3) inner unity, which gives the individual stability and a sense of his own identity; (4) good relationship to other human beings and to the community, expressed in the ability to move flexibly toward them in cooperation and love, against them in differing, opposing, and fighting, and away from them in the ability to

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stand alone, separate but not isolated from others, accepting the interdependence which is an aspect of man's being in community; (5) a good relationship to himself, which includes a realistic respect for his assets and limitations, the capacity to take responsibility for and be critical of moral and other shortcomings (healthy guilt, that is, with compassion), and the incentive to reach and extend his capacities without unreasonable demands for perfection; (6) a hierarchy of values arising out of genuine conviction rather than compulsive conformity or defiance; and (7) an affirmative attitude toward life, with a zestful interest in availing himself of opportunities for fulfillment and the acceptance of struggle as an invariable component of living. To the degree to which the individual can move in this direction, he will be able to have a sense of his own "I" and be able to affirm "I am" in healthy anxiety.

The phenomenon of neurotic anxiety differs from this picture in the nature of what threatens the individual and what is being endangered, but most of all in the nature of his involvement in anxiety. In neurosis, not only does the individual experience *Urangst* and the challenge of growth, but he also faces a host of threats, which endanger aspects of the neurotic character structure which he must maintain out of a stringent inner necessity to protect his feeling of safety and unity, and which have acquired enormous subjective value for him, so that he also must protect them in order to maintain his sense of identity and his feeling of worth. At the core of neurotic anxiety is a feeling of utter helplessness which pervades his being, stemming most particularly from his lack of a feeling of wholeness, derived from his dissociation from, denial, repression, externalization of, and active alienation from major aspects of his being, particularly the perceptual, sexual, and organic. The individual's feelings and behavior are dictated by compulsiveness, so that he is driven rather than moved, and cannot feel that he is an active force in his own life. Disunity pervades his whole being and is an expression of unresolved inner conflicts, so that he is unable to have a firm sense of his own identity. His relationships to others and to the community are impaired and are expressed in compulsive needs for dependency and symbiosis, aggression and domination, detachment and isolation. His relationship to himself is also impaired, involving both an extreme undervaluation of his own actual assets and possibilities and an equally extreme illusion of his own perfection, superiority, and invulnerability. This leads to intense self-hate when he cannot fulfill fantastic demands on himself (neurotic guilt), so that, to a large extent, he is both a stranger and an enemy to himself. His system of values derives from his need for safety and his search for glory. He has a negative attitude toward life, focused largely on avoiding struggle and pain. To the degree to which the individual has moved in this direction, he responds to threats to his being with feelings of intense helplessness and the previously noted attempts to shrink, to vanish, to curtail and restrict awareness, experience, feeling, and living. What causes this state will become clearer when I discuss the psychodynamics of the anxiety states.

¶ Anxiety as a Multidimensional Phenomenon

When we say that anxiety is a multidimensional phenomenon, we mean that the total organism is involved in every aspect of it—the individual's perception of the threat, his interpretation of it which involves his uniquely human capacity to symbolize and abstract, the role of the past in the present as well as the capacity to evaluate future possibilities, conscious and unconscious decisions concerning his way of coping with the threat, all within the context of his interpersonal and cultural milieu. I wish to make some reference at this point to the somatic dimension of this phenomenon.

The inseparability of the somatic, psychological, and interpersonal aspects of anxiety has been widely noted in recent experimental work. The varied responses of Masserman's[87] monkeys to tranquilizing drugs led him to conclude that "it is impossible to state the effects of

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any drug on any organism without considering the latter's genetic characteristics, past experiences, biologic status, and perceptions about, motivations toward and evaluations of its current and social milieu." Funkenstein's[10] Harvard students showed specific cardiovascular responses related to the emotional response in acute emergency. Individuals who responded to the experimental stresses with "anger out" showed a cardiovascular pattern characteristic of that produced by the excessive secretion of a substance similar to norepinephrine, while individuals who responded with "anger in" or severe anxiety showed a cardiovascular pattern characteristic of that produced by the excessive secretion of a substance similar to epinephrine. These studies demonstrated that the "anger-out," "anger-in," and severe-anxiety responses were determined by a host of factors, including the individual's personality, his cultural status, the nature of the threatening experience, and the relationship to the examiner. The individual's response in acute emergency was felt by Funkenstein to be determined by the individual's basic disposition, in which are combined innate biological factors and psychological factors involving his very early childhood experiences. Aspects of personality which Funkenstein found to be correlated to these acute emergency responses are the individual's perception of his parents, his internal concept of self, his fantasies, social attitudes, and social stratification. On the other hand, Funkenstein found no significant relationship between the individual's response in emergency and his ability to handle stress as time passes. He felt that the latter was an expression of ego-function related to the entire life experience of the individual. He found that the ability to master stress was correlated with the nature of the individual's interpersonal relationships, ability to assess reality, and the integration of his personality. One result, pertinent to our understanding of the interpersonal character of anxiety and having important implications for therapy, occurred when one examiner's doubts and anxieties about the experiments resulted in a response of severe anxiety in *every man* tested by him, results quite opposite to those obtained by other experimenters where anger was the subjects' most common response. Equally significant was the finding that the major conflicts evoked in these subjects centered around hostility—either fear of their own hostile and aggressive feelings or a fear of hostile retaliation. In brief, the subjects did not react, they responded.

While Cannon's formulations concerning the physiology of emotion, the fight-flight response, and homeostasis continue to constitute focal points for much of our present thinking, there is a definite trend toward thinking in more holistic terms about the physical aspects as well as the other major aspects of the anxiety process. Recent work[33] has focused on the role of the reticular activating system in the brain stem in the phenomenon of anxiety as well as in the processes of consciousness and arousal. Beginning with the thesis that the cortex exercises an inhibitory action on the lower centers, Malmo[33] (p. 45) suggests that "pathological anxiety is most probably a state characterized by reduced central inhibition," and, following Eccles, suggests that there is a chemical transmitter for inhibition, the effectiveness of which has been significantly decreased, perhaps as a result of attrition, "possibly produced by mechanisms described by Selye" (p. 47).

Although Gellhorn[12] (p. 359) finds that Cannon's thalamic theory of emotion has in the main been corroborated, Spiegel,[53] in a review of fifty-eight cases of individuals treated by various psychosurgical procedures, noted that "it is not possible to refer emotional reactions to a single circumscribed nucleus within the diencephalon or its connections with the frontal lobes, but that there exists a multiple representation of this function." Gerard,[13] (p. 431), commenting on these findings, stated: "If, as I suspect, the patterns of activity of great numbers of neurones proves more crucial than whether or not any particular neurones participate in the pattern, the final answer will come more from functional than from localization studies." Here, too, we note the trend toward pattern thinking, with emphasis on integration rather than on localization of function.

Similarly, there is increasing evidence that

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the homeostatic mechanisms involve the organism far more extensively and in a far more complex manner than had previously been recognized. The pattern of organismic response in acute stress appears to involve the hypothalamic-thalamic-cortical tracts as well as the reticulo-thalamic-cortical connections in its upward discharge, and the hypothalamic-sympathetic-adrenal medullary system in its downward discharge, with the familiar peripheral effects of sympathetic excitation—raised blood pressure and pulse rate, inhibited peristalsis, palmar sweating, dryness in the mouth, etc. At the same time, involvement of the parasympathetic branch of the autonomic system, expressed peripherally in increased frequency of urination, emptying of the rectum, slowing of the heart rate, and lowered blood pressure, etc., are frequent aspects of the anxiety picture, particularly when stress is prolonged. These parasympathetic expressions may dominate the anxiety picture, as may also expressions of the participation of the somatic nervous system in the downward discharge. While the synergistic action of the sympathetic-adrenalin and the vago-insulin mechanisms appears to be a physiological necessity for the organism's capacity to fight or flee in the face of danger, the precise factors which account for the dominance of sympathetic or parasympathetic response in anxiety remain rooted in deeper aspects of personality functioning, the dynamics being as yet unclear.

Investigations into the electrical and chemical aspects of the anxiety phenomenon promise to shed further light on the physical dimension of this process. Recently Garb, Tiwari, and Chapman[11] found that a third amine, isuprel, differing in structure from epinephrine and norepinephrine and normally present in the adrenal medulla, was far more potent in its ability to evoke anxiety experimentally, and they suggested that it might be the chemical mediator in anxiety.

Selye's[49] important work in the field of stress has drawn attention to the fact that the endocrines, in particular the pituitary, play a far more significant role than had previously been realized. In his concept of the general adaptation syndrome, he has opened the way to further progress in the direction of a holistic biology. A hypothalamic-pituitary-adrenal-cortical mechanism is called into play in the organism's response particularly to prolonged stress, the stress syndrome being seen as developing in three stages—the alarm reaction, the stage of resistance, and the stage of exhaustion. While all of the body organs are involved in this process, integration of the endocrine and nervous systems is the central phenomenon. Many mechanisms have been suggested for this integration and for the integration of the acute emergency pattern and the pituitary pattern, particularly revolving around the role of adrenalin and its mode of action in this process. Gellhorn[12] (pp. 326, 328) concludes that various forms of stress lead to sympathetic adrenal discharge, with resulting consumption of the adrenal cortical hormones in the tissues. He believes that the lowered concentration of these hormones stimulates the pituitary toward increased ACTH secretion. ACTH, in turn, stimulates the secretion of adrenal cortical hormones, both gluco-corticoids and mineral corticoids, with widespread effects on tissue metabolism, including the cortex.

¶ Major Factors in the Etiology of the Anxiety States

Hereditary and Constitutional Factors

Progress in determining factors significant for the genesis of the anxiety states has been impeded by emphasis on monistic etiology. It is now recognized that many factors are involved in a complex interaction, and, as less energy is wasted on the nature versus nurture polemic, there is increasing interest in determining how the many elements subsumed under these headings unite in the process of healthy and neurotic growth.

Kallmann[24] notes that "current information about verified inheritance factors is least complete in the vast area of psychoneurotic traits, where representative twin data are most difficult to secure and few genetic questions have been fully answered." Gerard's[14] view that neurosis may result "more from unfortunate

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relations of the individual to his environment than to his ancestors" remains widely held. Hoch[19] notes the paucity of references to constitutional factors in the studies of the anxiety states and adds that "those engaged in constitutional research have failed to translate the term 'constitution' into reality." Matte-Blanco[39] has attempted to do so in an extension of Sheldon's theories concerning basic temperament and the somatotypes, while recognizing the importance of cultural factors. Fries[8] has suggested a classification of congenital-activity types with reference to the excitability of the newborn's neuromuscular system in response to certain stimuli. This "biological mode of adjustment" she feels to be determined in varying degrees by inheritance, factors related to intrauterine life, "body changes due to the birth process, illness, growth, stage of myelinization, emotional state and especially parents' emotional attitudes." She particularly notes the effect of this congenital-activity pattern on the parent-child relationship, the child's psychosexual and ego development, its defense mechanisms, and predisposition to pathology.

Cultural Factors

The position of the cultural anthropologists and the social psychiatrists in regard to this dimension of the human being is summarized by Opler.[42]

> "Mind" is of course in one sense mental functioning, but it is also an organization of beliefs, attitudes, and mental patterns derived from social experience in a particular culture. . . . culture . . . is a concrete and ever-active set of realities in the individual. . . . If culture influences types of family organization and the social experience and role position of its carriers, its deepest reflection will occur on any and all biosocial levels as evidenced in norms of behavior and in types of psychopathology.

Reference has already been made to general factors prevailing in our culture conducive to the increase of overtly felt anxiety. They may be considered to constitute the cultural atmosphere of our time. More pertinent to our study is a consideration of factors in the culture and subculture of the individual who develops the specific syndrome of the anxiety state. It is not within the province of this chapter to deal with this problem at length, but I wish to note some of the factors which have been emphasized and which have frequently appeared in my own practice.

Redlich *et al.*[45] noted the relatively higher incidence of neurosis in the higher social levels. Seward,[50] making similar observations, particularly stressed the significance of ambivalence and status strivings in the family environment of middle-class individuals. Here there tends to be great emphasis on parental love of the child, with overprotection and smothering, often actually a considerable pretense of love behind which lurk feelings of rejection and hostility, and undermining attitudes toward the child. In such an environment the child has difficulty adopting a consistent way of coping, particularly since friction with parents and siblings is taboo, and open expression of hostility is viewed as evidence of ingratitude, unlovableness, and defect in the child. Similarly, authoritarianism, with the mother often playing the dominant role as the focus of both authority and affection, tends to be rigidly, but covertly, maintained, so that rebellion is difficult. When it does occur, the usual response on the part of the parents is emotional isolation of the child, withdrawal of affection, and preference for other siblings as subtle punitive measures. Acceptance and approval are thus experienced by the child as being contingent on conformity and submission, though the verbal teachings in such an environment tend to stress independence and individualism. Striving toward higher social status tends to be powerful in this environment, and the child is viewed as an instrument for such upward movement, with acceptance and rejection the reward and penalty for the child's success or failure in this process. The attention given such children is very close but is motivated not so much by a genuine feeling for the child's needs but rather by the role he plays in the parents' striving toward superior status. Toward this

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end, unconscious molding of the child goes on from the moment of birth. It often includes particular ways of handling the child's body functions and body pleasures, these ways being *rigidly* adhered to in terms of the particular dominant theory for "perfect" child rearing. In this environment, whatever the surface pattern, there is considerable rejection of the child's sensual, organic, perceptual being, with great emphasis on the intellectual and conceptual aspects of being. Finally, conflicting values are an invariable component of this environment. Success is paramount at the same time that unselfishness is highly valued. Love, equality, and the brotherhood of man are stressed, and, at the same time, equal stress is placed on the importance of getting ahead, triumphing, and excelling over others. "Conspicuous consumption" clashes with a deep strain of Puritanism. The underlying hostile attitude and anticipation of hostility are often evidenced in the emphasis on living up to standards and being beyond criticism, not only for the sake of status advancement but also for the purpose of safety from the hostility of others.

The Traumatic Incident as an Etiologic Factor

It has frequently been noted that the first evidence of overt anxiety may follow a particular traumatic incident in the life of the infant and child. Levy[30] found accidents and operations to be particularly frequent "first situations" precipitating anxiety reactions. He also noted the frequency of "frights, separations, sudden privations, births of siblings, and sudden environmental changes." While there is ample evidence that such events may be traumatic to the child and can produce anxiety, a simple cause-and-effect relationship between such specific events and the development of anxiety states, as defined in this chapter, cannot be established. As Levy noted, these events are part of a total constellation which includes predisposing factors related to special susceptibility in the child, constitutional and organic factors, factors related to rearing practices and home environment, and factors concerning the parent-child relationship. In my own experience it is the last factor that is most decisive in the total gestalt.

¶ Psychodynamics of the Neurotic Development

The basis of this presentation is the work of Karen Horney, outlined by Kelman in Chapter 71, Vol. II. In this view, evidence amply indicates that the child's main requirement for healthy personality growth is a human environment which offers him genuine love, consistent acceptance of his actual being, respect for his child status and the needs deriving from it, and a recognition that the process of growth takes the child through the various stages of healthy dependency, healthy differing from and opposing, and healthy separation from the parents as he gains a sense of his own identity in his togetherness with them and as he begins to take his place in the broader-than-family community. The neurotic development does not begin as a consequence of the frustration of a particular pregenital sexual impulse but rather as a consequence of the frustration of the child's innate striving to be itself and to grow in the ways that are natural to it, that is, the striving toward self-realization. If the child experiences his human environment predominantly in terms of overt or covert rejection, approval contingent on rigid conformity to standards; if he is loved only when he is a particular kind of child; if he is exploited, treated inconsistently, glorified in terms of his possibilities, and belittled in terms of his actual resources and needs; if dependency and submission are unconsciously fostered by overprotection; if hostility and friction are inhibited, then, self-realization is hindered. The child develops a conflicting pattern of submission and defiance, the anlage of his future neurotic conflicts. He comes to feel helpless, isolated, and afraid in a potentially hostile world. Horney has called this group of feelings the "basic anxiety" and

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views this deep insecurity at the core of the person's being as the starting point of the neurotic development.

Much remains to be learned concerning the possible role of constitutional factors in determining the child's vulnerability to this inimical environment and the nature of the particular devices which it adopts to cope with life in the face of its basic anxiety. At present, it appears that it is the impact of the total interpersonal milieu, in particular parental neurosis, that is the major factor determining whether the child seeks safety through compliance, aggression, or detachment. Overprotection and exploitation, as described by Martin,[35] are frequently dominant. Horney[20] (p. 222) noted the frequency with which such children grow up in the shadow of an adored parent, self-sacrificing mother, or preferred sibling. ". . . affection of a kind was attainable at a price: that of a self-subordinating devotion." In contrast to the schizophrenic (Arieti,[1] p. 59), these children do not feel hopeless about the possibility of obtaining parental love and approval.

The histories of individuals with anxiety states contain brief periods in childhood and early adolescence in which the aggressive pattern appeared, with evidence of defiance, rebellion, and attempts to control and dominate others, usually in episodic outbursts of "moving against" others. Similarly, compulsive movements away from others, detachment, with emphasis on self-sufficiency, may also briefly dominate the picture. However, these individuals soon adopt as their basic safety pattern a compulsively compliant attitude toward their human environment. Their dominant needs focus on being loved and lovable, being protected and taken care of, being inoffensive, pleasing others, avoiding all friction and conflict with others. Here the groundwork is laid for the dependent pattern and the need to repress assertive and aggressive as well as autonomous strivings. The major possibilities of anxiety come to be rejection or disapproval by others and hostile impulses from within the self. The need to be loved, particularly by the parent who is viewed as the greater threat, may come to have sexual undertones as expressions of the child's search for safety through closeness and intimacy. It must be emphasized that this pattern of rigid, compulsive, anxiety-motivated compliance is quite different from the biological dependency of the child, just as its repressed aggressive needs and detachment are equally compulsive and not to be confused with the healthy self-assertiveness and independence which are natural expressions of growth.

What is particularly significant is the extension of the child's basic anxiety which comes to pervade all of its human relationships. In the basic anxiety and in these neurotic trends, we see the first steps in the evolution of the neurotic process, the beginnings of compulsiveness, the adoption of neurotic patterns of interpersonal relationships, and, above all, a beginning alienation from the real self. As Maslow[36] (p. 42) stated, "if the only way to maintain the self is to lose others, then the ordinary child will give up the self." Safety becomes a supreme principle of life.

While compliance is the dominant solution, it must be noted that inner conflict represents a constant threat to such individuals, since the repressed patterns of aggression and detachment are themselves powerful drives seeking for expression. The threat to the individual's inner unity, produced by this basic conflict between his neurotic moves toward, against, and away from others, arises from the compulsiveness and irreconcilable nature of these defensive trends. The compliant person's orientation centers around being helpless, submissive, appeasing, lovable, good, unselfish, needing to love and be loved, and to see others as kind, generous, and nice. The aggressive individual's orientation centers around hostility, friction, struggle, and competition; with compulsive needs to control, dominate, exploit, outsmart, and excel; requiring him to be hard, tough, and realistic, and to exclude all softer feelings. The detached individual's orientation centers around his compelling need to keep emotionally distant and isolated, to be independent and self-sufficient. As a result of the disintegrating threat of basic conflict, the individual finds himself faced with the stringent necessity to adopt defensive measures for the restoration of his sense of inner unity. In

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the evolution of the anxiety states, aggressive and withdrawing trends tend to be repressed, compartmentalized, unconsciously controlled, and passively externalized so that he experiences his disowned hostile and aggressive impulses in others directed against himself. Any tendency toward detachment must also be checked, because his center of gravity has come to reside in others to such a great degree, and his dominant needs require that he be emotionally as well as physically close to others.

The neurotic development up to this point may be visualized as essentially defensive in character. This stage of defensive development corresponds in general to the chronological period of childhood. It is one in which the individual is primarily concerned with finding ways to cope with others, to relieve anxiety, and to escape from conflicting orientations toward others. As the individual develops, he feels increasingly some of the major consequences of his neurotic development. As a result of the neurotic interference with the natural process of self-realization, he has been unable to develop a sense of his own identity. Each step in the neurotic development has moved him further and further from his real self—the potential source of identity, meaning, strength, autonomy, and healthy unity. He requires a solution which will not only help him to avoid experiencing his disruptive inner conflicts but will also give him some basis for existence, some sense of meaning and purpose in life, some feeling of identity and value. In a competitive society he requires also some means for coping with his feelings of inadequacy in relation to others, some means for feeling superior, some substitute for the self-confidence which he lacks. What he must have is a more comprehensive, in a certain sense a more positive and creative, solution than those previously mentioned. This solution he most commonly finds in our culture in "the search for glory" (Horney,[20] p. 17), which, with the search for safety and the search for inner unity, comes to constitute the major dynamic, unconscious motivation in his neurotic way of life. The search for glory begins with the process of self-idealization, the construction in imagination of an idealized image of absolute flawlessness, omnipotence, and omniscience. This image is in part fictional, in part an enormous exaggeration of existing assets, in part a glorification of neurotic needs. Imagination transforms the conflicting aspects of his being so that they can now be seen as harmonious parts of a godlike whole. While we readily perceive the fantastic character of grandiose delusions in schizophrenia, we do not as readily recognize the basically similar mechanism in the process of self-idealization in neurosis. This is perhaps due mainly to the fact that what the neurotic individual allows to appear on the surface so closely resembles the normal approved and admired personality of our time. It is only as we become more aware of the subtle expressions of the search for glory in the individual's dreams and fantasies, in his work, and in his human relationships that we recognize the true nature of this phenomenon and the destructive impact on the individual's life and further development. It is the intensity, the compulsiveness, the frantic quality of the individual's attempts to make this image seem real to himself and to others (that is, to actualize his idealized self) that distinguishes it from the cultural image.

In the drive toward the actualization of the idealized self, compulsive strivings for success, status, prestige as part of neurotic ambition, strivings toward vindictive triumph over others, and strivings toward perfection constitute the major elements. The first two elements are so opposed to the compliant individual's dominant orientation that they need to be kept in the background. What is in the foreground are the strivings for perfection. The compliant individual's image tends to be focused on the particular values of saintliness, unselfishness, helpfulness, goodness, inconspicuousness; on "loving and being lovable," being understanding, forgiving, and undemanding; on helplessness, suffering, and martyrdom. While he has an over-all need for perfection, it is particularly with regard to these values and qualities that he demands of himself absolute perfection, and, externalizing these demands to others, feels this is what they demand of him. To the degree that he is able to fulfill these "shoulds,"

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he experiences pride in his pseudo self, an emotion which he must, however, keep hidden. What does emerge openly are the reactions of intense humiliation, guilt, and shame when he fails to live up to these unfulfillable inner dictates. Inevitably, the process of self-glorification leads to hatred and contempt for the actual self, with its existing human limitations, and to further alienation from the real self. The hatred of self is an essential element in the dynamics of neurosis. It constitutes the major source of the individual's deep feelings of guilt and unworthiness; the merciless self-reproaches and self-accusations which constitute his neurotic conscience; his persistent unconscious need to belittle, torment, degrade, disparage, undermine, and crush the hated self. Here, too, is a new source of conflict, the intrapsychic conflict as the individual is driven toward self-aggrandizement and self-extinction. The individual whose predominant interpersonal orientation is aggression tends to "solve" this intrapsychic conflict by the solution of expansiveness, in which he identifies himself with his glorified self, the dominant value being placed on mastery of himself, of others, and of life. The predominantly detached individual will tend to deal with intrapsychic conflict by resignation, the dominant value being freedom from emotional involvement with others and with his own feelings and strivings. The predominantly compliant individual "solves" intrapsychic conflict by identifying with his despised self, the dominant value being love. While individuals whose predominant presenting orientation toward life is either mastery or resignation will be found in the anxiety states, and all three orientations are invariably present to some degree in every neurotic individual, it is my experience that, whatever the surface picture, the underlying constellation most frequently is that of the solution of self-effacement.

The central dynamic motivation in this solution is the individual's unconscious determination to eliminate himself, to vanish. In discussing healthy involvement in anxiety, I particularly emphasized the decisive role of the individual's asserting "I am" in the face of threatened self-disintegration. Here, in the neurotic individual's self-effacing solution, the basic statement is "I am not." There is an enormous taboo not only toward aggression, neurotic pride, and expansiveness, but also toward healthy self-assertion, self-respect, self-direction, spontaneity, and growth. Just as he responds with submission in relation to others, so does the individual respond submissively to his own inner dictates and to the judgment of his self-hate, which tells him he is not only weak, fragile, helpless, and impotent, but also worthless, unlovable, ridiculous, and guilty. At the same time, we must remember that neurotic pride, though it must be kept from awareness, continues to operate. On the basis of his helplessness, his suffering, and his pretenses of goodness, he feels entitled to be loved by everyone. Hostility of great intensity is frequently being generated when his hidden pride is hurt, when these special claims are not fulfilled, and as a result of his deep envy of the strength and independence of others. The increasing hostility and abused feelings threaten to conflict with his major orientation, and further repression and reinforcement of the self-effacing solution are required. Sooner or later, love may appear as a magical solution to all of his painful dilemmas. Through a symbiotic relationship with a powerful, aggressive, authority figure, he sees the possibility at one and the same time of relieving his anxiety and loneliness; finding some positive purpose and meaning in life; living through and for another individual since he has had to abandon his own being; losing his own identity in love and sex; secretly reuniting with his own consciously disowned pride, now invested through active externalization in the partner; secretly fulfilling repressed aggressive trends to control, possess, enslave, and devour through weakness and love. His orality, expressed in all areas of his being, including the sexual, is thus seen to be an expression of a fusion between passive-dependent and hostile-aggressive acquired neurotic drives. Viewed in this light, homosexual panics and the far more frequent heterosexual panics are seen to be not primarily expressions of sexual pathology but rather expressions in the sexual sphere of conflicting attitudes toward this pervasive drive to lose oneself in a morbid dependency relationship. The dynamics of the masochistic phenomena so frequently

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noted in the anxiety states are similarly viewed.

In the light of this theory of neurotic development, the chronic apprehension in the anxiety states is seen to be an expression of the individual's unconscious and pervasive awareness of the precariousness of his equilibrium and pseudo unity, the rigidity of the entire neurotic character structure, the strain of living under impossible standards with the sword of self-contempt constantly overhead, the extreme vulnerability arising from the mythologic nature of the individual's false pride, and the pervasive helplessness at the core of his being deriving from his extreme dependency on others and alienation from himself. The acute attacks of anxiety arise when an actual threat is imminent. The endangering situation is frequently symbolic in character, hence the tendency to think that the anxiety response is inappropriate or disproportionate to the threat. When the symbolic meaning of the endangering situation for the individual is known, when we perceive the vital nature of what is at stake and what is endangered, and above all when we realize the sources and depth of the individual's feeling of weakness, the anxiety response is seen to be an entirely appropriate and proportionate one.

What is endangered in neurotic anxiety is any aspect of the infinitely complex neurotic character structure whose every element is clung to out of stringent inner necessity and has acquired great subjective value for the individual; that is, all the defenses against anxiety, the means for avoiding involvement in and awareness of conflict, and the various components of the major solutions to conflict, particularly those relating to the pride system. While this holds true for all neuroses, in the anxiety states all the aspects of the passive-compliant-dependent-self-effacing solution, which has come to be the individual's main way of coping with and orienting to life, are especially threatened. The threat may originate outside himself from anything which he perceives as disapproval, rejection, abandonment, hostility, contempt, failure, or disgrace, but it also may arise from anything which emphasizes his individuality, his value, his worth, anything which threatens his need to be anonymous, including conspicuousness, praise, recognition, and success. From within, the threat may be any impulse, healthy or neurotic, which threatens the individual's safety and moves him in the direction of conflict. Most particularly, acute anxiety appears when the individual is thrown into conflict by emerging feelings of hostility, envy, competitiveness, and the unconscious arrogance which underlie his façade; when he is caught between equally compulsive conflicting inner demands; when failure to fulfill dependent needs or inner dictates produces a massive increase of self-hate and self-contempt with a surge toward self-destructiveness; when he is vindictively "going to pieces" (Horney,[20] p. 236); when he is threatened with exposure of his pretenses of goodness and lovingness; when he is thrown back on himself and experiences his inner emptiness and deep unrelatedness. To the degree that his pride condemns it, and to the degree that our culture rejects such dependent attitudes in men and, increasingly, in women, the intensity, the irrational compulsive nature of his neurotic needs must be hidden from others as well as from himself. Acute anxiety is thus experienced not only when neurotic defenses and values are threatened but also when the real nature of these trends is exposed, whether by general life experiences or in the particular life experience of therapy. It must also be remembered that repressed drives toward mastery and resignation remain active, so that anything which threatens these solutions will, in turn, evoke anxiety.

At the center of these neurotic anxiety responses is the individual's deep and intense feeling of helplessness. Originating in the basic anxiety and constituting the center of the individual's orientation to life, this feeling of helplessness is perpetuated and increased by his progressively increasing alienation from his real self during the course of his neurotic development in which he has moved further and further from the dynamic, integrating core of his being. The most important source of this alienation is the process of self-idealization with the substitution of a pseudo self and the rejection of his own reality. A vicious cycle of crucial significance is seen to be operating here. The more alienated the individual becomes, the weaker grows his ability to cope

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with conflict and the more he must reinforce and rely on neurotic solutions, which, in turn, increases his alienation.

What has been outlined is a particular kind of neurotic character development most frequently seen in the anxiety states in our culture. It is important to add that in the anxiety states, perhaps more than in any other neurotic or psychotic syndrome, healthy growth has taken place. To the picture of an anxious individual apprehensively coping with life in the face of inner and outer dangers must also be added the picture of a human being with courage, able to endure this much anxiety without the more massive defenses and character distortions which characterize the other psychiatric syndromes.

¶ Differential Diagnosis

Overt anxiety is not pathognomonic of the anxiety states. Attacks of anxiety occur in phobic, conversion, psychosomatic, and psychopathic disorders, as well as in more or less healthy individuals under overwhelming stress. The schizophrenic and the manic-depressive, as well as the more organically based personality reactions, all have greater or lesser degrees of overt anxiety. Masserman[37] (p. 127) draws attention to a whole host of organic conditions whose symptoms may simulate aspects of the anxiety syndrome. These include cardiac disturbances; hyperthyroidism; hypoglycemia; carotid sinus hyperirritability; diffuse central-nervous-system diseases; lesions involving the cerebellum, semicircular canals, and the vicinity of the diencephalon; Benzedrine and caffeine intoxication; endocrine dyscrasias; and hysterical tetany. Careful examination will establish the diagnosis. It must be remembered, however, that organic conditions and anxiety states may coexist.

¶ Prevention and Therapy

Implicit in what has been written about the cultural and familial determinants of the anxiety states are the conditions for its prevention. The evolution of a more stable and consistent social structure, which emphasizes individual growth rather than the "market value" of the individual (Fromm,[9] p. 69), will reduce the number of anxiety states. A human environment in which the individual receives genuine acceptance and respect will further his healthy development and self-realization. As May[40] (p. 89) and others have noted, the goal is not the prevention of anxiety. As defined earlier, the anxiety response is inherent in our being living organisms and arises inevitably as the individual meets the challenges and shocks of existence (Goldstein,[17] p. 306). The endeavor must be to create conditions which will enable the individual to have less neurotic anxiety and to increase his capacity to experience fully, to live creatively, and to grow through the experience of normal anxiety.

Treatment of the anxiety states may be divided into measures aiming primarily at the relief of anxiety and those whose goal is a change in the basic character structure. Measures for the relief of anxiety currently being used are the various drug therapies, physiotherapy, hydrotherapy, occupational therapy, the shock therapies, carbon dioxide inhalation, and the various psychosurgical procedures. While all of these measures have demonstrated effectiveness in lessening the experienced anxiety,[32] the use of the shock therapies and psychosurgical procedures appears to constitute an admission of therapeutic hopelessness and failure. In my opinion, they are not indicated even in the symptomatic therapy of the anxiety states. Acute anxiety and panic reactions will require emergency treatment at times. The indications and drawbacks of the barbiturates are long familiar. More recently, the autonomic suppressants (such as Thorazine, etc.) acting on the hypothalamus, and meprobamate (Miltown, etc.) acting primarily on the thalamus,[44] have been widely used for the relief of anxiety. Complications of the former drugs—agranulocytosis, jaundice, parkinsonism, depression, etc., have led to increasing caution in their use. Meprobamate therapy, while free from these major complications, lends itself to indiscriminate use. As Dickel and Dixon[4] have noted in an extensive study, the danger of indiscriminate use of the tranquilizing drugs includes not only the physical complications but, perhaps more important,

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the effect on physicians and patients alike of the failure to realize that tension and anxiety are important elements in living and in "the shaping of progress."

These various symptomatic measures are used together with a host of psychotherapeutic devices designed to remove the sources of pressure and stress, lessen tension, and restore the patient's equilibrium by strengthening his neurotic defenses, including intellectualization and control. These measures include environmental manipulation; reassurance and education, particularly concerning the fear of insanity and of organic illness produced by the autonomic phenomena; suggestion; emotional catharsis; and desensitization. Here the therapist's role is that of a benevolent authority who serves as an anchor in a world which seems to the patient to be disintegrating. The therapist's ability to convey to the patient, through nonverbal as well as verbal means, his sympathetic acceptance of the reality of the patient's suffering (though he is not caught up in the uses to which the patient puts his compulsive need to suffer); his refusal to view the experience as catastrophic; his ability often to protect the patient from his own self destructiveness—these are among the psychotherapeutic approaches which may help relieve the intensity of the patient's anxiety and suffering.

On a somewhat deeper level are the psychotherapies which Wolberg[58] (p. 8) classifies under the heading "Insight therapy with reeducative goals." Here the primary objectives are "Insight into the more conscious conflicts with deliberate efforts at readjustment, goal modification, and the living up to existing creative potentialities." Here the appeal is chiefly to the patient's rationality, as the therapist helps him recognize some irrational aspects of his unreasonable demands on himself and what he feels others demand of him as the price of his acceptability. The insight gained into some of his gross distortions in perception can be very helpful in lessening anxiety and the intensity of inner conflict.

The deep therapies, of which psychoanalysis is the prototype, have as their primary goal a basic change in character. Where such therapy is available for the individual and where he is available for such therapy, it is the treatment of choice. The specific nature of the depth therapy employed will depend on the particular theory of human motivation and neurotic development with which the therapist is working. In holistic psychoanalysis, based on Horney's work (see Chap. 71, Vol. *II*), the method involves analysis of the total character structure as it finds expression in the dimensions of past, present, and future; in the individual's interpersonal relationships, particularly the analytic relationship; in his relationship to himself and to the world at large; in his unconscious as well as conscious living; in his organic and perceptual as well as intellectual and conceptual being; in his dreams and fantasies as well as in his behavior. The aim is to help the individual become increasingly aware of and able to own, experience, and be involved in his whole being, including his inner conflicts. Through the strength gained in this process of increasing awareness, and particularly as the patient experiences the reality of his neurotic patterns in the analytic relationship, alienation and basic anxiety diminish, neurotic trends weaken, neurotic defenses against anxiety and solutions to conflict —particularly the striving toward self-idealization—can be gradually relinquished to a considerable degree. The goal is a reorientation of values as the individual is increasingly able to take responsibility for himself; increasingly capable of genuine mutuality in his interpersonal relationships; increasingly able to recognize his own individuality, tap his constructive potentialities, and accept his human limitations and his natural interdependency with others. The goal is self-realization (Horney,[20] p. 364).

The outcome of therapy is generally favorable. It depends on the severity of the underlying pathology, the amount of healthy growth which has taken place, and the therapist's belief in and ability to help the patient reach his innate constructiveness.

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CHAPTER 17

OBSESSIVE BEHAVIOR

So-called Obsessive-Compulsive Neurosis

Sandor Rado

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THE FIRST PSYCHIATRIC OBSERVATIONS on obsessive behavior date from the 1860's,[24] but it was not until after the turn of the century that Freud opened the way to a deeper understanding of this disorder and its recognition as a well-defined clinical entity.* His classical description of the clinical picture, published in 1917,[12] follows:

The obsessional neurosis takes this form: the patient's mind is occupied with thoughts that do not really interest him, he feels impulses which seem alien to him, and he is impelled to perform actions which not only afford him no pleasure but from which he is powerless to desist. The thoughts (obsessions) may be meaningless in themselves or only of no interest to the patient; they are often absolutely silly; in every case they are the starting-point of a strained concentration of thought which exhausts the patient and to which he yields most unwillingly. Against his will he has to worry and speculate as if it were a matter of life or death to him. The impulses which he perceives within him may seem to be of an equally childish and meaningless character; mostly, however, they consist of something terrifying, such as temptations to commit serious crimes, so that the patient not only repudiates them as alien, but flees from them in horror, and guards himself by prohibitions, precautions, and restrictions against the possibility of carrying them out. As a matter of fact he never literally, not even once, carries these impulses into effect; flight and precautions invariably win. What he does really commit are very harmless, certainly trivial acts—what are termed the obsessive actions—which are mostly repetitions and ceremonial elaborations of ordinary every-day performances, making these common necessary actions—going to bed, washing, dressing, going for walks, etc.—into highly laborious tasks of almost insuperable difficulty. The morbid ideas, impulses and actions are not by any means combined in the same proportions in individual types and cases of the obsessional neurosis; on the

* Freud, like Kraepelin before him, called this entity *Zwangsneurose;* by way of different translations, *Zwang* became "obsession" in London and "compulsion" in New York. Subsequent authors, apparently unaware of this fact and eager to ascertain what is meant by "obsessive" and what by "compulsive," settled for the unhappy designation "obsessive-compulsive." The "standard edition" of Freud's work, published recently in London, abides by rendering *Zwangsneurose* as "obsessional neurosis"; hence my term "obsessive behavior."

contrary, the rule is that one or another of these manifestations dominates the picture and gives the disease its name; but what is common to all forms of it is unmistakable enough.

. . . he [the patient] can displace and he can exchange; instead of one silly idea he can adopt another of a slightly milder character, instead of one ceremonial rite he can perform another. He can displace his sense of compulsion, but he cannot dispel it. This capacity for displacing all the symptoms, involving radical alteration of their original forms, is a main characteristic of the disease; it is, moreover, striking that in this condition the "*opposite-values*" (polarities) pervading mental life appear to be exceptionally sharply differentiated. In addition to compulsions of both positive and negative character, doubt appears in the intellectual sphere, gradually spreading until it gnaws even at what is usually held to be certain. All these things combine to bring about an ever-increasing indecisiveness, loss of energy, and curtailment of freedom; and that although the obsessional neurotic is originally always a person of a very energetic disposition, often highly opinionated, and as a rule intellectually gifted above the average. He has usually attained to an agreeable high standard of ethical development, is overconscientious, and more than usually correct.

¶ Clinical Picture

The designation "obsessive behavior" will be applied to patients who have obsessive attacks and obsessive traits. For convenience, I shall subdivide obsessive attacks into spells of doubting and brooding, bouts of ritual making, and fits of horrific temptation. In time, the form of attacks may shift from one to the other. They may be mild or severe, last half an hour, an hour, or longer; may be quiescent for a while or occur many times a day. Obsessive traits, however, once evolved, do not change significantly. I shall describe and illustrate first the three forms of attacks, and then the traits.

Spells of doubting and brooding may be described as a swinging back and forth between the same set of pros and the same set of cons without being able to reach a decision. They are thought activities that tend to defeat the purpose of thinking. Doubt may invade a belief, proposition, observation, or recollection, spreading from one to the other. The patient can trust neither his memory nor the testimony of his own eyes. Upon leaving home, he may feel forced to rush back to make sure that he turned off the light or locked a certain door, eventually repeating this "making sure" trip several times; or, upon sealing an envelope, he may have to open it over and over again to reassure himself that he has signed the enclosed check, etc.

In his bouts of ritual making, the patient repetitively executes a sequence of motor acts. Most often these sequences are ceremonial and distortive elaborations of some routine of daily life, such as going to bed, getting up, taking a bath, dressing and undressing, settling down to work or finishing work. They may, however, also be composed of out-of-place or apparently nonsensical motor acts. Repetition of the sequence tends to be continued until the patient is exhausted.

The term "ritual making" includes obsessive hand washing, washing or cleansing of pieces of wearing apparel or other objects of daily use, as if they had been soiled or somehow contaminated; the obsession to count (for example, the number of parked cars), to touch (for example, every lamppost on the street), or, on the contrary, to avoid touching certain objects (for example, doorknobs), or to step on or avoid stepping on certain spots (for example, the pavement cracks) and the like; ceremonial and stereotyped elaborations of sexual performance, in particular, of its "before" and "after" phases; of the patient's table manners and eating habits; of his toilet habits; of the way he makes and keeps social engagements, parts with money, makes purchases or presents gifts, etc.

In his "fits of horrific temptation" the patient, suddenly beset by the urge or idea to kill someone (characteristically a close and beloved relative), shrinks back in horror from a temptation so alien to his entire being.

Turning to the obsessive traits, we observe that the patient is overconscientious in his own particular way. What he is mostly concerned about are the minutiae, the inconsequential details, the meticulous observance of

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minor rules and petty formalities. Specializing as he does in trifles, he is always in danger of missing the essentials. Similarly, his orderliness tends to be excessive and inappropriate, costing valuable time and effort; in his life, the clock is a menace. He may, for instance, keep papers on file that should be discarded and save or record matters of little or no importance. Upon arriving at his office, he may spend hours putting his desk in "order," arranging utensils and papers; turning at last to his job, he is capable of making important decisions hurriedly, without qualms. A scientist, though never noticing that his shoelaces were untied, was so meticulous in his literary documentation that his colleagues dubbed him a footnote fetishist. A patient recorded all his railroad travels from grammar school to high school, listing all the station stops, even when repeating the same trip. Another had his secretary keep a pyramid of indexes to his private files —a regular index, an ever-growing series of cross indexes, and an index of the indexes. Regardless of how rushed he may have been, whenever he consulted the files himself, he had to take time out to see whether the item concerned was indexed to perfection. Another, the product of a Victorian upbringing, from adolescence on kept a meticulous record in secret signs about his orgasms and failures—long before Kinsey and without the latter's point of view. Another, so instructed by his equally obsessive mother who always worried that he might catch cold, kept his supply of socks in the drawer in carefully separated piles marked "heavy," "light heavy," "heavy light," and "light."

A rough sketch of the obsessive patient would depict him as highly opinionated and proud of his superior intelligence, avowed rationality, keen sense of reality, and "unswerving integrity." He may indeed be an honest man, but he may also turn out to be a sanctimonious hypocrite. He is the ultimate perfectionist. While very sensitive to his own hurt, he may, at the same time, be destructively critical, spiteful, vindictive, and given to bitter irony and to bearing grudges in trivial matters. Or, on the contrary, he may be overcautious, bent on avoiding any possibility of conflict. His "common sense" militates against what he views as fancies of the imagination: he is a "man of facts," not of fancies. He smiles condescendingly at people who are fascinated by mysticism, including "the unconscious" and dreams, but let him undergo some psychoanalytic treatment of the classical type, and he will switch to attributing oracular significance to slips of the tongue or the pen. As a "man of reason" he cannot admit even to himself that he is superstitious. His interest in fine arts is slight or pretended; his true admiration is reserved for mathematics, the exact sciences, technology, the new world of electronic computing machines. In contrast to the expressional (so-called hysterical) type, he rarely has artistic gifts and conspicuously lacks genuine charm and grace. His amatory interests are laden with ulterior motivations and pretense. His envy of a successful rival—in work, for example—may carry him to dangerous lengths: if the opportunity arises, he may subtly cut the man's throat—a token of his admiration and respect. This sort of thing is usually termed "ambivalence"—a term itself in need of clarification. Finally, the obsessive patient is almost never completely free from tension and irritability, though in general the degree of these characteristics fluctuates from slight to severe.

¶ Pathology

I shall preface this discussion of the pathology of obsessive behavior with brief statements on methodology and adaptational psychodynamics. The latter, a revised system of psychoanalytic thought, is our chief conceptual tool.

Methodology

In all branches of medicine, inquiry into the nature and causes of disorder begins with examination of the clinical picture, continues as a search for the underlying pathological processes (changes in the organism's structure and function), and culminates in the disclosure of that specific constellation of influences which has brought them about. The pathologist, like all human biologists, must,

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of necessity, use introspective as well as inspective procedures, for these two approaches to the human organism are irreducible yet complementary to each other. He must also realize that it is the hereditary basis of the actual organism which determines, from conception to death, its mode of interaction with its changing environment. The geneticist calls the actual organism the phenotype, its hereditary basis—the cause of its development—the genotype. From womb and nourishing mother, environment gradually widens to include family, school, community, and mankind at large. Psychodynamics, the science dealing chiefly with the part played in behavior by systems of motivation and control, views behavior as the biological organism's interaction with its cultural environment, the society in which it lives. In time, psychodynamics will be flanked with disciplines ranging from physiological to sociological psychodynamics.

In general, the comprehensive pathology of disorder must be visualized as the integrated whole of its psychodynamics, physiodynamics, and genetics. In the pathology of many behavior disorders, we must depend almost exclusively on psychodynamic investigation, for the physiodynamics and genetics of these disorders are undeveloped.

Adaptational Psychodynamics

All true psychodynamics is based on Freud's investigative method, his pioneering clinical findings and points of view. After publication in 1900 of his masterpiece *The Interpretation of Dreams*,[15] however, Freud's theoretical development did not, and could not, keep pace with the growth of his empirical insights. He became increasingly speculative, enamored of explanatory concepts which he himself admitted were "superbly indefinite" and remote.[16] This was the outcome of a drastic decision he had made back in the mid-1880's. At that time, frustrated by the unfriendly reception given his early work by the coriphaei of medicine in Vienna, he retreated into an almost complete scientific isolation from which he never emerged. Out of touch with progress in the biological and cultural sciences, in the twentieth century he was creating nineteenth-century theories—revitalized by a generous infusion of golden Greek philosophy. Despite their captivating artistic beauty, these theories could not, and did not, bear scientific fruit.

Adaptational psychodynamics has evolved a conceptual scheme that remains close to the empirical subject matter of psychoanalysis, meanwhile developing a descriptive language bent on conveying the most information in the fewest words. Here we can sketch only some of its features, contrasting them for the sake of clarity with those of Freud's now-classical system.

The organism seeks to fit its needs to its environment, and its environment to its needs. The first process is called autoplastic adaptation; the second, alloplastic adaptation.[8] Exploration of the adaptive value of the organism's behavior is of overriding importance, since whatever the organism does may work for it or against it. While all behavior may be viewed as the effect of underlying causes, not all behavior can be classified as goal-directed. Our chief concern is goal-directed behavior,* in which, moving from desire to fulfillment, the organism analyzes experience into cause and effect in order to find the means that will lead to the ends it desires.

Freud's elucidation of behavior traced it to instincts, which he thought were composed in varying proportions of the same two conflicting elements: Eros' divine lust to live, and living matter's dark and nostalgic longing to die (revert to the inanimate state). The forces of the former were libidinal; those of the latter self-destructive or, when turned outward, destructive. Despite our sincere admiration of this poetic idea, in our still-young clinical discipline we are obligated to trace behavior to empirically ascertainable motives and motivating systems. Freud attributed irrational thought to the influence of instincts, with emotions implied; we attribute irrational thought

* The properties of so-called goal fields were examined by Kurt Lewin[27] and Thomas M. French[9]; the significance of now so-called feedback in goal-directed behavior was first recognized by Julius Pikler,[29] and, in the last decades, brilliantly explored by Norbert Wiener[52] and his cybernetic school. Chances for establishing physiological correlations in goal-directed behavior have been first opened up through L. von Bertalanffy's "organismic" conception of biology.[2]

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to the influence of emotions, with nothing implied but the organism which has them. We place emotions in the forefront of investigative interest.

On grounds of hedonic derivation and motivating action, emotions are divided into two classes: emergency emotions, such as fear, rage, guilty fear, and guilty rage, based on present pain or the anticipation of pain, and welfare emotions, such as pleasurable desire, joy, affection, love, and pride, based on present pleasure or the anticipation of pleasure.

Freud's structural theory envisaged a "mental apparatus" composed of super-ego, described as internalization of the demanding father; id, from the description given, recognizable as unwitting internalization of a seductive mother; and ego, described as mediator between the super-ego, the id, and the outer world.[11] The arrangement recalls the traditional imagery of earth placed between heaven and hell. Super-ego, id, and ego are artistic personifications of conscience, passion, and adaptive common sense.[40]

I have introduced the concept of a "psychodynamic cerebral system" which includes a hierarchically organized "integrative apparatus."[31, 34, 38, 40, 42, 47] This apparatus is composed of four evolutionary levels connected by a common stem. The latter, called the action self, is the supreme unit of the entire apparatus, controlling activity at each of its four levels. It may be described as the organism's systemic picture of itself, derived from the information it receives about its own activities by means of its sensory equipment. If, as Sherrington thought,[51] mind develops as manager of muscle, it is fitting that the action self should arise from kinesthetic (proprioceptive) information. In our mammalian species, presumably it is the infant's sucking at the mother's breast, his most forceful and pleasurable activity, that first engenders in him, in an unfathomable manner, an awareness of self: "I am the one who sucks." This hypothesis, derived from psychoanalytic observation, is splendidly supported by William James's self-observation aimed at discovering the site and quality of the feeling of self. "*When carefully examined,*" he stated, "*the self is found to consist mainly of the collection of these peculiar* [bodily] *motions in the head or between the head and the throat*" [James's italics].[20] Thus, from its kinesthetic reports arises the organism's circular pattern of self-awareness and willed action. This is then complemented by information arriving through haptic, olfactory, acoustic, optic and other sensory channels, including the comments on its performance which the organism receives in its communicative exchange with its human environment. The action self's outward expression is cultural self-realization, fulfillment of the organism's desire to have its own way.

At the phylogenetically oldest level, hedonic self-regulation is established: moving toward the source of pleasure and away from the cause of pain, the organism seeks to repeat pleasurable experiences and to avoid repeating painful ones.[34] During the process of maturation, however, experience forces it to accept delayed reward in lieu of immediate reward.

At the next three levels, behavior is integrated by means of increasingly higher order—preverbal brute emotion, emotional thought, and unemotional (impartial) thought, respectively. Emotional thought is strongly biased, feeding the emotion from which it springs and by which it is controlled. Its ubiquitous conflicts with rational thought make its exploration a major task of psychiatry.

The socially crucial function whose traditional name is conscience develops during childhood in the situation of parental dependence.[31, 34, 35, 40] Its essential mechanisms perform the tasks of self-examination, self-prodding through self-reward (self-respect and moral pride), self-restraint through fear of inescapable punishment, and repair through expiatory self-punishment. These mechanisms develop through anticipation of parental criticism, parental reward (bestowing of pleasure), and parental punishment (inflicting of pain), through the gradual automatization of these anticipatory acts and the use of parental behavior as a model for emulation. True to its adaptive purpose, healthy conscience effects moral self-restraint and promotes peaceful cooperation and cultural achievement by means of self-reward. It is a beautiful example of autoplastic adaptation. The appearance of automatized mechanisms of expiatory self-

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punishment in its organization signifies pathological developments.

The nervous activity of the brain is in part reporting, in part nonreporting.[34,41] Reporting brain activity produces the state and contents of consciousness; hence, we speak of the brain-physiological reporting process, and the corresponding psychodynamic awareness process, or stream of consciousness; we arrive at the former concept when viewing the organism from without (inspection) and at the latter when viewing it from within (introspection). A gross correlation is better than none. Therefore, in the sense of Spinoza we assume that the physiological reporting process and the psychodynamic awareness process are synchronous and congruent; they depict but two aspects of the same reality—one in the language and conceptual scheme of inspection, and the other, of introspection. The terms of the former are reducible to measurement by yardstick and clock; those of the latter are not. In my opinion the overdue construction of a logically consistent and truly complementary theory of the human organism can make no substantial progress without first exploring—in particular, from the linguistic angle—the profound differences between these two conceptual schemes.

Most of the brain's activity is purely physiological; thus, from the psychodynamic point of view, it is nonreporting; yet it profoundly influences behavior, and its motivational significance may, to some extent, be inferred from the contents of consciousness. In making such inferences, we interpret purely physiological brain activity in an extrapolated language of psychodynamics. We thus speak of nonreporting thoughts, feelings, tensions, intentions, and, in general, of nonreporting processes.

The concept of a "psychodynamic cerebral system" thus embraces (1) the reporting range of the brain's nervous activity in both its psychodynamic and physiodynamic aspects, and (2) that range of nonreporting brain activity which is nonetheless accessible to "extrapolative" investigation by psychodynamic methods as well as to ordinary investigation by physiological methods. If (1) is called mind, then (2) may be called the "inferred mind." "The unconscious" was never related to brain activity. Originally the cornerstone of Freud's work, it has since become a phantom, a prolific source of obscurantist thought.

Integrative activity may have both conscious and nonreporting phases and may involve more than one level of the apparatus.

Memories stored in the inferred mind—in nonreporting brain activity—are either on recall or are excluded from recall by the action of precautionary mechanisms constituting the "pain barrier" and the "social pain guard."[38] Working to avoid pain, these mechanisms also prevent unwelcome feelings and intentions from rising into consciousness. The most powerful precautionary mechanism is known as repression.

It was Freud's epochal feat to explore the patient in a controlled emotional situation that enabled him to relax his precautionary mechanisms; in this situation, expecting to be helped by the procedure, the patient could reproduce and express freely an abundance of heretofore repressed feelings and thoughts.[33] This process of communicated introspection is the essence of the psychoanalytic technique of investigation. Adaptational psychodynamics is based chiefly on information gathered with this technique.

The Dynamics of Obsessive Behavior

We are now prepared to turn to the pathology of obsessive behavior. Overreactive disorders arise from the organism's inability to handle danger situations effectively by its available means of emergency control: in this event, instead of acting as signals, its emergency emotions themselves inflict, or threaten to inflict, damage upon the organism. Thus, in the face of an external danger, far from increasing the organism's efficiency, they come to disorder its systemic operations, adding trouble within to the trouble without. We call this development "emergency dyscontrol." It begins in childhood with the parents' prohibitive measures, their punishments and threats of punishment. The disorder so created may continue or may flare up again in later life. It is then complicated by the consequences of the organism's own miscarried repair work which always includes unnecessary

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inhibitions and a reactivation of the long since out-dated adaptive pattern of infantile dependence. Obsessive behavior is a subdivision of the class of overreactive disorders.

In Freud's view, all neuroses originate in childhood, from conflicts between the child and his parents. Dependent upon loving parental care, the child is, at the same time, subject to parental discipline. Though the conflict and its consequences become repressed, they may nonetheless disturb the patient's development and produce his neurosis.[12] These findings, now widely recognized, are embodied in adaptational psychodynamics. As regards the specific etiology of obsessive neurosis, Freud held that the patient's development was to some extent arrested and thrown back to an earlier stage. The patient's "genital level" was weakened by "fixation" at the previous level; his regression to that level, at which the child's life was dominated by "anal-erotic and sado-masochistic impulses," was considered the key to his obsessive neurosis.[11,12,14,17,21]

Freud's theory calls attention to the processes of bowel training. The child must be helped to bring evacuation under voluntary control. However, bowel control presupposes maturation of the requisite neuromuscular apparatus. If the mother is overambitious, demanding, and impatient, and if the child is marked by a particular combination of characteristics, then the stage is set for the battle of the chamber pot.

Irritated by the mother's interference with his bowel clock, the child responds to her entreaties with enraged defiance, to her punishments and threats of punishment with fearful obedience. The battle is a seesaw, and the mother, to fortify her position, makes the disobedient child feel guilty, undergo deserved punishment, and ask forgiveness. This indoctrination transforms the child's fear into guilty fear, and impresses upon him the reparative procedure of expiatory behavior. The mother-child conflict provokes in the child a struggle between his own guilty fear and his own defiant rage. It is a characteristic of the type of child under consideration that his guilty fear is always somewhat stronger; sooner or later, it represses his defiant rage. Henceforth, his relationship to the mother, and soon to the father, will be determined by this motivating system: *guilty fear over defiant rage* or, *obedience* versus *defiance*. The severity of the conflict, sustained by the inordinate and unrelenting strength of fear and rage, perpetuates this outcome. In our view, with the establishment of this motivating system, the child acquires a crucial factor toward a predisposition to obsessive behavior.

Freud's theory of obsessional neurosis features a "sadistic super-ego" and a "masochistic ego,"[11,14] a dramatization unquestionably inspired by observations similar to the ones from which our interpretation derived. Thus, our interpretation is a development of Freud's early insight. On the other hand, his emphasis on the destinies of evacuative pleasure, their significance in the causation of obsessive behavior, is refuted by clinical experience. He assumed that bowel obedience forces the child to relinquish evacuative pleasure by "sublimating" the desire for it or by stemming its tide by "reaction-formations." These developments were then reflected in the shaping of obsessive symptoms. Bowel defiance, he thought, increases the child's evacuative pleasure. The fact is, however, that children forced into bowel obedience enjoy the evacuative act just as heartily as other children, whereas bowel defiance is often enough strengthened by the intent to avoid an act rendered painful by an anal fissure or some other local disturbance. With her insistence on bowel regularity, the mother hurts not the child's evacuative pleasure but his pride in having his own way. Furthermore, one sees obsessive patients whose bowel training has been uneventful, but they are nonetheless marked by the same severe conflict between guilty fear and defiant rage; it originated in other behavior areas. The future obsessive patient's emphatic obedience and stubborn defiance, far from being limited to his bowel responses as a child, are spread over his entire behavior.*

The pathological development of conscience is directly traceable to the unusual strength of two presumably inherited traits, hopelessly at variance with each other. One is the child's

* The manifestations of defiance were meticulously investigated by David Levy who speaks of them as "oppositional behavior."[25]

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craving for autonomous self-realization, a derivative of his primordial belief in his own omnipotence that drives him to reshape the world about him in his own image, which may also be described as a strong bent for alloplastic adaptation. The other trait is his rationalism, his realistic foresight that forces him to take no chances when it comes to preserving the parent's loving care. In adult life this trait is manifested as a strong desire to be treated by one's social environment as an admiring parent treats a favorite child. Since, however, the parents insist on obedience, and later, society on adherence to its laws and mores, the organism so constituted will eventually do its utmost to conform.

That a child is born to stubborn and tenacious self-assertion may be surmised from the inordinate strength of his rage. This provokes the parents into severe retaliatory measures which, in turn, elicit his defiant rage and even stronger fears. He is thus forced to move with undue haste from ordinary fear of punishment contingent upon detection to fear of conscience, that is, fear of inescapable punishment, and then to guilty fear and the reparative pattern of expiatory self-punishment. Automatization at such an early stage makes these mechanisms overstrong as well as rigid. Healthy conscience fulfills its adaptive function smoothly; it has little need for guilty fear and the reparative work of repentance. But with early automatization, conscience grows into an organization dominated not by the healthy mechanisms of self-reward but by the morbid mechanisms of expiatory self-punishment. The latter are morbid because they are automatized operations not of, but in, the patient; he does not initiate them, nor is he or his environment aware of their meaning; he is aware of only the damaging effects these nonreporting processes inflict upon him. A conscience so constituted will diminish rather than increase the organism's capacity for happiness. It is an example not of autoplastic adaptation but of autoplastic maladaptation.

A closer look at these developments is indicated. Endangered by its rage, and forced to control it, the organism does not rely on merely repressing it; through accumulation, repressed rage may, indeed, reach the point of explosive discharge. To forestall this possibility, as its next precautionary move, the organism turns the larger part of its repressed rage against itself, or, more precisely, against the rest of its repressed rage—the strategy of defeating the enemy with the help of its deserters. The retroflexion is achieved by assimilating repressed rage with the now-prevailing mood of repentance. This explains the clinical fact that the child's (and later the adult's) self-reproaches may far exceed in vehemence the reproaches his parents ever leveled against him, and that his self-punishments may be far more severe than were his parents' threats. The strength of these mechanisms of self-control is determined not by the actual attitude taken by the parents but by the strength of the child's own retroflexed rage.

Fear of conscience and its derivative, guilty fear, rest on the belief in inescapable punishment. This belief cannot stem from experience. The child knows he was punished only when caught. Nor can religious indoctrination be its ultimate source, for it flourishes in agnostic patients as well.

The chain of psychodynamic inferences leads us back to the infant. Elated by the success of his early muscular activities, the infant pictures himself as an omnipotent being. The hard facts force this grand illusion to recede slowly into the range of nonreporting processes. Sensing that his beloved omnipotence is about to evaporate, the child fancies that he has merely delegated it to his parents: they exercise *his* magic powers *for* him. He is then terrified to discover that the parents can turn *his* omnipotence *against* him; he has *no* way of telling what they can now do to him. The dread of inescapable punishment, appearing within his fear of conscience and within his guilty fear, is basically a dread of his own omnipotence, which he now feels the parents can cause to work in reverse. It is powerful enough to retroflex the bulk of his repressed rage. We must assume that stronger-than-average residues of primordial omnipotence are a factor in the predisposition to obsessive behavior.

In the healthy individual, the supreme pleasure of genital orgasm gives rise to a host of affectionate desires, which soften rage by their

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counterbalancing effect. In the obsessive patient, in whom the pleasure of genital orgasm is seen to be comparatively weak, these derivative motivations are enfeebled, without power to soften rage; the job must be done, and is being done, by conscience alone.

One must assume that a shortage of sexual love is genetically determined; in any case, we consider this deficiency a factor in the predisposition to obsessive behavior. It may well be that, genetically, it is linked with the innate strength of rage.

The early rigidity of conscience vitiates its adjustment to the conditions of adult existence. One must qualify the oft-repeated statement that the obsessive patient is overconscientious: he is that chiefly, if not only, in the areas of infantile discipline. His silly excesses in cleanliness, orderliness, regularity, and punctuality show that his conscience still operates in the world of the nursery—ruled most often by an obsessive mother.

Some twenty-five years ago, listening to the jeremiad of a torturous and self-tortured patient, the idea struck me that his obsessive attacks derived from the rage attacks of his childhood.[39] This discovery, abundantly corroborated by subsequent experience, sparked the entire investigation here presented.

In a temper tantrum the discharge of rage is explosive. In an obsessive attack we see the organism struggling with the imperative task of ridding itself of its morbid tensions. Here the discharge of rage, continuously interrupted by counterdischarges of guilty fear, is extremely slow and always incomplete.

The dynamic structure of such attacks is best seen in a simple bout of obsessive ritual making. Here, driven by his tension, the patient performs a sequence of two motor acts and then goes on repeating this same sequence over again. For example, going to bed, he places his shoes on the floor first at right angle, then side by side; then again at right angle, then side by side again, etc. Analysis shows that both acts are symbolic. One expresses the intent of defiant rage to carry out a prohibited desire; the other, the opposite intent of guilty fear. Consequently, one act achieves a fragmentary discharge of morbid rage tension; the other, of morbid fear tension. Repetition of the sequence is continued until tension is somewhat reduced and the patient is exhausted. In its entirety, the process is a mechanism for the alternating discharge of opposite tensions. We call it an interference pattern of discharge;[46] its mode of organization explains why it is so slow and torturous. If the patient tries to stop, his tension becomes so unbearable that he must yield to it and continue. In other forms of obsessive ritual making, the two opposite tensions are discharged by repeating a single act or a stereotyped series of acts; though the motor picture is different, the pattern of discharge is built on the same principle.

The interference pattern of discharge also operates in the brooding spell. Here the discharge is mediated not by seesawing motor acts but by trains of thought traveling in opposite directions. However, doubt and brooding may eventually open the door to mechanisms which are familiar to us from the nonschizophrenic form of paranoid behavior. While, as a rule, their appearance in this context is transient and their form rather rudimentary, such a development is an unwelcome complication of the obsessive picture. In these mechanisms the patient discharges not naked tensions but, in prolonged and separate phases, the full-blooded emergency emotions of guilty fear and guilty rage. Through the quasi delusions of the hypochondriac mechanism, he releases excessive guilty fear at the organismic level; through the quasi-delusional self-preoccupations of the referential mechanism, he likewise releases excessive guilty fear, but this time at the social level; on the other hand, through the quasi delusions of the persecutory mechanism, he vents, in presumed self-defense, his guilty rage.[39]

The problem of discharge in fits of horrific temptation will be considered later.

At this point the relation of full-blooded emotions to their denuded tensions must be clarified by completing our examination of the organism's repressive activities. The patient is just as unaware of his guilty fear as he is of his defiant rage. As stated before, excessive guilty fear prompts the organism to repress its slightly less excessive defiant rage. We must now add: Humiliated by its guilty fear, the organism soon represses its guilty fear as well. The out-

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come is a tripartite motivating system: restored pride over repressed guilty fear over more strongly repressed defiant rage. In contradistinction to the brute pride that the organism takes in its self-assertive rage, we call this restored pride domesticated or moral pride; now proud of its virtuous conduct, the organism does not choose to remember that it has been forced into morality by its guilty fear of inescapable punishment.

These repressions do not, however, sufficiently control the patient's excessive, if not altogether inappropriate, emergency emotions. Though the repressive mechanism succeeds in inhibiting their characteristic feeling tone and peripheral expression, as well as the thoughts engendered by them, nevertheless the overflowing tensions of the patient's fears and rages penetrate his consciousness. Though his tension fluctuates in degree, he feels tense most of the time, complains about it, and recognizes it when it is brought to his attention. Excessive emergency emotions tax the power of the repressive mechanism. Healthy persons, too, experience naked tensions arising from an imperfectly repressed emotional turmoil, though far less frequently, but in the obsessive patient this failure is chronic and produces far more serious consequences.

Our next task is to trace the multifarious influences that contribute to the shaping of obsessive attacks and traits. The rage that filters through in an obsessive attack is the characteristic reaction to frustration. Some of the patient's present resentments repeat the ones he had experienced in childhood when his parents denied him fulfillment of his most highly valued desires. His rage was then, as it is now, his instrument for making them give in or go away. He wished they were dead. Of course, he took it for granted that when needed they would promptly return—and behave. The child's quick death-wishes, reflecting his ignorance, are not really murderous; they are only coercive, as are so many other expressions of his rage.

At first the child uses rage to force satisfaction of a particular prohibited desire. Later, as a matter of policy, he wishes to keep the parents under permanent control; they should let him have his own way and still love him. While continuing to serve other ends, the desire to dominate becomes a goal in itself. Next, the child wishes to eliminate, or at least dominate, his siblings; they must not be allowed to compete with him for the position of the favorite child. This motive produces the clinical pictures of "sibling rivalry."[26] The obsessive patient is the child who has, despite innumerable defeats, retained these attitudes for life. His ritual making and brooding perpetuate the struggle for dominance, drawing their original dramatic contents from the long-since-repressed conflict situations of his early years. This remarkable fact shows that its repressed rage glues the organism to humiliating experiences of its past. Its thirst for wiping out those humiliations takes precedence over its desire to repeat routine gratifications: triumph is a stronger self-reward than routine pride.

The child's first orgastic experience, made often by chance, awakens his desire for genital self-stimulation. This applies to boys and girls alike. The mother (father) counters the child's practice with a campaign of deterrence, threatening, among other things, punitive removal of his (her) guilty hands and of the boy's penis (Freud's "threat of castration"). He (she) is now caught in the clash between two groups of forces of almost equal strength: *prohibited sexual desire plus defiant rage* versus *fear of conscience plus guilty fear*. This is a precarious situation; to touch or not to touch is now the question. He (she) may find a mode of orgastic arousal that does not depend for its success upon touching the genital organ. He outsmarts the parents by sticking to their words. Later, he will try to circumvent, in the same manner, prohibitions of whatever kind.

If, however, guilty fear prevails and he represses his prohibited genital desire, he may switch his pleasure-seeking tendency and self-stimulatory practices to his anus, or resign and develop a tic, or go into ritual making. It is almost unbelievable to what extent the obsessive ritual may draw its basic conflicts from the now-repressed tragedies of the past. This is particularly true of the struggle, begun in childhood and resumed at puberty, to achieve the genital abstinence demanded of him.

The child may advance his forced precau-

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tionary moves to an earlier target point. His parents' intimacies, which he witnessed by chance if not surreptitiously, aroused him. Were it not for his parents' example, he would not have to struggle with his temptation. His effort to keep the parents sexually apart may continue under the guise of an obsessive ritual.

In passing, it should be noted that motives of this kind may produce socially valuable results rather than disorder. A brilliant electrical engineer, in his middle twenties, had more than a dozen patents to his credit. His inventions ranged over a wide variety of technologically unrelated problems. Until his treatment, he never realized that, each time, his success hinged upon preventing the formation of an electric spark. He was an only child who, as an adolescent, had managed to break up his parents' marriage; his infantile obsession to prevent them from having another child eventually besieged his scientific imagination.

The organs the obsessive patient most often uses in his ritual making are the four extremities. Their psychodynamic significance dates from the corresponding stages of neuromuscular maturation and derives from the sequence of illusions which the child develops about his newly won powers. Gorged with his success in coordination, he grandiosely overestimates the might of his hands and feet, in particular, of his trampling feet. This illusion persists in the patient's ritual making, whose procedures, as we shall see, are performed not for their physical but for their hoped-for magical effect.

Earlier, the child believes that his mouth, in particular the biting teeth, is his most powerful weapon. He will have fear-ridden dreams —as will later the adult—in which he loses his teeth; this means that he loses the magic power of his coercive rage to secure domination for him and the magic power of his sexual organ to give him orgastic satisfaction. Attempts to control the dangerous power of teeth may eventuate in their compulsive grinding in sleep. The charm may spread to saliva (compulsive spitting) and to speech. Verbal attack knows no limits when words have magic power. This is seen in the obsessive patient's resort to magic words and in the ordinary citizen's use of cursing. As we shall later see, the magic of words is also a significant component in the dynamics of stammering.

To spit, void, or defecate upon someone are the expressions used in the vernacular to signify contempt. This language usage derives from the annihilating magical effect attributed by the child to his excretions and evacuative acts. But, in the contrary emotional context of yearning for help, the same excretions are relied upon to produce a healing effect. The puzzle of their antithetical meaning and significance is solved by the simple fact that they are utilized as tools by love and hate alike. In ritual making, no nonreporting motive occurs more frequently than the fear of having been contaminated by someone's secretions or excretions, or the desire thus to contaminate someone else.

The fact that magic thought appears in the shaping of obsessive behavior was discovered at an early date by Freud and Ferenczi.[7,18] We have shown that magic's deepest root is the infant's belief in his own omnipotence, in his primordial self which we view as the nucleus of the action self. From this source derive the obsessive patient's superstitions which he is reluctant to admit even to himself.

Our theory of primordial self also explains the fact that magic is universal. In our culture its most common manifestations are our wishful or fear-ridden dreams and daydreams, the creative arts, the performing arts, the born leader's charism, etc. In emotional thought—be it lovebound, ragebound, or fearbound—the power of the wish corrects reality. To a degree, all emotional thought is magic thought. In pathology, however, the purpose for which magic is used depends upon the nature of the disorder. The obsessive disorder specializes in coercive magic; the expressional (so-called hysteric), in the performance magic of illusory fulfillment. In the former, unknown to himself, the patient seeks to break his prohibitive parent, intent on turning him into a first-class slave; in the latter, likewise unknown to himself, he materializes his adolescent dreams of drama, romance, and glory.[39]

We shall now revert to the patient's fits of horrific temptation. Though hardly more than a signal of rage below, his temptation shakes

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the patient's proud morality. His reaction of horror amounts to a voluminous discharge of guilty fear; it may take him hours to regain his composure. His groping for safeguards tends to disrupt the pattern of his routine activities; he is distracted, makes mistakes, loses himself in aimless repetitions, and does not really know where to turn.

It would be a serious mistake to surmise that the patient bursts with repressed rage. On the contrary, closer examination shows that his outward-bound rage has been almost completely retroflexed, turned upon himself; all he can do with it now is to torture himself. To be able to vent it, instead, upon the environment would be his salvation. This inspiration of despair is, indeed, the secret message that his horrific temptation to kill conveys: "I wish I were a murderer."

Extreme retroflexion of rage may be precipitated by opposite errors in education. Too harsh discipline is bound to break the child; oversolicitousness is likely to disarm him: "My parents are so nice to me, I cannot allow myself to get angry at them even when I should." A patient who suffered from the horrific temptation to kill the grandchild she loved most had been overindulged all her life.

Horrific temptation may take the form of obsessive confession, a mechanism first described by Theodor Reik.[50] Learning about a crime from the newspapers, the patient may at once be convinced that it was committed by himself. Nonreporting guilty fears may accumulate from an endless series of nonreporting temptations. To relieve such insupportable guilty fears, to secure deserved punishment and eventual forgiveness, the patient may confess to a crime he never committed. Fëdor Dostoevski, our best pathologist of conscience so far, described memorable examples of this obsession. Police chronicles literally abound with such cases.

If the patient develops a severe depression, his morbid self-accusations not infrequently refer to a beloved person whose actual wrongdoings he blames on himself. Such self-inculpatory fits have, invariably, an ironic intent.[46]

Under the accidental influences of his changing life situation, the patient may shift his doubts and broodings from one favored subject matter to another, and move the seesaw of his symbolic transgressions and repentances further and further away from the original contents of his conflict. But the motivating system responsible for these activities remains the same, showing that the obsessive attack must be understood in terms not of its dramatics but of its function of discharge.

From the model of the patient's obsessive attacks, we can readily understand his obsessive traits, for, in one way or the other, most of these permanent marks derive from the same motivating system—perpetuation of the infantile conflict between the child's overstrong tendency to self-assertive domination versus his still stronger clinging to the security of being loved and cared for. The more environment-directed rage slips through, the stronger the self-assertive aspect of his traits; and, on the contrary, the keener his rational foresight and prudence, the more prevalent will be his traits of cautious avoidance.

The patient's craving for perfection is a direct expression of his primordial almightiness; to the warning that no one can be perfect in an imperfect world, he will respond with a polite smile.

Special mention must be made of the attitude the obsessive patient displays toward the competitive aspects of life. He may be prudent enough to limit his fierce competitive efforts to his major areas of aspiration. He often professes the doctrine of fair play which calls for competitive cooperation, victory through superior performance. At the same time, not always unwittingly, he may quietly employ all the tricks of sibling rivalry, seeking to discourage if not to disqualify his most dangerous competitors from staying in the race, then rush to offer assistance to his victims. When in a slightly elated state, he may be seen competing indiscriminately for almost anything.

In the obsessive patient the manifold and widespread motivations ordinarily sustained by affection and sexual love are diminished in both strength and scope, presumably because his genital orgasm lacks the overwhelming force and pleasure it has in healthy people.

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We suspect strongly that this is an innate trait. It must not be confused with the patient's capacity for sexual performance, which may be unimpaired. Unwittingly, the patient is prone to make up for his romantic impoverishment by pedantic execution of the act. He is not exactly a lover, but he is a dependable ritual maker. If an impairment of performance is present, however, its pathological mechanisms are the same as elsewhere.[32, 37] The question of sexual pain dependence will be dealt with in another context.

A few words should be added about the obsessive patient's "ambivalence." Bleuler, who coined the term in his work on schizophrenia, distinguished between intellectual, emotional, and volitional ambivalence.[3] We trace these manifestations uniformly to the severity of the underlying obedience-defiance conflict. Bleuler stressed the fact that the schizophrenic patient, like the child, tolerates the coexistence of conflicting thoughts or feelings or impulses in his consciousness. The opposite is true of the obsessive patient. While the schizophrenic patient is, or appears to be, unaware of such conflicts in him, the obsessive patient is, more often than not, only too keenly aware of them. He ponders unendingly: Must he give in, or could he gain the upper hand without giving offense? Facing the same question, the ordinary citizen makes a decision and sticks to it. But to the obsessive patient this question is a dilemma that throws him into endless broodings and keeps him engaged in countless postmortems. Since the two tendencies concerned are almost equally overstrong, he will always believe that he made the wrong decision. He could have won, why didn't he try? If he wins, he is afraid he will have to pay for it. He cannot make up his mind: Does he love his wife or does he hate her? If he loves her, why does he resent almost everything she does? And if he hates her, why does he cling to her so firmly? He is aware that his indecision is both widespread and chronic.

The obsessive patient excels in repeating the component acts of performance. Repetition enters as an organizing principle into his ritual making, brooding, and, to some extent, the entire routine of his daily life. Its origin is unmistakable. Repetition is pre-eminently the technique employed in the learning process. Whatever the child has to or wants to learn must be repeated and practiced. The point is that it is the parents who impose this maxim upon him. The defiantly obedient child, the future obsessive patient, carries it, in utmost seriousness, to absurdity: "All right, all right, if this is how you want me to do it, I shall go on and on until *you* get sick and tired of it." His senseless use of repetition is a travesty of the learning technique. Aside from this, repetition is forced upon him by the prompt interdictions of conscience. Interrupted by them as soon as he starts, he must make a fresh start over and over again. He never gets beyond the first step toward the nonreporting goal of his forced effort. Without loss of ironic intent, repetition thus becomes an integral feature of the interference pattern of discharge.

Stammering is a speech disorder closely related to obsessive behavior. They have two dynamic features in common—motivating system and interference pattern of discharge. The stammerer gives a drastic illustration of the afore-mentioned point: He, too, gets stuck at the start—in the first letter or syllable—and repeats it until he is able to complete the word. In stammering the organism acts upon the early illusion that its most powerful weapon is the mouth; its rage is channeled into speech. Naturally, in the motivational context of rage, the magic of words is coercive or vindictive. To the nonreporting range the letters or syllables in which the patient most often gets stuck signify the beginning of a verbal assault —obscenity, cursing, etc. Without knowing why, he gets scared. Guilty fear promptly stops his speech, as if to warn, "Watch your words." This mechanism explains why stammering disappears in situations which obviate the necessity of precautions. As is generally known, the stammerer's speech is undisturbed when he is alone, or recites the same lines together with an entire group, or when he sings, etc. Otherwise, humiliated by his defect, he tends to withdraw and reduce his speech to a minimum; this phobic avoidance is, of course, a secondary development. Or, if the patient is angered by his defect, he will stubbornly insist on speak-

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ing and finishing what he wants to say. In this effort, one of my patients pressed his teeth together, blushed, his cheek muscle vibrating restlessly and going into spasm. I should like to close these remarks on stammering with a personal reminiscence. When I was a young psychoanalyst, a dear friend and mentor of mine referred a severe stammerer to me for treatment, explaining the nature of this disorder as follows: "Stammering is a conflict between the urethral-erotic tendency to expulsion and the anal-erotic tendency to retention, displaced upward to the mouth. *Eine Verschiebung von unten nach oben,* that's what it is." In this explanation my friend's romantic enthusiasm for the libido theory eclipsed his native brilliance; he was, in human quality as well as in scientific achievement, the towering figure among Freud's early disciples.

Like all chronic disorders, obsessive behavior imposes unfavorable modifications upon the organism's pattern of interaction with its social environment. It forces the patient to live on an ever-rising obsessive note of tension, lowering his adaptive efficiency, capacity for enjoyment, and active achievement in life.

The onset and further course of the disorder, as well as the measure of its severity, vary widely. In evaluating the degree, we have to consider three pathological factors: the first is the degree to which the self-punitive mechanisms of conscience have become automatized; the second is the degree of the patient's pleasure deficiency, which is indirectly responsible for his severity of conscience; the third, closely linked with the first, is the presence and degree of pain dependence.

Clinically, we can readily appraise degrees of automatization and residual flexibility, by watching, as we do in a laboratory experiment, the influence that stress, absence of stress, and other factors have upon an established response. But about the organization of these highly significant processes we are completely in the dark and will probably remain there until behavior physiology comes to our aid. Unfortunately, as far as mechanisms of conscience are concerned, little help can be expected from animal studies.

Pain dependence is a chronic disturbance imposed upon the organism chiefly by its own retroflexed rage, which, in turn, is an outcome of restrictive upbringing.[31, 32, 37] Its various forms may be observed in the pathological context of any disorder. In the obsessive patient, the form called moral pain dependence is most frequent. Its development may be summed up as follows: His omnipresent and unrelenting fear of conscience—fear of inescapable punishment—and his refusal to take chances with his security force the patient to shy further and further away from activities that could lead him into temptation. From its original area the inhibition thus spreads to include the approaches to this area, thence to include approaches to these aproaches, and so on in ever-widening circles of precautions.

A graphic and typical illustration of this process is supplied by a patient who, as an adolescent, was prohibited from visiting a house of ill repute. He avoided the house as ordered, then he felt compelled to avoid the street in which the house was located, and eventually he avoided the entire section of the city. By coincidence, he subsequently had to move to a town in which there was no house of ill repute; he departed with a sigh of relief. Unfortunately, in this town he discovered a former schoolmate who had since acquired an unsavory reputation; step by step he developed the same series of precautions. Changing circumstances are powerless to terminate obsessive preoccupation; the same idea will force itself upon the patient in another form. In this patient his house-of-ill-repute experience became the hidden content of an obsessive ritual.

Yet no man can stay alive without satisfying, one way or another, the organism's minimal hedonic requirements, and so the patient is forced to find solace and high moral gratification in the fact that he is a "fine man." He discovers more and more opportunities to "fulfill his duty," imposing upon himself burdens and sacrifices which often enough do no good either to him or to anyone else. He becomes a self-styled martyr—without a cause. In moral pain dependence, under the supremacy of retroflexed rage, conscience defeats its purpose.

However, the obsessive patient may also

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suffer from sexual pain dependence. As a source of pleasure, genital orgasm is unrivaled. If, as they usually do, the parents interfere, the organism puts up a hard fight to protect it. We have already seen that the child may circumvent the parental prohibition by indirect modes of stimulation. But there are other methods. Defeated as a child by the campaign of deterrence, the adolescent may find himself incapacitated for standard sexual performance. By chance, he then discovers that his submission to humiliation or other abuse has a disinhibitory effect upon his performance. Analysis reveals the reason: He has taken the inescapable punishment beforehand; now he is entitled to prove that he deserved it. He develops the practice of inviting abuse (short of serious injury) from the mate, thereby restoring his (her) capacity for performance. We call this practice the fear-ridden or submissive version of sexual pain dependence.

Another patient may discover that coercive rage takes care of his trouble. Assuming the role of the authority, he (she) inflicts the dreaded punishment upon the mate, enjoying vicariously the mate's suffering. The triumph unfreezes and strengthens his (her) sexual potency even more. This practice is called the enraged or triumphant version of sexual pain dependence. The two versions of this disturbance are far less self-destructive than is moral pain dependence.

I shall now sum up the etiologically significant results of this analysis. Obsessive behavior is based on a predisposition which is acquired in childhood and includes five clearly discernible factors: (1) overstrong rage; (2) guilty fear made stronger by retroflexion of the larger part of repressed rage; (3) stronger-than-average residues of primordial omnipotence that make rage strong and its paradoxical retroflexion possible; (4) relative pleasure deficiency in the area of genital orgasm, with its consequent enfeeblement of genital love and affection—a deficiency that makes it imperative to control repressed rage by retroflexion; (5) intelligent foresight leading to realistic fears. Presumably, the acquired predisposition to obsessive behavior is based on a genetic predisposition in which the overstrength of rage may be linked with the pleasure deficiency of sexual orgasm.

Parental punishment initiates a pathological development of conscience—repression of defiant rage, first by fear of punishment contingent upon detection, and, later, by fear of conscience—of inescapable punishment and guilty fear. The child's fear that the parents can make his omnipotence work in reverse increases his fear of conscience and guilty fear to such a degree that they become capable of retroflexing, as an added safety measure, the larger part of his repressed rage. Retroflexed rage makes remorseful self-reproaches and expiatory self-punishments all the more severe.

Accumulation of excessive emergency emotions in the nonreporting range—guilty fear and the rest of outward-bound rage—forces the organism to create an outlet. His denuded tensions filter through the pain barrier of repression and produce the obsessive attacks with their interference pattern of discharge. Horrific temptations arise when the retroflexion of rage is carried to an extreme. They show that, in his despair, the tortured patient would prefer to be a murderer.

Looking once again at the motivating system, we find rage at the bottom, in the key position: restored pride over repressed guilty fear over more strongly repressed defiant rage. Beyond a shadow of a doubt, in the etiology of obsessive behavior the ultimate psychodynamically ascertainable factor is rage.

In 1926 Freud[14] summed up his etiological theory of neurosis in the following beautifully phrased (in the German original) passage that ends on a disarming note:

> These minor rectifications cannot in any way alter the main fact that a great many people remain infantile in their behaviour in regard to danger and do not overcome age-old determinants of fear [*Angst*]. To deny this would be to deny the existence of neurosis, for it is precisely such people whom we call neurotics. But how is this possible? Why are not all neuroses episodes in the development of the individual which come to a close when the next phase is reached? Whence comes the element of persistence in these reactions to danger? Why does the affect

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of *fear* [*Angst*] *alone* seem to enjoy the advantage over all other affects of evoking reactions which are distinguished from the rest in being abnormal and which, through their inexpedience, run counter to the movement of life? In other words, we have once more unexpectedly come upon the riddle which has so often confronted us: whence does neurosis come—what is its ultimate, its own peculiar meaning? After whole tens of years of psychoanalytic work we are as much in the dark about this problem as ever. [Italics supplied.]

In the above paragraph Freud does not so much as mention rage, or even imply it, say, by some reference to his so-called "death instinct," that "instinct of destruction and self-destruction."

I have shown here that persistence and excessive strength of the child's fears are necessary consequences of the fact that the child—and later the adult—is forced to hold his rage in check. My examination of the other psychoneuroses (the overreactive and mood-cyclic disorders of our classification) has led me to the same conclusion. Summing up a series of studies, I wrote in 1955:[31]

Caught in the clash between their own defiant rage (violence from within) and the retaliatory rage of their parents (violence from without), these patients [suffering from overreactive and moodcyclic disorders] have emerged from childhood with an established pattern of adaptation that forces them unawares to damage themselves in order to avoid the dreaded danger of damaging others. Their suffering is increased if they develop pain-dependence.

The primary task of education is to domesticate the infant, to make him fit for social life by taming his rage. If this process miscarries, the child's inadequately controlled rage will cause behavior disorders. Trapped for decades in a labyrinth of misconstructed theories, it may well be that we are at last finding our way back to the obvious.

From the analysis of obsessive behavior, we derive a general insight. Since, in all overreactive and mood-cyclic disorders, the root disturbance is emergency dyscontrol, the principal dynamic function of these disorders is to discharge the insupportable tensions created by emergency dyscontrol. Or, to put it more precisely, these disorders are created by the biological necessity to discharge insupportable tensions; in each of them, formation of the characteristic clinical picture is then influenced by contributory causes.

The physiological pathology and the genetics of obsessive behavior have hardly reached even the preparatory stage of development. To offer clues to such investigations is a psychodynamic task of paramount importance.

¶ Differential Diagnosis

A sprinkling of obsessive mechanisms may be found in any person. The diagnosis of obsessive behavior must rest on the evaluation of the total picture. On the other hand, as will presently be shown, obsessive behavior may be complicated by mechanisms known to be characteristic of other disorders; this fact calls for differential diagnosis.

Phobic avoidance, the mechanism of the so-called phobias, is frequently seen in obsessive behavior, but there is no difficulty in telling the two disorders apart. We speak of phobia when the clinical picture is dominated by the avoidance mechanism but other signs of obsessive behavior are absent. Analogous considerations apply to the differential diagnosis between nonschizophrenic paranoid behavior and obsessive behavior.

The presence of sexual pain dependence does not by any means point to obsessive behavior. As mentioned before, this disturbance may occur in a variety of behavior disorders or may constitute one by itself.

I have never seen a true expressional pattern combined with true obsessive behavior in the same patient. In early psychoanalytic literature, statements to the effect that obsessional neurosis always has a "hysteric nucleus" are explained by the fact that Freud called the phobias "fear hysterias" (*Angsthysterien*). We classify them as phobic forms of emergency dyscontrol; psychodynamically, they are quite unrelated to the syndromes of expressional behavior.

Obsessive behavior may appear during the

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intervals between two phases of mood-cyclic behavior.[1, 46] This fact is revealed by the patient's history.

Though these questions may claim theoretical interest, their practical value is nil. In contradistinction, the diagnostic separation of genuinely obsessive behavior from certain forms of schizophrenia is a task of serious theoretical as well as practical significance. The occurrence in schizophrenic patients of obsessive, hysteric, phobic, and other apparently neurotic symptoms has been established by Bleuler,[4] Freud, and other clinical observers. More recently, Paul H. Hoch and Philip Polatin designated this group of cases as "pseudoneurotic schizophrenia."[19] In retrospect, there can be no doubt that Josef Breuer's famous patient suffered not, as he and Freud believed, from hysteria but from schizophrenia.[5] Freud suspected that his famous "Wolfman" was schizophrenic.[13] With our increasing knowledge of schizophrenia, we are now sure that he was. The analysis of this case became a classic in the psychoanalytic literature of the psychoneuroses. The patient from whose observation Ferenczi abstracted his concept of "pathoneurosis"[6] was subsequently treated by myself in a mental hospital where he spent month after month in a catatonic stupor. One cannot escape the impression that the number of schizophrenic patients erroneously diagnosed and treated as "obsessive-compulsive neurosis," "conversion hysteria," "anxiety hysteria," "mixed psychoneurosis," and so forth has been and continues to be very high.

Help may come from the "theory of schizotypal organization."[34, 49] The genetic origin of schizophrenia was definitely established by the work of Franz Kallmann[22, 23] and others. Taking this fact as a point of departure, my theory of schizotypal organization holds that the organizing causes of schizophrenic differentness reside, more than anywhere else, in the integrative apparatus. The individual called schizotype—schizophrenic phenotype—is marked by two fundamental, genetically determined, impairments:

1. The capacity for pleasure is diminished, pleasure's ordinarily strong motivating action enfeebled; this impairment is designated as integrative pleasure deficiency.

2. The individual's awareness of his own body is, or tends to become, distorted; this clinical fact is interpreted as an impairment of the action self, hence, in the last analysis, of the proprioceptive system.

It must be stressed that the degree of these impairments varies widely from patient to patient. Together, integrative pleasure deficiency and proprioceptive impairment give rise to a compensatory system of adaptation which is peculiar to the schizotype. If properly developed, the system of schizoadaptation may work well and hold the individual in a compensated state for the rest of his life. Otherwise, emergency dyscontrol may precipitate decompensation, producing the clinical pictures of pseudoneurotic schizophrenia. In a gradual breakdown of the system of schizoadaptation, next appears the stage of disintegration, of adaptive incompetence manifested in the clinical pictures of overt schizophrenic psychosis. The last stage, known as deterioration, may, in most instances, be due to lack of proper care. It is marked by a lasting cessation of function, signifying a nearly complete withdrawal from the adaptive task.

The clinical pictures of schizotypal disintegration can hardly be mistaken for obsessive behavior, but there is a large margin for diagnostic error in pseudoneurotic schizophrenia. Here the clinical picture may include a variety of pseudo-obsessive, pseudophobic, pseudo-expressional, and still other mechanisms, all deriving from the obedience-defiance conflict, which, in my view, is the predominant motivating system in schizoadaptive behavior. The differential diagnosis rests on the presence or absence of minute schizophrenic traits and on the experienced psychiatrist's ability to use his own emotional resonance as an exploratory tool.[44, 47] Verification of his findings by subsequent developments may teach him to spot the schizotype "by feel."

Statistics on schizophrenia are misleading, for they deal only with the incidence of overt schizophrenic psychosis; increasing familiarity with pseudoneurotic schizophrenia has opened

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our eyes to the fact that, in the general population, the number of schizotypes is a multiple of 0.8 per cent.[23] Now the pendulum of privately voiced opinion is in the process of swinging to the other extreme. Looking at the procession of patients in private practice as well as in outpatient clinics, competent observers wonder if they will ever again encounter a case of genuine "obsessive-compulsive neurosis" (obsessive behavior) or "conversion hysteria" (expressional behavior). The implication is that such things do not exist. In my opinion they do, though in the last few decades in the United States their incidence has conspicuously declined. The development of obsessive (and even more so, of expressional) behavior is strongly influenced by the cultural climate, in particular by our shift from "prohibitive" to "permissive" education. In the teens and twenties on the European continent, the incidence of obsessive (and of expressional) behavior was high, and that of juvenile delinquency low; today, in the United States, the picture is exactly reversed.

One can only urge that the differential diagnosis be made as early as possible, since the overreactive (and mood-cyclic) disorders on the one hand, and the schizotypal disorders on the other, require radically different treatment procedures.

In view of the wide distribution of schizogenic heredity, one may speculate that, though in the schizotype the two constitutive impairments are firmly linked, there may be individuals of another type who are what they are because they have inherited only integrative pleasure deficiency. The proprioceptive impairment got lost in the Mendelian shuffle. A hemischizophrenic heredity such as this may contribute a significant component to the presumed genetic basis of obsessive behavior. The patient's integrative pleasure deficiency, even if limited to the pleasure of genital orgasm (and the sexual love derived from it) may give him the appearance of a schizotype, which he is not. In my view, without proprioceptive impairment there is no schizotype; hence no schizophrenia. If we had a method for disclosing a latent proprioceptive impairment, the problem of differential diagnosis would, I strongly believe, be solved.

¶ Treatment

Self-control by obsessions is a torturous outgrowth of emergency dyscontrol. The damage it inflicts upon the organism may be measured in terms of suffering, lost time, and wasted effort. Every reduction of these losses is a potential gain for the patient's healthy pursuits. It is only by means of psychotherapy that we can help him extricate himself from the clutches of his obsessions, or, if this is impossible, at least diminish their hold on him.

We distinguish (1) reconstructive, (2) quasi-reconstructive, and (3) reparative methods.[30, 47, 48]

Reconstructive Treatment

Reconstructive therapy is a psychoanalytic procedure which is based on adaptational psychodynamics and employs the adaptational technique.[30, 47, 48] It is the method of choice for the treatment of patients suffering from an overreactive disorder. These patients have remained at, or regressed to, the adaptive level of infantile dependence. By removing their inhibitions, the reconstructive method seeks to enable them to rise to the level of maturity. Toward this end it (1) engenders in them processes of *emotional* learning and un-learning, (2) keeps them, as much as possible, at the level of self-reliant cooperation (adult treatment behavior) throughout the entire course of treatment. The reconstructive method should be used only by psychiatrists who have received special training and acquired full command of its technique. Of special value in the treatment of obsessive patients are its revised conception of the dynamics of obsessive behavior, its strict avoidance of ambiguous terms and theories, its abstention from ritualized proceedings, and its special measures for probing, releasing, and dissipating the patient's repressed rages.

Under the classical "transference" procedure, the patient lavishly used the psychoanalyst as

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a willing scapegoat, thus replenishing his supply of guilty fears. For, regardless of the analyst's interpretations ("You don't mean me, you mean your father") he, in fact, never lost sight of his actual dependence upon this man's therapeutic skill and interest. Unnoticed by either of the parties, the seesaw of the patient's outbursts and repentances tended to become a ritual in itself—neat, interminable, and inconsequential. "My patient," I once heard a colleague exclaim in a conference, "seems to take special delight in reciting to me the entire Freudian theory back and forth, but otherwise nothing whatsoever has changed." I remarked: "Don't you think your patient is teasing you?"

Under the adaptational technique the patient is led to discover the true objects of his repressed rages and to discharge his repressed rages in the memory context of the original cast and experiences that provoked them.[30] As soon as the patient regains his composure, an exploratory analysis follows, conducted in simple terms of motivation, showing him why he behaved in the reported situation the way he did, and, by contrast, how healthy people behave in similar circumstances. The same technique is repeated on every single occasion of this kind—the oftener, the better. Patients with a period of classical treatment to their credit may, at first, resent and resist this technique. The obsessive patient likes nothing better than to make a monkey of the therapist and himself, without having the remotest inkling that this is precisely what he is doing.

The patient must be kept motivated for hopeful and realistic cooperation throughout the entire treatment procedure. If and when such an atmosphere is achieved, then the main task is to modify the tripartite motivating system by breaking up the mechanism of retroflexed rage, thus reducing the patient's guilty fears and expiatory self-punishments. He must learn, first, to face his full rage and then to nip it in the bud with a special technique of complete and instantaneous relaxation. It is a technique of rage abortion; as a control measure, the exact opposite of rage suppression. It requires prolonged and patient practicing until it becomes semiautomatized. It does not replace insight; it makes it effective. Decades of experience have shown that insight by itself is powerless to forestall either renewed repression of rage or its renewed explosions.

Since the mechanisms of conscience are automatized, the technical procedure is difficult. In the average patient the results are from fair to good. Severe and inveterate patients are hopeless, notably if their integrative pleasure deficiency is rather conspicuous. This pathological factor is naturally inaccessible to psychotherapy. To use Linus Pauling's term,[28] we consider it a "molecular disease." We may look forward to the time when the biochemist will give us the means of controlling it by replacement therapy. Sitting before the crystal ball, another biochemical development may also be predicted—drugs of pin-point action and lasting effect designed to reduce the overstrength of rage. Biochemical advances such as these will open up new opportunities for reconstructive treatment of the obsessive patient and of other patients as well.

Quasi-Reconstructive Treatment

Though the therapeutic goal of reconstruction through re-education was first envisaged by Freud, his original (now classical) technique of psychoanalytic therapy can only be classified as quasi-reconstructive: it keeps the patient's treatment-behavior at the level of childlike emotional dependence upon the physician ("transference").[12] Designed more than forty years ago, this technique is becoming increasingly obsolete. The patient's disordered life-performance (his "neurosis") is in direct view and can be dealt with directly. But the patient tends to disorder his treatment-behavior as well, in the image of his disordered life-performance. Freud accepted this tendency and proceeded to treat the patient's disordered life-performance via his "transference-neurosis," which is in fact disordered treatment behavior. It is superfluous, if not self-defeating, to view and treat through a distorted mirror-image what can be seen and dealt with directly. The post-Freudian doctrine of "corrective therapeutic experience" is a rationalization.

Quasi-reconstructive psychoanalytic therapy,

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usually designated as orthodox or classical, requires special training for the psychiatrist. Its practitioners tend to think that the obsessional patient benefits but little from it.

Reparative Methods

Reparative therapy includes a sizable number of procedures, most of them inadequately described and undefined. One or the other may offer the obsessive patient temporary or even some lasting relief.

Today we have a number of psychoanalytic schools, marked by revised theoretical approaches and therapeutic techniques. As to the merit of each school's treatment of obsessional behavior, one would have first to clarify whether the goal pursued is reconstructive, quasi-reconstructive, or reparative. And one would have to be familiar with each school's technique through practical experience; to my regret, I am not. Unfortunately, every psychoanalytic school speaks its own language. Reduction of this Babel to one tongue has not yet been attempted.

Once the obsessive patient has reached the stage of a chronic and severe tension state, our chances of reaching him with psychotherapy are reduced to nil. Attempts to treat such patients with surgical, electrical, and pharmacological procedures still yield rather discouraging results. This further demonstrates how important it is for the obsessive patient to seek psychotherapy as early as possible.

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CHAPTER 18

REACTIVE DEPRESSIONS

Emil A. Gutheil

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A REACTIVE DEPRESSION is an acute feeling of despondency and dysphoria of varying intensity and duration. As the name indicates, it is not an illness but a reaction, a response to conditions of loss and disappointment. This response is highly subjective; what depresses one individual may leave another unaffected.

Etiology

Reactive depression can be physiologic (normal) or neurotic. A physiologic (normal) depression is a reaction to life's acute difficulties. Such difficulties are loss of a job, loss of a sex object, or the like. The dysphoria is transient and ends with a spontaneous remission without causing a deep-rooted change in the patient's life adjustments. The neurotic dysphoria is one of the most frequent neurotic symptoms. It (1) may remain the only presenting symptom (the "essential" or "genuine" form of depression); (2) may be the first noticeable sign of an oncoming or concurrent somatic or psychic disease (symptomatic depression; most physical and mental conditions show a depressive incubation stage in which the patients complain of an unexplainable feeling of foreboding about the future, apathy, and fatigue); or (3) may be hidden behind other somatic and psychic symptoms, in which case we speak of "equivalents of depression."

Reactive depression* usually follows some unpleasant experience which, under ordinary circumstances, might not have caused more than a passing feeling of disappointment, sadness, or lowering of the prevailing mood. What makes this pathologic reaction noteworthy is that it is more marked and prolonged than the usual one, and that the patient, in most cases, cannot overcome it by his own efforts. Among the pathogenic experiences we may find a financial setback, illness or death of a close relative, loss of love, loss of prestige, a professional or occupational disappointment, and the like. The patient's capacity for work is usually more or less severely affected.

Some investigators (Kretschmer,[4] Kallmann,[5] and others) assume that a constitutional predisposition exists even in the psychogenic forms of depression, and that this organic predisposition is responsible for the afore-mentioned pro-

* In order not to complicate the nomenclature, we shall refer to the "neurotic" reactive depression simply as "reactive depression."

longed and more intense reaction. However, we can always find also predisposing psychic factors, among them a conspicuous psychic overcharge (overcathexis) of certain objective values, such as money, prestige, or the like, the loss of which affects the patient in an abnormally strong way. We must assume that, under normal circumstances, the loss of a love object should not have such far-reaching consequences. The same is true with the loss of a job.

The immediate cause for the outbreak of a depressive dysphoria can be explored by obtaining a detailed history of the symptom and by projecting it, as it were, against the backdrop of the patient's total personality. Both the pathogenic situation and the affected individual have to be explored.

In elderly patients, excitements and emotional shocks are more likely to set off a depression than in young individuals. Older people have, as a rule, a lowered threshold for stress, especially in its chronic form. Their depressions have often an added element of anxiety ("apprehensive" forms of depression). It is clear that the older a person gets, the more chance he has to lose his old contacts, his relatives, his friends, and his position, the more likely is it also that his prestige and self-confidence will suffer. In general, we may say that social conditions under which an individual is forced to live contribute some of the influences which make him susceptible to depressive reactions. People who live a life lacking in incentives, who are surrounded by uninspiring company and removed from meaningful associations, people who work hard without too much hope for recognition, these are natural candidates for all sorts of dysphorias, especially under conditions of duress.

In young people it is the adolescent, with his marked lability of mood and temperament, who is particularly susceptible to reactive depressions.

Most patients suffering from reactive depression are able to describe the circumstances which have led to it. Their memory is usually intact, and their relation to reality is undisturbed. Only in exceptional cases is analytic exploration necessary to bring the underlying cause to light. The more pathologic the personality structure of the patient, the more is this procedure indicated. The ego in such patients will probably show lowered defensive strength, which can be seen in concomitant symptoms of denial, projection, depersonalization, undoing, and other immature forms of defense.

The so-called anaclitic depression holds a special place among the depressions and is supposed to be the result of severe emotional neglect of young children, in some cases even proving fatal.[7] According to Spitz, it especially affects children who are brought up in communal homes, hospitals, or in any atmosphere which lacks a mother's love and care. It is, of course, difficult to evaluate the extent of such emotional neglect. The hospital routines, as such, even if they are superficially beyond reproach, do have all sorts of deficiencies other than lack of mother's love.

As stated above, some psychogenic depressions are of symptomatic nature. They may accompany a physical or mental disorder, sometimes completely hiding the underlying condition. This type is found in patients suffering from a malignant or debilitating physical disease such as cancer, tuberculosis, or the like. It may also be present in patients who are victims of mutilating accidents, which represent a severe injury to the patient's narcissism. In early hypoglycemia, depression may be the only presenting symptom.[8] It can be found also among other symptoms of mental diseases, for example, in schizophrenia.

Finally, there are depressions which do not present any noteworthy mood changes but, instead, a number of mental and physical symptoms. Conditions of this kind can rightly be called equivalents of depression.

To the somatic equivalents of depression belong especially fatigue and pain, the latter of varying localization and intensity. Fatigue is the result of internal tensions created by deep-seated emotional conflicts. It is often a consequence of the patient's intensive efforts to neutralize his upsurging antisocial impulses generated by a specific stressful situation. Pain, usually generalized, vague and rheumatoid, or localized—for example, headache—is another

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type of a successfully neutralized aggressive trend. In such cases we speak of *introjection*; it is a discharge inward of aggression combined with self-punishment, as a concession to the super-ego.

Other equivalents of depression which may be observed are dyspepsia, nausea, a bad taste in the mouth, constipation, and general irritability. Physical examination of the patient may yield no pathologic findings to account for these complaints.

To the psychic equivalents belong all sorts of impulsions, such as phagomania, dipsomania, drug addiction, and others.

As we see, most of these equivalents are of oral character. They represent attempts at self-cure; attempts to counter the depressive trend with an artificially created elation (drugs, alcohol, food, etc.). In most instances such attempts do lead to a temporary relief. There are cases, however, in which self-help fails, and the latent depression breaks through the camouflage of equivalents. We find this especially true with alcoholism. Some patients become overly depressed only *after* they have ingested alcohol.

¶ Symptoms

The most conspicuous symptoms of reactive depression are diminished activity, lowered self-assurance, apprehension, constricted interests (including the sexual one), and a general loss of initiative. All these symptoms make the patient's performance of his everyday tasks difficult but not impossible. The difficulty lies in his lack of concentration on his duties. However, most of our depressed patients are able to maintain their jobs, even though they have to work harder to obtain halfway satisfactory results.

The following are the symptoms of Spitz's anaclitic depression in children: loss of appetite (hence also failure to gain weight), apathy, dysphoria, frequent stools, and general progressive marasmus which may end in death. In some of these children, failure to get attention at an early age may lead to exaggerated needs for attention and affection at a later age, and—if the youngsters are rebuffed or frustrated—to the development of antisocial behavior patterns.

¶ Diagnosis

The diagnosis of reactive depression may, at times, be difficult. We have to differentiate it from (1) the psychotic depression, (2) the physiologic lowering of the mood level in so-called normal individuals, (3) depression which occurs in another mental disease, and (4) a depression preceding (and sometimes masking) an organic disease (such as general paresis, arteriosclerosis, or others).

The individual who suffers from reactive depression complains of a general loss of capacity to enjoy his social contacts, his work, and his hobbies. However, he is accessible to reassurance and encouragement. Since, as a rule, he is fully able to maintain relations with others and (fortunately) also with the therapist, his mood can be influenced therapeutically and, in most cases, he can be consoled in his grief. Distractions, change of environment, light entertainment, and other measures of this type are of definite help; they can be used not only therapeutically but also diagnostically, for patients suffering from a psychotic depression are completely inaccessible to these types of superficial influences.

A detailed history of the complaints will, in most cases of depression, enable us to obtain a picture of its intrinsic mechanism. Contrary to the organic and psychotic forms of depression, a psychogenic depression has always a logical reason. In order to find the precipitating factor, it is often desirable to establish the so-called "critical area" of the patient's life history, when the traumatic event(s) must have taken place which set off the depression.

The time period toward which we have to flash back may represent hours, days, months, or years. In order to find the approximate demarcation lines of the critical area, we must first ascertain what was the last period of time when the patient had been carefree and not depressed. Let us call that point A. Then we try to find out (with the patient's aid) when

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he recalls having been definitely depressed. We can call this point *B*. Somewhere between the points *A* and *B*, lies the critical area in which the pathogenic factor(s) must have assailed the patient, triggering off his depressive reaction.

Having thus established the approximate time of the onset of the depression, we submit this period to an especially careful scrutiny, trying to elicit in the patient as many recollections as possible. The time employed in the clarification of this issue must be considered well spent, for if we come upon recollections which prove to be relevant, a successful attempt can be made toward establishing the so-called basic formula of the given depression. The formula then reveals the specific target for our therapeutic attack. In general, the basic formula of depression is:

$$D = S + P$$

Depression *D* is a combination of sadness *S* and pessimism *P*. The pessimistic component is the essential part of the formula. It is the patient's conscious or unconscious neurotic idea that what happened to him now will always continue happening, or that the condition in which he has recently found himself will never change. This pessimistic attitude, this inept attempt by the patient to forecast his future, is one of the factors responsible for turning sadness into depression.*

Loss of something of value (for example, money) may lead to sadness but not to depression; loss by death of a beloved person may lead to grief and mourning but not to depression. Only thoughts essentially unrelated to the loss but connected with a neurotic attempt to generalize the experience and to prophesy the future can bring about a depressive reaction. They lead to a decrease of self-value, to self-accusations, and to general constriction of the patient's adopted life patterns.

Pessimism is especially easily induced, if the object lost had been subjectively overcathected. The patient's self-esteem depends, to a great extent, on whether or not some of his ego ideals (originating within the super-ego) have been fulfilled. It is in the question of ego ideals that overcathexis usually originates.

As stated above, it is diagnostically significant for the psychogenic depression that the patient is accessible to encouragement, that the explanations can take root in his personality, and that self-reproaches, if at all present, are of logical character. In addition, changes in external conditions are capable of affecting the patient's reactions. The patient himself usually makes every effort to help himself; he knows that he is sick, and he wants to get well, instead of blaming himself for being "bad, lazy, and unworthy," as does the melancholic patient. The reactive depression, as a rule, is also a dysphoria without mental inhibition or agitation.

Especially significant is the absence of physical symptoms which are considered pathognomonic for the endogenous form of depression. Among them are: (1) a significant and progressive loss of weight which terminates only after the deepest point of depression has been passed; (2) precordial anxiety; (3) reduction of bodily secretions (dry mouth, lack of appetite, constipation, dry skin, hypomenorrhea or amenorrhea, and others); and (4) stubborn and often intractable insomnia.

In cases of psychogenic depression, we find none of these and, as a rule, no outspoken diurnal rhythm. If a fluctuation of mood is at all noticeable, the mood level is lower toward the evening hours, when the "day's hopeless struggle" has brought about feelings of mental and physical fatigue. But we must not forget that slight fluctuations in the mood level occur also in so-called normal individuals, especially those of the cyclothymic personality type. We must, therefore, consider the intensity, duration, and character of the mood changes as well as the circumstances which brought them about, if we wish to record them as parts of the patient's pathologic reaction.

In taking the patient's history, we inquire whether a similar condition has existed before. This is an important diagnostic question, as periodicity points toward an endogenous character of the disorder, especially if the depressive attacks show a tendency toward presenting a "photographic likeness" to one another.

A fifty-three-year-old female patient, whose

* Incidentally, it is also one of the weakest logical points in his reasoning and can be easily challenged by the therapist.

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melancholic depression occurred periodically for twenty-four years, had a peculiar kinesthetic sensation at the onset of every spell of depression. She had the feeling as though a train were passing over her body. The reoccurrence of this "train" was an unmistakable sign that another depressive mood swing was developing.

The nature of reactive depression precludes the appearance of such stereotyped sensations. However, some life histories of depressed patients do show several spells which have occurred at different times, under different conditions of internal or external stress. In cases of this kind, it is diagnostically important to exclude the periodic mood changes of melancholia especially, since many melancholic individuals are also inclined to attribute their recurrent melancholic attacks to some external experiences. The total picture of the illness and the patient's personality must, therefore, be considered in arriving at the correct diagnosis.

The differential diagnosis between psychogenic depression and the physiologic (normal) phenomenon of mourning is often extremely difficult. Both may follow the death of a beloved person. Mourning is needed for the psychic assimilation of the trauma suffered by the loss, and for the dissolution of the emotional ties between the individual and the object he mourns. This process—the "work of mourning"[2] —requires a certain amount of time which varies with the individual case. According to old psychiatric experience,[6] mourning requiring a period of more than six months should be considered pathologic.

Some grief reactions are delayed. The patient, who, at the moment of the loss, appeared to be unaffected, at some later time may suddenly develop feelings of grief which are uncontrollable. We find such delayed grief reactions in people whose attitude toward objects they mourn had always been ambivalent. The delayed reaction is usually the result of a resurgence of guilt feelings, which must be worked out in therapy.

Depressions in schizophrenia have the tendency to last for shorter periods and to occur more frequently, after short intervals. Sometimes such spells occur several times in a single day. However, the schizophrenic depression impresses us, in most cases, as an absence of affect rather than as a lowering of it. Also, the patient's grasp of reality may be deficient and his motivation less logical, and his hypochondriacal self-observation may show signs of autistic self-preoccupation. A thorough exploration of the total personality is, therefore, necessary in such cases to establish the diagnosis.

The prognosis of psychogenic depression is good. The patient may experience spontaneous recovery; that is, his depression may wear itself out. This may be the case when the original pathogenic circumstances have improved. At the depth of depression, the patient may be suicidal but, in most cases, he can be talked out of committing an act of despair, especially if he is under psychiatric care. Once the patient has established a positive transference relationship, the danger of suicide, as a rule, diminishes.

¶ Psychodynamics

As stated above, most reactive depressions are caused by some sort of traumatic experience. What has made the experience traumatic is subject to conjecture. In many cases it is the past events which supplied the psychologic matrix for subsequent exaggerated reactions. The analytic exploration must answer this question. These patients have been sensitized to the traumatic event by losses they have sustained in the past, by insecurities, and by unendurable situations of stress to which they were exposed in their childhood. The stronger the ego, the better can the individual absorb the traumas. Persons with weak egos, individuals who, even under normal circumstances, are able to maintain only a precarious emotional equilibrium, do so by taking recourse to all sorts of internal self-reassurances. When the traumatic event occurs, or when the patients are exposed to acute or chronic stress conditions, these internal self-reassurances may be upset, and various old anxieties are remobilized. One of these anxieties is the fear of losing love or of being deprived of other "narcissistic supplies."[2] Foremost among the internal self-reassurances by which the patient succeeds in maintaining his equilibrium are unconscious fictions[1] based on the patient's

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belief in omnipotence: that the patient is a favored child of fate; that providence will always protect him in adversity—as his parents did. The traumatic experience of loss of love or prestige may have a shockingly sobering effect on the daydreamer who suddenly finds himself unprotected, unloved, abandoned.

Chronic stress has its biologic and physiologic repercussions.[5] Biologically, it endangers the individual's basic adaptive pattern, while psychologically it represents a condition of prolonged frustration. Some patients adopt a system of ingratiating themselves to their fellow man. They use all sorts of stratagems to create, or to preserve, an atmosphere of friendliness and acceptance as the only medium in which they can live and breathe without a permanent fear of rejection. Often they succeed in this endeavor. However, this fiction—the attempt to prove to themselves that people do love and accept them—cannot be maintained indefinitely. Reverses of fate and other disappointing events of the unpredictable real life make those bubbles burst, and the magic phantoms of security disappear. The patients, deprived of their vital defensive devices, are then inclined to react with all the more severe feelings of despondency and inadequacy.

In some cases we find another maneuver by which the patients try to control their meager adaptations to mature life. Driven by neurotic needs to prove to themselves that they are able to love in a mature way (while in reality they are too infantile to do so), they may not be able to stand the loss of a love object even for a short time. Having lost the object, they are inclined to "fall in love" anew, and often precipitately, or to seek immediate substitute gratification by drinking, gambling, or other neurotic devices.

Still others court sympathy as the next best substitute for love. They demonstrate their misery to their environment by lamentations and other displays of suffering. Sadistic elements often color this attitude. It is as though these patients were proclaiming to the world, "love me, or else. . . ." They try to force the environment into supplying them with the love they are missing, while unconsciously they offer hate for having been disappointed to begin with. Guilt feelings and depressions may be the result of this process.

Under stress, narcissistic and autistic fictions such as, "I must be the best," or "Everybody must love me," constructed as they are to overcompensate the patient's basic insecurity and the weaknesses of his personality and maintained by the patient as pillars of his precarious adaptation, may be obliterated or may swing to their opposites. They then become pessimistic prophecies, such as, "I will always be a failure," or "Nobody will ever love me," or the like, a mechanism to which we referred before as the basic pessimism in the psychodynamics of depression.

Depressions which occur in the initial stages of neurotic disturbances are indications that an instinctual conflict is taking place in the depths of the patient's personality, a conflict which involves the patient's self-esteem. It is usually the super-ego's attack against unruly surgings of the id, a duplication of a strict parental disapproval which is known to create morbid feelings of guilt.

There are certain stress situations which are more traumatic than anything the individual has ever imagined. I am referring here to experiences in concentrations camps, where individuals are subjected to tortures, privations, "brain washing," humiliation, and frustration —and yet do not respond to them with reactive depressions. As a matter of fact, many survivors of the Nazi concentration camps remarked that they were astounded about not having seen more cases of suicide than actually did take place. In most cases it was the intrinsic moral force of the brutalized individual and the secret rebellion against the debauchery of oppression that kept the victim's ego well charged and strong. The prisoner felt himself as a morally victorious victim of inhumanity and hoped that ultimately evil would find its retribution. This explains, in part, why some of the survivors of concentration camps suffered breakdowns and even committed suicide, *after* they had found a haven in a free country and were exposed to the everyday frustrations and unavoidable rejections in their new lives. Suddenly, their egos felt all the privations,

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anxieties, and narcissistic injuries which were no longer covered up by the all-powerful righteous indignation and by the basic desire to survive.

In some forms of sexual deviation, particularly in homosexuality, we sometimes find a peculiar form of psychogenic depression which may lead the otherwise reluctant patient to the attention of the psychiatrist. A homosexual patient may introduce himself to the psychiatrist with the words, "Please, do not try to change my sexual attitude, with which I feel perfectly satisfied; my depression is the only thing I should like to lose."

Upon closer examination, the psychiatrist may become convinced that at least a part of the patient's personality feels deeply unhappy. The unverbalized feeling in question is that homosexuality keeps the patient out of the great creative process of life; that he is the last link of a chain; that in him his generation finds its termination, and that ultimately he will fall off the tree of life like an empty fruit. It is this melancholy teleologic attitude which is (consciously or unconsciously) perceived by the patient and which thus creates a matrix for a psychogenic depression. Onto this matrix are planted the specific conflicts of the patient, which may be oedipal in character or may originate on a pregenital level and, as such, are replete with their own guilt complexes, capable of leading to despondency. Feelings of the afore-mentioned kind are likely to occur especially in those homosexuals who are unable to sublimate their creative ability—as so many of their fellow deviates do—in art or other outlets, and thus suffer from a latent sense of futility and worthlessness.

¶ Therapy

In dealing with patients suffering from reactive depression, an empathetic, sincere attitude of the therapist will soon secure for him the proper friendly relationship with the patient, which is the premise of all therapeutic successes. Since most patients of this type are victims of an overstrict super-ego, the therapist, a super-ego substitute, has an important part to play in the shift of identifications which is to take place in the patient's mind. The therapist must conduct himself with strength, yet also with kindness, which, as a rule, quickly allays the patient's initial anxieties. Too much permissiveness is not desirable. The patient needs guidance and counsel, but above all strength, which he should be able to derive from his therapeutic relationship.

Prolonged, especially orthodox, analysis is hardly ever needed to cope with this condition. Active analysis or brief psychotherapy are, as a rule, the therapies of choice.

The therapist has to confront the individual with the situation which he has recognized as having been traumatic. He proceeds from the supposition that, for example, being jilted by a partner should not be a cause for despair. The therapist must work out with the patient the underlying dynamics of the given situation, which may have been conditioned by early rejections, and will encourage the patient to seek other adjustments. He will point out that it is up to the patient not to accept life as a series of repetitions and stereotypes. He will awaken in the individual his dormant creative forces which will help him to break the repetitive pattern in a healthy search for new experiences.

Loss of a job, as a cause of depression, will offer the therapist ample opportunities for discussing the patient's relation toward employers, his ambitions, his dormant resources and hidden talents, and for directing his thoughts toward the goal of regaining lost territory. Social agencies may be recommended to help the patient in planning his future more realistically.

In all these endeavors, the therapist will point out that "similarity is not identity," that two similar experiences, past and present, must not be permitted to be perceived as though they were the same experience, and that they must be evaluated without bias, on their own specific merits. Usually, the psychiatrist can bring about a better concentration on the present as something to which the patient has brought many potentialities—ready to be applied successfully.

In addition, all sorts of supportive measures

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can be considered; among them are change of milieu, removal from a noxious family or work environment, and others.

Hospitalization is unnecessary in most cases, unless the hospital in question, in addition to offering effective dynamic psychotherapy, is also equipped for an intensive occupational and recreational psychotherapy. Only serious suicidal tendencies should be considered as an absolute indication for hospitalization. This is also the case if the patient is completely lacking in supervision or company. Under ordinary circumstances, hospital treatments are not without harm. The deficiencies of the patients' personalities make them easy preys for all sorts of autosuggestion. This complicates the problem of isolating the patients from noxious influences in a hospital, in which conversation revolves almost exclusively around illness and suffering. Unless such exchanges can be controlled, or even utilized therapeutically as a part of group psychotherapy, they must be considered undesirable. Work is beneficial; it prevents depressed patients from brooding and spinning gloomy daydreams. It gives them a feeling of achievement and self-worth, an important ego-strengthening influence. However, one should not expect too much from supportive measures alone.

Of great value as a "friend of the lonesome," a source of distraction and consolation for depressed individuals, apart from books, is the movie. (Recently, the television has taken over, in part, this role.) The type of picture is not even of too great an importance. We can safely say that any amount of time the depressed patient is able to spend in the movies (or before the TV set) is a contribution toward his recovery. It is not necessary that the patient be entertained by the picture, if it can only make him forget his worries for a time.

Another great help as a supportive measure is sleep; it can withdraw the patient's mind temporarily from painful thoughts and memories. The psychiatrist will, therefore, have to take an effective sedation of the patient into consideration. Sedatives and/or tranquilizers, taken during the day only, are preferable to hypnotics prescribed for the bedtime. Sufficient sedation during the day offers the relaxation the patient needs for falling asleep "on his own power," as it were. This system does not leave him as much opportunity for developing a dependency on the magic power of the pill. Falling asleep spontaneously can also bolster his morale and make him aware of the progress he is making.

The use of drugs is indicated primarily in the initial phases of the depression. It should be reduced and ultimately discontinued as soon as the patient begins to manage his affairs satisfactorily, and psychotherapy can assert its sovereign rights.

Some authors recommend the use of electric convulsive therapy for the more refractory cases of psychogenic depression, but I have rarely seen the need for it when effective psychotherapy and supportive, manipulative, and chemical measures are available.

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CHAPTER 19

CHARACTER STRUCTURE AND CHARACTER DISORDERS

Joseph J. Michaels

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THIS CHAPTER* will attempt to deal with the problem of character and character structure; it represents a biased point of view, however, and is only a beginning venture. Character is a complex concept, for it has many meanings. Ordinarily, character means a moral and ethical value judgment of behavior. In this general lay sense character and traits of character are merely descriptive and pertain to such qualities as honesty, sincerity, and integrity. It is common usage to describe the individual character as a "good" or "bad character," with all types of variations, so that there are eccentric characters, conforming characters, and so forth.

Character in General

The problem of what constitutes character has received attention from the fields of education, psychology, sociology, philosophy, and religion; divergent points of view are reflected in the use of the term "behavior" by the students of personality, and the term "conduct" by the students of ethics. Kilpatrick,[81] the educator, believes that character is the structural basis of conduct, something that is largely built up through training and experience and upon which we can more or less rely for the conduct that is to follow. A more picturesque conception is given by the critic, Chamberlain:[18]

When we speak of character we mean a human being's ability to remain more or less constant despite the corrosiveness of time—a personal insistence upon permanence and stability amid ceaseless change.

The psychologist, Allport,[6] in writing of character, defines it thus:

The aspect of personality that engenders stability and dependability, that is responsible for sustained

* I wish to acknowledge my gratefulness to Dr. Helen H. Tartakoff for her comments and criticism.

effort in the face of obstacles, or works for remote ends rather than those that are nearer in time but of less worth. Character enters the situation only when this personal effort is judged from the standpoint of some code. Character is personality evaluated and personality is character devaluated.

In discussing the problem of the relation of personality to character, Herbert Read,[101] the poet and critic, stated that "character must be placed in opposition to personality, which is the general-common-denominator of our sentiments and emotions." Roback,[109] in a comprehensive, eclectic review of the subject of character which includes about thirty-five hundred references, concluded that character is "an enduring psycho-physical disposition to inhibit impulses in accordance with a regulative principle." The social psychologist, Riesman,[107] speaking of social character, defines character structure "as the more or less permanent, socially and historically conditioned organization of an individual's drives and satisfactions."

Studies of character and character structure within various frames of reference have been made in anthropology—Mead,[90] Gorer,[61] La Barre[84]; in sociology—Adorno *et al.*;[3] in politics—Lasswell,[85] Lindner.[88] Of special interest is the study of literary figures by psychoanalysts—Bonaparte,[15] Greenacre,[62] Hitschmann,[74] the Sterbas, [114] and Weissman.[120]

When character is used in a psychiatric sense, it has a more specific meaning, although the term has been utilized differently in psychiatry and in psychoanalysis. In the field of American psychiatry the term most commonly used to apply to the individual has been "personality." In contrast, in German psychiatry one finds that the word character has been used in a similar sense. Hinsie and Shatzky,[73] in their *Psychiatric Dictionary* state:

> Character as used by psychiatrists today is more or less synonymous with personality. It is made up of patterns of behavior, characteristic for the given individual as physical and mental activities. The character of an individual is the resultant of forces emanating from the inner life of the person and from the environment.

Psychobiologic psychiatry before the influence of psychoanalysis seldom referred to character in discussing personality; in fact, the tendency persists to speak of the total personality when some concept of character seems to be implied. From the standpoint of nosology and psychopathology, the diagnosis of character disorder has been applied to those disturbances in personality which manifest themselves in the social behavior of the individual when his actions lead to difficulties with society. The diagnostic category in psychiatry which embraces character disorders has been psychopathic personality.

A reflection of how a frame of reference affects diagnosis and nosology can be seen in comparing the *Diagnostic and Statistical Manual: Mental Disorders*,[22] utilized by the American Psychiatric Association, and *Nomenclature of Psychiatric Disorders and Reactions*,[88] prepared by the Veterans Administration. In the former, character disorders are not listed as such but would be found under the headings of personality disorders, personality pattern disturbance, personality trait disturbance, and sociopathic personality disturbance. In the latter, a main classification of character and behavior disorders with various subheadings is designated. It is evident that the VA nomenclature is more dynamic in its orientation.

¶ Psychoanalytic Concepts of Character

Tartakoff[117] has presented a broad historical perspective of the development of the theoretical aspects pertaining to character structure. To the writer's knowledge, it is the first attempt at an integrated description of the psychoanalytic concept of character in the literature. Bibring[18] has lucidly traced the evolution of the theory of instincts; Hartmann[67] has concentrated on the vicissitudes of ego psychology. Tartakoff mentioned that the function of the ego which has been least studied is that of integration. To this statement might be added that even less is known about the integrative aspects of character structure as a whole within the framework of the total personality.

In reviewing some of the literature on char-

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acter neurosis and character disorder, it becomes evident that each writer views the problem of character according to his own character structure, his training, his psychologic orientation, and the discipline within which he has worked. Thus, in some of the typologies which have evolved in regard to character and to personality, these above-mentioned qualifications will become apparent.

The difficulty in constructing a theory of character results from the fact that this must be an integrated concept. In the development of psychoanalysis the theoretical concepts were evolved primarily in so far as they pertained to the explanation of the neuroses. Freud began with elucidating various aspects of the personality, and, although a metapsychology of the personality was evolved, it was not explicitly applied to the total picture of character structure.

Looking back upon Freud's early clinical studies, it is apparent that characterological features were not emphasized. Because neurotic symptomatology was the focus of attention, the main diagnosis was given in terms of a specific neurosis, although characterological overtones were present. Today we recognize that there is an admixture of character problems and neurosis. (Nunberg[99] emphasizes the similarities between a character neurosis and the symptom neurosis and minimizes their differences.) Contemporary analysts are shifting the emphasis from neurotic features to the character structure of the individual, and there is a growing movement to construct a theory of character structure.

In psychoanalysis the psychobiologic concept of the total personality has been dealt with primarily under the heading of character structure. Diagnostically, what the psychiatrists have designated as character disorders the psychoanalysts usually refer to as character neuroses. The use of such terms as the oral and anal character or oral and anal traits of character has been traced back to their dynamic-genetic origins. Because the science of psychoanalysis is uniquely sensitive to the individual aspects of personality and aware of the complexities in human behavior, it has been largely preoccupied with emphasizing these features of particularity and has only recently begun to investigate the more structural problems. In the latter area, psychoanalytic studies have been chiefly focused on "neurotic" characters, with emphasis on their origin. Psychoanalysis has as yet not offered a *weltanschauung* or an evaluation of character as such. Concerning this subject, psychiatry is in the same stage as was medicine when it was almost exclusively preoccupied with disease or pathology rather than health, although certain preliminary steps taken by psychoanalysts constitute a beginning to the solution of the problem.

As psychoanalysis has evolved, the term "character" has been used predominantly, so that we have traits of character, character structure, disorders of character, and character neuroses. Therefore, when we speak of character structure, we are limiting ourselves to viewing this concept from psychoanalytic metapsychology. When we refer to the total personality, we mean something in addition to character structure, such as the degree of intelligence, individual talents, and even perhaps temperament added to, or combined with, the character structure. Brierley, in her attempted integration of psychoanalytic concepts,[17] recommended that, in our consideration of character structure, the term personology be used to include the concept of the total personality. She states, "Concepts of personology refer to experience, whereas the concepts of metapsychology refer to objective mental processes, although they are also inferred from experience."

The problem of character formation interested Freud from the beginning of his work, where one can observe broad references to character in accordance with the metapsychological theory prevailing. One of the first explanations of character occurs in *The Interpretation of Dreams*,[41] in which it is stated that "what we describe as our character is based on the memory—traces of our impressions; and moreover, the impressions which have had the greatest effect on us—those of our earliest youth—are precisely the ones which scarcely ever become conscious." In this instance, the basis of character is ascribed to a functional locus in the brain which later becomes a part of the functions of the ego.

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As might have been expected, Freud's early conceptions about character were within the frame of reference of the libido theory. Since the first concern was with the unconscious, the conceptions were colored accordingly and traits of character and aspects of character were seen as derivatives, reactions, or sublimations of instinctual forces. In a certain sense, traits of character and the character itself were viewed in a manner similar to symptom formation, i.e., according to the theory of neurosis. Later, when the structural point of view prevailed, a broader perspective toward traits of character and character itself developed.

When Freud, in 1905, discussed character from the libidinal point of view in "Three Essays on the Theory of Sexuality,"[48] he stated:

> A person's "character" is built up to a considerable extent from the material of sexual excitations and is composed of instincts that have been fixed since childhood, of constructions achieved by means of sublimation, and of other constructions, employed for effectively holding in check perverse impulses which have been recognized as being unutilizable.

In 1908, Freud[37] wrote, "The behavior of a human being in sexual matters is often a prototype for the whole of his other modes of reaction to life." Thus the emphasis on instincts and the unconscious (later the id) is observed with the construction of the first character type as the anal character.[36]

It must always be borne in mind how Freud interwove theory and fact, especially as his therapeutic techniques evolved. In 1915, while describing "Some Character-Types Met with in Psychoanalytic Work,"[47] he indicated how the patient's resistances which can be attributed to his character interfere with the treatment. He[47] referred to them as:

> . . . character traits, individual attitudes of the ego, which are thus mobilized to oppose the attempted alterations. One learns then how these character traits have been developed in connection with the conditions of the neurosis and in reaction against the demands, and observes features in this character which would not otherwise appear, at least, not so clearly, i.e., which may be designated latent.

In this early period Freud referred to character in much the same manner as the psychiatrists referred to personality. When he described character in this general sense, he offered explanations paralleling his theory of neurosis existent at the time. An example of this point of view occurs in "Psychopathic Characters on the Stage."[46] Some broad clinical studies of character types such as "the exceptions," "those wrecked by success," and "criminality from a sense of guilt" appeared in 1915, to be followed by the study of Dostoevsky[38] whom Freud classified as an instinctual character.

Reich[103] was a decisive influence in focusing psychoanalytic theory and practice on the problem of character. His basic assumption was that the social order had a repressing and inhibiting effect inherent in the character structure which prevented the attainment of genital sexual gratification. With his firm beliefs in the power of the social order to affect character, he stated that character structure is the crystallization of the sociological process of a given epoch. Character, he postulated, consists in a chronic alteration of the ego, the exposed part of the personality—stemming from the continued influence of the conflict between libidinal need and threatening outer world—which one might describe as a rigidity, an automatically functioning mode of reaction.[103] He believed that the final quality of character was determined qualitatively by the stage of libido development—the specific fixation point of libido—and quantitatively by the libido economy. Some of the character types which he described were the hysterical, compulsive, phallic–narcissistic, masochistic, genital, and neurotic. In describing the impulsive psychopath, he stated that "there is a largely unformed character structure, the opposite of a thorough armoring toward the inside and outside." With this degree of character formation, the impulsive psychopath lacks one of the cardinal functions of character, that of binding "free floating" anxiety, or absorbing dammed up energy. Reich allocated the impulsive psychopath to the phallic-narcissistic level.

In 1939 Kardiner[79] wrote:

> Character is a special differentiation of ego structure arising within the ego. Ego structure is a

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cultural precipitate; character is a special variation of each individual to this cultural norm. In contrast, by the basic personality structure is meant—the effective adaptive tools of the individual which are common to every individual in this society.

Fromm,[50] minimizing libidinal origins and emphasizing a socioeconomic orientation, delineates five character types: receptive, exploitative, hoarding, marketing, and productive. In criticizing the "orthodox Freudian approach," Fromm[51] indicated that psychoanalysts assumed that social phenomena and cultural patterns are to be explained as direct outcomes of libidinal trends. He contended that capitalism is explained by Freudians as a result of anal eroticism or of the operation of the death instinct. According to this writer such a condensation indicates a distortion of basic psychoanalytical concepts.

Horney[75] developed a simple classification of character according to what she considered the three basic strategies of life: (1) the detached personality—the person who moves away from people; (2) the aggressive personality—the person who moves against people; and (3) the compliant personality—the person who moves toward people.

Relying on the concepts of Fromm, and emphasizing changes in population and technology as the chief correlates of changes in the social character, Riesman,[108] the social psychologist, constructed three types of social character: tradition-directed, inner-directed, and other-directed. Havighurst and Taba,[69] emphasizing the moral aspects of character, delineated the following personality types: the self-directive person, the adaptive, the submissive, the defiant, and the unadjusted.

In the development of psychoanalysis there have been two main trends toward a theory of characterology: the first one appeared during the pre-ego psychology period, when the libidinal point of view (zonal phase) was dominant; the second one appeared following the inclusion of the structural point of view. Thus, the first phase emphasizes the erogenous zones as the main determinants and postulates oral, anal, phallic, and genital traits and the oral, anal, phallic, and genital character. The second phase—with the new orientation of the libidinal-structural concept of the personality; id, ego, and super-ego—provided a much broader perspective. In his further elaboration of the structural aspects of personality, Freud[45] stated:

> Character belongs entirely to the ego and . . . the super-ego was the most important and decisive element; next came identification with the parents of a later date and with persons in authority, and the same identifications as precipitates of abandoned object-relations. Contributions which are never apart, are the reaction-formations, which the ego acquires, first in making its repressions, and later in a more normal way, in repudiating undesirable impulses.

A third classification system may also be considered—ego types such as the inhibited, controlled, impulsive, aggressive, and even delinquent ego.

Where Freud dealt with problems of character, it was usually in relation to the specific traits of character most often related to certain libidinal zones. His discoveries in this area which appeared in the earlier papers,[36] have led to further development of these concepts, e.g., Abraham,[1] Jones,[78] Ferenczi,[27] Coriat,[20] Glover,[57] etc. Freud realized that there were possibilities of constructing other types of character when he said, "One ought to consider whether other types of character do not also show a connection with the excitability of particular erotogenic zones."[36] He was hinting at the urethral zone when he indicated the intense burning ambition of those who formerly suffered from enuresis.

R. Sterba[118] combines a descriptive and psychoanalytic approach in stating:

> Character designates the features of personality which are more or less indelibly engraved upon it, features which express themselves in actions and reactions, features that are "characteristic" of the individual, features by which one ego structure can be differentiated from others.

Anna Freud[32] suggested that character formation is the whole act of adopting habitual attitudes by an individual ego in order to solve the conflicts that arise in choosing which instinctive urges to help toward satisfaction,

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which to oppose, and what methods to adopt in the ego's defense against the threats represented by a painful outer world as well as a powerful inner world.

¶ Characterology and Typology

There has been an apparent disregard of typology in psychoanalytic theory, paralleling its inattention to psychopathy. Here also there are logical and historical explanations: (1) The word typology may suggest something fixed, static, constitutional, in opposition to dynamic explanations. (2) The concept of typology may seem to run counter to the fact psychoanalysis has demonstrated—that all symptoms are multidetermined and that the character of the individual is a complex composite of many factors. (3) Psychiatric typologic studies, for example, Kretschmer,[82] have not proved fruitful for psychoanalysts because they cannot be integrated or understood within a psychoanalytic frame of reference. (4) There is a tendency in the psychoanalytic literature to try to fit the manifestations of human behavior into the theoretic formulations under which neurosis and psychosis can be subsumed. Some authors go so far as to envisage the explanation of all personality disorders of a nonorganic nature within the orbit of neurotic mechanisms, thus including psychoses as a severe form of neuroses; i.e., similarities are maximized and differences minimized (e.g., Saul,[110] Bowman and Rose[16]). (5) Freud, by broadly dividing the neuroses into transference and narcissistic neuroses, may have inadvertently contributed to this trend, although he indicated that neuroses and psychoses were different qualitative entities.

The absence of a psychoanalytic typology may also be explained by the absence of a complete theory of character structure. Now, however, in view of our present understanding of ego functions, it would seem that the construction of a psychoanalytic theory of character structure is due and that, when it is drawn, it will form an important architectural plan in psychoanalytic theory and practice, furnishing a blueprint for the problems of the choice of the neurosis, psychopathy, psychosis, and psychosomatic disorders and perhaps a closer link to psychiatry and medicine.

The total personality, in a psychoanalytic frame of reference, involves many dynamic aspects. If we are to coordinate the topographical agencies (the id, ego, and super-ego), the libidinal development, mental principles, and object relationships within the single framework of the nature of the total personality another dimension—the structural aspect—proves most useful.

Although Freud indicated that mental activities, in order to be fully understood, should be explained topographically, dynamically, and economically, this conception was applied primarily to the nature of symptoms; it was not expanded to encompass the total personality. The concept of the structure of the total personality would be a broader, inclusive one, integrating all aspects and levels. Such integration seems logical, particularly since the conceptions of structure and process can be complementary rather than antithetical. Furthermore, structural analysis and synthesis will provide a basis for the further development of psychoanalytic typology, which is as yet in its infancy.

The emphasis, in psychoanalysis, on causation—on "why," "when," and "how"—has delayed the development of adequate definitions of "what." A broad nosology of psychobiologic illness has not yet evolved, partly as a result of the neglect of typology and character theory. This fact has hindered comparative studies of the evaluation of psychoanalytic therapy. It is no accident that the statistics of patient-illness treated psychoanalytically are given in terms of discrete symptoms—for example, impotence, frigidity, enuresis, etc. Kubie[83] has emphasized the importance of a more coordinated approach, as did Brierley,[17] who recognized the need for clarification in the area of typology in her attempt to formulate a theory of personality.

Freud laid the groundwork for a beginning typology but confined himself to libidinal considerations in classifying certain purely psychological types. In the sphere of character, however, in which all components of the personality —biological, psychological, and sociological—

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should be envisaged, one questions whether character types can be viewed only psychologically. Freud implied that biological factors should always be taken into consideration. In *A Psychosexual Study of Leonardo da Vinci*,[42] he stated: "The tendency to repression, as well as the ability to sublimate, must be traced back to the organic bases of the character, upon which alone the psychic structure springs up." In fact, he[43] states: "It will be most valuable of all if we can make our classification on the basis of a regularly occurring combination of physical and mental characteristics." Nevertheless, his approach to typology was colored more by his earlier thinking than by his later conceptions of the total personality, and he dealt largely with libidinal types without encompassing a holistic point of view. An ideal typology would comprise libidinal, aggressive, and ego features with their characteristic defense mechanisms.

Freud distinguished three main libidinal types according to the allocation of the subject's libido mainly to one or another region of the mental apparatus. The three types were (1) the erotic, in whom the relatively largest amount of libido is focused on love, (2) the obsessional, in which the super-ego exercises supremacy, and (3) the narcissistic, in the main negatively described, in which no tension exists between the ego and the super-ego. Usually the three types appear in mixed forms as erotic-obsessional, erotic-narcissistic, and narcissistic-obsessional, with the erotic-narcissistic the most common.

In the sphere of character disorders most attention has been paid to those disorders more closely allied to the neuroses. Thus there has been an extensive psychoanalytic literature on the hysterical, compulsive, and narcissistic character neuroses, with their libidinal relationship respectively to the genital, anal, and oral libidinal zones. As has been mentioned before, a character neurosis is composed of a mixture of these types, and each is designated as a specific neurosis according to the most predominant feature.

I shall describe these types in brief detail (and mention a few others often discussed in the literature) before proceeding to a lengthier description of a suggested fourth type to be included in this system of characterological typology.

¶ Genital Character Traits: the Hysterical Character

Genital character, as applied to a "normal" person, is essentially an ideal concept. It implies that ambivalence has been overcome and that instinctual energies are economically regulated. In the genital character, periodic discharge of libidinal tension reduces the instinctual demands on the ego. The ego takes over, without any guilt feelings, the genital libido and certain pregenital tendencies of the id for gratification. It sublimates natural aggression and certain aspects of the pregenital libido in social action. Because the ego has no negative attitude toward the id as far as genitality is concerned, it can all the more easily impose inhibitions on it, since it does not interfere in the main respect wth libidinal gratifications. This seems to be the only condition under which the id can be held in check without recourse to repression.

With the giving up of the wish for incest and the wish to eliminate the father (mother) —in other words, with the achievement of the post-ambivalent genital stage—genital interests become transferred to a heterosexual object which does not, as in the case of the neurotic character, actually represent the incest object but instead has taken its place. The Oedipus complex no longer exists in actuality; it is a moot question whether it is successfully repressed or is free of cathexis. Pregenital tendencies, such as anality, oral eroticism, etc., are anchored partly in cultural sublimations and partly in the forepleasure acts; at any rate, they are subordinated to genitality. Aggression is also sublimated in social achievement to the extent to which it is not a part of normal genitality—it never urges for direct and exclusive gratification. This distribution of instinctual drives satisfies not only the true genital drives but also the pregenital libidinal and aggressive

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tendencies. The more the two systems, genitality and pregenitality, communicate with each other, the more complete is the capacity for satisfaction and the less does one find pathogenic stasis of libido.

In the case of hysterical character, one finds that the problem lies in a fixation on the genital phase of infantile development. The Oedipus complex unresolved, there is a strong incestuous wish always in operation; the direct genital aggression of the hysterical character represents both the incest wish—which has retained its full cathexis—and the attempt to escape the anxiety of the incest wish by a form of direct confrontation of the fear, a never-ending and never-successful attempt to feel out, as it were, the nature and magnitude of the infantile dangers.

The hysterical character, more predominant in the female sex, is evidenced by coquetry in walk, expression, and speech, together with a strong apprehensiveness. More hidden traits are those of lability of emotion, unexpected behavior, strong suggestibility, and a tendency toward representing fantasy as fact. Because the incestuous objects have an actual cathexis, or the corresponding libido is warded off by mechanisms which supplement repression, the hysterical character is usually more or less orgastically impotent.

To the extent to which other than genital mechanisms are found in the hysterical character, they no longer belong specifically to this character type. For example, depressive mechanisms are common, and in these cases the genital-incestuous fixation is in part replaced by a regression to oral mechanisms. The hysterical character, then presents itself in pure form if it is agile, nervous, and lively; if it is depressive, autistic, and retiring, it shows mechanisms which are no longer specifically hysterical.

¶ Anal Character Traits: the Compulsive Character

Persons whose instinctual life is anally oriented show certain character traits which are partly reaction formations against and partly sublimations of anal-erotic activities. Specifically, orderliness, frugality, and obstinacy are clear indicators of the anal orientation. In the case of compulsion neurosis, one finds an intensification of these trends.

Anal character traits are formed around the training for cleanliness in infancy, when the child must forego an instinctual pleasure in deference to the demands of society. At the same time, the child is acquiring an active mastery of his instinctual drives. Whether or not this period is traumatic for the child is apt to determine the degree to which he develops strong anal traits of character.

Frugality represents a continuation of anal retention; it can be motivated either by a fear of losing or by erogenous pleasure. Orderliness is an elaboration of the obedience to the environmental demand to be clean; obstinacy, on the other hand, represents the rebellion against these environmental demands. Stubbornness, or obstinacy, can also represent getting one's way against superior forces. As the child refuses to produce feces for the adult, he is expressing an active hostility through a passive form of aggression. On the other hand, orderliness, punctuality, propriety, all represent obedience and are revealed as reaction formations. Frequently these reaction formations break down and the orderly person becomes surprisingly disorderly.

Anal orientation implies a high allocation of libido to the super-ego. Speaking of the compulsive type who has achieved successful sublimation of his anal-erotic conflicts, we find a high degree of harmony between id and super-ego. The genital libido, being gratified directly, is not hidden in the ego-ideal strivings. Social achievements, therefore, are not a proof of potency, as in the neurotic character, but are a means of providing a natural narcissistic gratification. Without potency disturbance, there are no feelings of inferiority. The ego-ideal and the real ego do not differ greatly from each other; there is consequently, no appreciable tension between the two.

In the compulsive neurotic character, on the other hand, there is a marked conflict between id and super-ego. A major factor in compulsion neurosis is the existence of the unresolved

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Oedipus complex. As a result, the incest prohibition, which is the core of the super-ego, is also fully maintained, disturbing mature sexual relationships. The sexual and aggressive repressions intensify sadistic impulses, which express themselves, among other ways, in a harsh morality. Since there is often a more or less conscious feeling of impotence, social achievements become primarily compensating proofs of potency. These, however, cannot replace the genital potency feeling, and for this reason the neurotic character is troubled with inner emptiness and feelings of incapacity—a constant sense of inferiority. Thus, in time the positive demands on the ego are increased steadily, while the ego, impotent and doubly paralyzed by inferiority feelings, becomes more and more incapable.

One of the most striking phenomenon in the compulsive character is the blocking of affect. The numerous defense mechanisms have done their work effectively, resulting in a restrained, self-controlled individual, lacking in spontaneity and cautious in his actions. The typical mode of repression in the compulsive character is dissociation of affects from ideas, so that frequently highly censorable ideas can appear in consciousness. Other defense mechanisms following regression are reaction formation, isolation, and undoing used against pregenital strivings. From this, one also arrives at the affective anchorings of the first identifications and the super-ego: The demand for self-control, originally imposed from the outside on a resisting ego, was internally accepted. More than that, it became a rigid, chronic, unalterable mode of reaction; this could be achieved only with the aid of repressed id energies.

We find, then, two layers of repressions in the compulsive character: more superficially, the sadistic and the anal; more deeply, the phallic ones. This corresponds to the reversal of direction in the process of regression. What was more recently invested with affect in the process of regression lies closer to the surface; the object-libidinal genital impulses are most deeply repressed and covered up by layers of pregenital positions. These structural relationships make clear how erroneous it would be to try to make the compulsive understand affectively the weak manifestations of genital object-strivings before having worked through the pregenital layers. If one were to try to do this, everything would be accepted coldly or warded off with doubt and distrust.

¶ Oral Character Traits: the Narcissistic Character

Oral character traits are consistently recognizable in emphases on taking or giving which indicate the oral origin. Self-assurance and optimism, for example, would indicate pronounced early oral satisfaction. The not uncommon traits of generosity and altruism, which contain a high element of narcissism, are oral traits reminiscent of the "nursing mother," and represent identification with the object by whom the person wants to be fed. Displacing "hunger" to the mental field, curiosity may become an oral trait.

In the sense of normal or healthy character traits, narcissistic trends refer to the goal and origin of the cathexes—implying that the cathexis is of a libidinal nature and that it is not only turned toward the inner world but has pertained to the ego and emanates from it. In the strict dictionary sense, oral traits and narcissistic trends cannot be used as terms for describing object relationships. For, reverting to the idea of primary narcissism, just as the infant experiences external satisfactions as part of itself, undifferentiated from its own body, orality and narcissism imply the containment of the ego in any act. In actuality, normal narcissism refers to that ego cathexis which enters into relationship with the external world and with object representations. These cathexes are ego libidinal in nature. Normal narcissistic fantasies are in comparative accord with reality and do not involve a high degree of infantile striving for omnipotence. The narcissistic character appears self-confident, often aggressive, impressive, and vain. In contrast to the compulsive character, he can be openly aggressive and sadistic.

Oral neurotics—or narcissistic characters—show the fixation on the oral infantile period. Such persons require a constant source of sup-

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plies from the external world for the satisfaction of their immediate needs. One finds, in this category, the "independent" personality who has more or less regained the security of primary narcissism and feels that "nothing can happen to me." On the other hand, one finds the dependent neurotics who, fixated in the infantile relationship to objects, must look to the external world for every kind of gratification. The chameleon personality who can do nothing but fulfill the assumed expectations of others indicates multiple and evanescent identifications. Such persons have not progressed from the infantile stage of object relationship which is identification.

Oral deprivation may determine either a pessimistic (depressive) or sadistic (redress-demanding) attitude, each expressing the fixation to the world or oral wishes through the demand that others look after him. As in the two substages of oral eroticism, this demand may be expressed either passively or in an active oral-sadistic manner. Identification with a frustrating mother can produce a fixed unwillingness to give anything to others. In all such cases of narcissism, one finds a high proportion of libido directed to the ego.

¶ Some Other Character Disorders, in Brief

As the interest in ego psychology has developed, a variety of character disorders have been delineated in children and adults. I shall mention briefly some of these areas; however, these disorders require further detailed study to align them within a systematic framework of medical psychology.

We find discussed, among the character disorders of children, the autistic child (Kanner), the atypical child (B. Rank), and children with ego variations (Beres). The literature pertaining to adults is quite extensive; however, a few special types are the "as-if" (H. Deutsch), persons with ego-modifications (Freud), pregenital and ego-defect characters (Hendrick), persons with ego distortions (Gitelson), and individuals with borderline conditions (Greenacre).

Among character disorders related to borderline states and psychoses, we would include perversions and drug addictions, which are discussed in Chapters 29 and 30. These conditions are characterized primarily by a disturbance in the ego, which is fragile, vulnerable and shows some impairment in reality-testing. The object relationship of these individuals is unstable and there is an impairment in their capacity for identification. There is a high degree of narcissism and intense oral fixation, and defusion of instincts may occur—giving the impression that their aggressive energy has not been sufficiently neutralized. In these disorders the more primitive mechanisms of defense, introjection, and projection are especially prominent.

Although there are many character disorders related to borderline and psychotic conditions, only a few types will be briefly considered. The cycloid type is extroverted, outgoing, with tenuous ties to many objects in the external world. He is subject to variations in mood, with mechanisms similar to those encountered in the manic-depressive psychosis. Abraham[1] indicated that the basic character structure of these individuals is similar to that found in the obsessional neuroses. Denial is the major mechanism of defense utilized in dealing with their instinctual drives and reality. The schizoid type is autistic, shy, introverted, and withdrawn. He may go through life restricted in his object relationships and emotionally detached without ever developing a psychosis. Under adverse circumstances, e.g., intense emotional traumatic incidents, a psychotic (schizophreniclike) episode may erupt, indicating a fragile ego which is momentarily disrupted. The paranoid type is recognized by his suspiciousness and jealousness and a heightened sensitivity in perceiving the unconscious of others, especially their hostile intentions. These three types give the impression that they harbor a latent psychotic core and that, under certain stressful situations, a transient psychosis may become manifest.

¶ The Impulsive Character

The phenomenon of impulsiveness has not been accredited the importance that it deserves in either the theory of character development

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or the theory of neurotic formation. If an impulsive type were to be added to the three types suggested by Freud, a much broader area in characterology would be encompassed. With this addition, a greater richness and more precise differentiation in the mixture of types would be possible, with the ideal "norm" probably consisting of an erotic-obsessional-impulsive-narcissistic mixture.

Just as aggressiveness is neutralized by eros, so it may be that impulsiveness is balanced by compulsiveness. There has been much study of the origins of the compulsive neurosis and the compulsive character, but relatively little of impulsiveness and of impulsive character and psychopathic personality (as Freud related types to pathology—for instance, the erotic to hysteria, the impulsive type may correlate with psychopathy). The mixture of impulsive-compulsive-narcissistic types would probably furnish us with the matrix for the large, unwieldly group of individuals who are commonly said to have borderline conditions.

In discussing the above problem elsewhere,[94] I suggested that, if the urethral zone is included in the theory of erogenous zonal phases, it is possible to round out the libidinal series as a developmental sequence; thus, the urethral trait and the urethral character can be envisaged logically in the typologic system that preceded the structural point of view. To reconcile the impulsive type with Freud's three libidinal types within the structural framework presents greater difficulties. Freud's emphasis was on the creation of a normal typology in which there was a harmonious balance between the three agencies. The addition of a fourth type raises the question of the psychic agency to which the libido might be ascribed. This problem is resolved if one assumes a weak super-ego, so that tension arises between the ego and super-ego.

It may be that the concept of the impulsive character could be further divided into two types: (1) the impulsive psychopathic character, which would embrace the psychopathic personality of psychiatry and be consistent with the group designated by Glover[56] as impulsive and with the impulse disorders described by Frosch and Wortis,[52] and (2) the impulsive neurotic character, which has been described within the psychoanalytic theory as the impulsive character by Reich,[104] as the neurotic character by Alexander,[4] and as the reactive group by Glover.[56] The first type would be considered more alloplastic, with ego disturbances less serious in nature than those found in the psychosis but involving more impairment than is present in the neurosis. The second would be much more autoplastic, with neurotic mechanisms of the compulsive form.

The impulsive neurotic character presents dormant psychopathic tendencies which are held in check by the compulsive neurotic components of his character. When these components are predominant, the individual behaves like the severe compulsive neurotic, showing marked inhibition, feelings of guilt, ambivalence, doubts, and suffering. Psychoanalysis finds evidence in such patients of a mixture of the features found in the impulsive psychopathic character and those characteristic of the compulsive neurotic character. It should be kept clearly in mind that persons with impulsive psychopathic character represent an extreme type. There are many individuals with distorted characters, with super-egos which corrupt easily, who perpetrate crimes in a most sophisticated manner but who belong to types quite different from the impulsive psychopathic character. The disturbances in their character structure are probably not as pervasive as in the impulsive psychopathic character nor do they possess a similar psychosomatic substructure.

The relationships between psychopathy, compulsive neurosis, borderline states, and the psychoses become easier to trace, once the typology is expanded to include a classification of impulsive psychopathic character. In general, the compulsive neurosis tends to strengthen the character structure through the capacity to bind anxiety and to furnish defensive reaction-formation mechanisms. In the psychiatric literature there have been numerous studies on the relationship of compulsive neurosis to the psychoses. Some authors stress the belief that when the individual with a severe compulsive neurosis breaks down, there is a tendency to schizophrenia: others see the direction as one toward manic-depressive psychosis. With the

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inclusion of the impulsive type of character and the recognition of borderline disorders whose matrix is a mixture of impulsive-compulsive components, decompensation of the compulsive neurosis might be viewed as the breakthrough of impulsive factors also resulting in psychopathic reactions. Thus, the particular form of reaction to the devolution of the compulsive neurosis would be dependent on the type of personality organization with its specific sensitized loci of ego-libidinal fixations.

I shall not, at this point, discuss in detail the impulsive psychopathic character from the standpoint of zonal phases in libidinal theory. In a previous book,[94] however, I discussed certain relationships between the lowest incidence and lowest persistence of enuresis and compulsive neurosis and manic-depressive psychosis. In the same study, I indicated that enuresis may have different meanings according to the basic structure of the persons who suffer from this symptom.

If one examines the psychodynamics of the resolution of emotions in a similar way—from the standpoint of the variability of meaning of a symptom—it becomes possible to see how hate is resolved differently according to character structure. For instance, it has been found that hate and aggressiveness are most freely expressed in the impulsive psychopathic character. When we differentiate the two main types of impulsive character as suggested (impulsive psychopath and impulsive neurotic), a rounded-out picture appears of the different ways in which hate and aggressiveness are resolved in the continuum of character structures.

Here again, it must be emphasized that there are no pure types of character structures. In the admixtures that occur, however, there may be a predominance of one type which gives the main coloring to the total personality. In the individual with a predominant character structure of a psychoneurotic type, for example, with hysteria, the symptoms reflect primarily the vicissitudes of dealing with love and its sexual aspects; when confronted with impulses of hate, such a person wards them off through the mechanism of repression, the typical defense of the ego in hysteria. In the compulsive neurotic, with his many reaction formations, aggression is bound and, together with anxiety, gives rise to the cardinal symptom of ambivalence. When psychosomatic symptom formation is the chief tendency of a personality disorder, the patient has the possibility of binding or neutralizing aggressiveness within an organ or organ system. This capacity is predicated on the presence of compulsive components in the character structure.

In the impulsive psychopathic character, along with impulsiveness there is an enormous quantity of aggressiveness in the form of hate that is freely expressed. Certainly the impulsive psychopathic character is not ambivalent; he does not hesitate to give vent to his feelings, a process which in turn leads to his fight with the outside world. In the impulsive neurotic character, however, aggressiveness is somewhat bound and neutralized by defensive reaction formation mechanisms. Clearly, the difficulties of the impulsive psychopathic character are externalized, whereas the difficulties of the impulsive neurotic character are sufficiently internalized to account for the greater degree of conflict within the latter. Finally, in the psychotic character, the greatest degree of defusion of instincts occurs. Where the problem of dealing with hate is paramount, as in the paranoid individual, aggressiveness and hate are dealt with in a distorted manner through the defensive mechanism of projection. In brief, viewing the typological continuum as a whole, aggressiveness in the form of hate is resolved by being repressed, turned inward, bound, expressed, or projected according to the predominant type of character structure.

By setting up the impulsive type of character we may be opening the road to the inclusion of clinical conditions which previously were not encompassed in the scheme of typology or psychopathology. Thus the syndromes of traumatic neurosis and epilepsy may be envisaged in closer relationship with impulsive types than with any other categories. The three conditions of psychopathic personality, traumatic neurosis, and epilepsy have in common a high degree of narcissism, a fragile ego in which both the ability to bind anxiety and the threshold to external and internal stimuli are low, a marked tendency to respond with action (action-syn-

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drome-Kardiner[80]), and a lack of inhibition with a high degree of impulsivity. It may be of some significance that Wheelan,[121] in an intensive investigation of a pair of uniovular twin brothers who were extremely different in moral organization and social adjustment, found that one was a serious delinquent and a psychopathic personality, the other was morally stable but subject to attacks of unconsciousness which were considered to be epileptic.

Of neurophysiologic significance is the presence of electroencephalographic abnormalities, specific for epilepsy and nonspecific for psychopathic personality. Evidence for associating electroencephalographic findings in aggressive psychopaths with epileptic cerebral pathophysiology has been presented by Hill.[71] The presence of an abnormal electroencephalogram among psychopathic personalities raises many questions which cannot be answered in this presentation. For example, is such a finding coincidental, is it another discordant manifestation at the cerebro-physiologic level,[95] or does it have more specific implications of organic disease of the brain reflected in a defective ego?

Finally, the continuum of impulsive character would range from the impulsive psychopathic character, traumatic neurosis, and epilepsy at the simplest and most primitive pole, with the impulsive neurotic character at the most complex pole. Thus neurotic and conflictual features would be least evident in the impulsive psychopathic character, greatest in the impulsive neurotic character. The impulsive psychopathic character and the epileptic character would have more neurophysiological elements in common—e.g., electroencephalographic abnormalities—the individual with traumatic neurosis and the impulsive neurotic character more psychodynamic features. From the standpoint of Freud's mental principles, a hierarchy might be structured, with the repetition compulsion more dominant at the pole of impulsive psychopathic character and the reality principle developed to the greatest degree in the impulsive neurotic character. Here again one realizes that mixtures of these two particular types do occur, but for the purposes of emphasis they are presented in this schematic manner.

The Impulsive Character and Acting Upon Impulse

Atkin[8] and A. Reich[102] have described patients with character problems in an illuminating manner and demonstrated elaborate specific defensive structures. A. Reich's patient, as a matter of fact, was an obsessional character. If one swings to the other extreme, a composite picture of the opposite type of character—the impulsive character with acting-out tendencies—becomes evident. Viewing character types as a continuum, the compulsive character appears at one end and the impulsive character at the other. Within this continuum, I shall attempt to delineate the impulsive character from a typological point of view, although the concepts are elaborated from clinical experience.

In neurosis, the cardinal manifestation is that of conflict. The solution of a conflict usually results in a compromise formation and takes the form of a symptom. Thus, the symptom is ego alien and results in an awareness of illness with suffering. In impulsive character disorders the solution of the conflict is resolved in a different manner and may actually be taken up into the character structure. Whatever difficulties there may be, these are ego syntonic without an awareness of illness and little, if any, suffering. Furthermore, in the neurosis there is a struggle between the id, ego, and super-ego. In the character disorder the struggle exists primarily between the ego, super-ego, and the outside world. This process is similar to what occurs in a psychosis, and yet it has certain differences. In the psychosis, there are distortions of reality such as delusions and hallucinations. Cleckley,[19] interestingly, considers the psychopathic personality closely allied to the psychosis; he sees it as having a semantic nature in which experience as a whole cannot be grasped or utilized in its ordinary significance or meaning. Freud[44] suggested that the illogicalities, eccentricities, and follies which are encountered in the analysis of characterological attitudes have a relationship to the psychoses which is similar to that of the perversions to the neuroses.

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In the severe type of character disorder in which acting upon impulse is prevalent, there is a difficulty in control, indicating a disturbance in inhibition, an incapacity to delay action in which tension is expressed freely. These individuals show a pregenital orientation and there is a similar configuration of the ego. The ego characteristics of these individuals are probably related to the type of ego found in borderline conditions. Some of these variations have been described as ego-modifications by Freud,[35] the ego-defect neuroses by Hendrick,[70] and fragmentation of the ego in the atypical child by Rank and Macnaughton[100] and Beres.[10] The ego of persons who act upon impulse is not equipped to bind anxieties. This accounts for the low threshold to stimuli. One finds in them a high degree of uninhibited aggressiveness with a lack of fusion of the libidinal and aggressive instincts. The main mechanisms of defense available to this type of ego are those of introjection and projection.

Consideration of the super-ego in relation to the impulsive character disorder indicates that the super-ego may be malformed, implying an incomplete formation. According to Johnson,[76] the condition of super-ego lacunae is a type of variation of the super-ego. The capacity to become neurotic, to develop feelings of guilt and shame are dependent upon the full evolution of the super-ego.

Of equal importance in considering the impulsive character disorder is the disturbance in object relations. Individuals with such disturbances have difficulty in establishing good basic object relations; the object is sought primarily for need satisfaction.

Impulsive character disorders are specially characterized by action tendencies which include the living out of impulses, acting upon impulses, and "acting out." The phenomenon of "acting out" was first recognized as resistance in the course of psychoanalytic therapy and was used in a very specific sense by Freud:[39] namely, that, although the patient does not remember what is forgotten and repressed, he expresses it in action, he reproduces it in behavior, and he repeats without knowing that he is repeating. The term "acting out" later came to be used generally to apply to almost any overt behavior that had social implications, usually of a derogatory nature.

The tendency to action is least marked in the individual with a compulsive obsessive character structure and most evident in the individual with an impulsive psychopathic character. The word behavior implies action, but our concern here is that type of action which is unrestrained, impulsive, and detrimental to either the individual or society.

In individuals who act upon impulse,[91] there seems to be a primary orientation to senses and things, so that perception and concreteness take precedence over conception and abstraction. Furthermore, retardation in the development of language is reflected in a high incidence of reading disability among delinquents. Both conditions may be related to an overcathexis of the tactual sphere and preverbal state and a lack of differentiation of the ego and super-ego systems. There is a lack of differentiation in the character structure of individuals with these disabilities. When they experience conflict, it is characteristically generalized and diffuse, in contrast to the more specific, isolated conflicts which are present in the neuroses. The tendency to react in an all-or-none manner leads to events being experienced dramatically and interpreted subjectively as crises. The actions of these individuals resemble qualities of the primary processes; their sense of time is seriously impaired, which probably contributes to the reaction of urgency to trivial events.

Since the concept of character, in a general sense, is involved with a social, evaluative judgment, the factor of control, which is associated with the capacity to tolerate frustration, anxiety, and aggression—thus allowing behavior that is in conformity with social and moral expectations—is an important factor in evaluating character.

It is no accident that the individual whose impulses are the least controlled—the persistent delinquent—manifests the greatest deficiency in the ability to control. Persistent enuresis and persistent delinquency generally indicate character disorders with the common denominator of lack of control.[93] Obversely, overcon-

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trol of impulses and actions even to the point of passivity and hyper-morality would be found in the obsessive compulsive individual. In view of these observations, the need for studying the relationship between all types of action in behavior such as acting upon impulse, "acting out," "living out," abreacting, becomes obvious. Furthermore, it seems that as much emphasis should be given to the somatopsyche as has been given to the psychosoma. The complexity and variegation in character structure and the total personality make it difficult to include all the pertinent and significant basic factors.

One of the difficulties in developing a theory of character is the fact that the theory of neurosis had as its central core the factor of conflict. Atkin[8] and A. Reich[102] have demonstrated sublimations and reaction formations in their patients as ways of dealing with conflict. When traits of character, however, develop as a solution, they become ego syntonic and thus create more difficulties for the environment than do neurotic symptoms. Although Freud dealt primarily with reaction formation and sublimations and seldom elaborated upon that part of character which pertains to unchanged perpetuations, he stated, in discussing character formation:[36]

> One can give a formula for the formation of the ultimate character from the constituent character-traits: the permanent character-traits are either unchanged perpetuations of the original impulses, sublimations of them, or reaction-formations against them.

In the impulsive psychopathic character with a history of persistent enuresis, the continuation and persistence of enuresis is an "unchanged perpetuation of the original impulse," where there has been little if any sublimation of the urethral component. The tendency to uninhibited reactions as revealed in the persistent enuresis permeates the whole character. It is this writer's impression that in the character disorder in which primary acting out or acting upon impulse[91] plays such a predominant role, a large increment of unchanged perpetuations of the original impulses will be found.

¶ Biological Aspects of Character Structure

It is necessary to regard character structure as a biopsychosocial phenomenon. American psychoanalysts tend to shy away from the subject of constitution, as if this connotes an irreversible process with a pessimistic outlook. There is something in the American scene which fosters an exceedingly optimistic point of view and appeals especially to that group of psychoanalysts whom we might label as culturalists. Freud[48] always took constitutional factors into consideration in his explicit statement about the complemental series: "The constitutional factor must await experiences before it can make itself felt; the accidental factor must have a constitutional basis in order to come into operation." Momentarily, I propose to be the devil's advocate and discuss some aspects of constitution which are ordinarily bypassed; I do not, however, mean to minimize the experiential and psychological factors which play such a significant role in the development of character structure.

There are many biological factors which need to be considered—some of these will be elaborated, others will be mentioned briefly. The factor of age must be taken into consideration, with character formation and development varying accordingly. Organic disease of the brain may lead to a reduction in the inhibitory factors and result in a caricature of character traits. There are specific psychoses which occur more frequently in certain racial or ethnic groups, e.g., the higher incidence of manic-depressive psychoses among the Jews. Drugs, hormones, and body build play roles in the determination of character structure.

The problem of integrating the organic bases of character and personality is a difficult one, methodologically. So too is the construction of an acceptable theoretical framework. Nevertheless, the factor of basic disposition related to constitutional factors requires consideration, whether one regards this disposition as psychosomatic or somatopsychic.

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From the time Galen described the four humors to the period when Freud formulated libidinal types, medicine has recognized the relationship of somatic factors to character and personality. Kretschmer[82] attempted to correlate certain body types with specific mental disorders. In this country, Sheldon and his co-workers[111] developed a more intricate schema and related it to embryologic conceptions. Utilizing Sheldon's concepts, the Gluecks[60] reported a very high incidence of mesomorphic (muscular, solid) dominance in the body structure of persistent delinquents, and they also found less disharmony in physique among a delinquent group than in a nondelinquent group.

In the field of psychosomatic medicine, similar efforts were made in drawing profiles of personality characteristic of specific disease syndromes, e.g., Alexander and his co-workers,[5] Binger, *et al.*,[14] and Dunbar.[23] Alexander sought to establish whether there is any constant parallelism of psychologic features in cases with the same organic syndromes of the gastrointestinal tract. Apart from identical conflict-situations (intensive in-taking tendencies both of a passive-receptive and of an aggressive-taking nature), a remarkable similarity has been found with respect to emotional attitudes toward the environment. These conflict situations may develop in very different personalities. In contrasting patients with ulcerative colitis, Daniels' impression[21] was that the difference lies in the more narcissistic organization of their personalities, the underlying reaction being more closely related to a psychotic than to a psychoneurotic one. Results have been suggestive, but inconclusive.

Electroencephalographic finding have indicated some type of nonspecific abnormalities of the electroencephalogram in certain clinical entities. Hill[72] reported that the electroencephalograms of behavior problem children and adult psychopaths often showed abnormalities which in younger age groups would be considered normal. The relationship of certain conduct disorders to organic disease of the brain was especially highlighted by Bender[9] in children with postencephalitis. Glover[55] has proposed a primary functional stage in which there are simple disorders of excitation and discharge without fixed psychic content, giving rise to the purest form of psychosomatic reaction. He[58] goes so far as to raise the question of whether there is a functional delinquency (psychosomatic) as distinct from a "conflict delinquency." From another angle, Jones[77] suggests the presence of an organic factor related to the capacity of inhibition. He stated:

> The capacity to endure the non-gratification of a wish without either reacting to the privation or renouncing the wish, holding it as it were in suspense, probably corresponds with a neurological capacity, perhaps of an electrical nature, to retain the stimulating effects of an afferent impulse without immediately discharging them in a different direction.

In a personal communication, Valenstein, reviewing neurophysiologic studies on animals, stated that there are neurophysiologic receptors and feedback mechanisms between the periphery and the central nervous system which may block the very transmission of perception beyond the peripheral receptors themselves.

Ferenczi[28] speculated that there may be a kind of physiological precursor of the super-ego, which he called sphincter morality. He believed that this physiological morality may form the essential groundwork of later mental morality. Conversely, it is possible that the early sphincter immorality of persistent enuresis foreshadows later social immorality. The data[94] indicating a high incidence of persistent enuresis in severe delinquents would tend to corroborate this thesis. Some of the hypotheses suggested by these observations were: (1) Persistent enuresis is a biopsychosocial paradigm for behavior that is characterized by the lack of control due to deficiency in inhibition. (2) The general pattern of lack of control permeating all levels of the persistently enuretic delinquent-psychopathic personality (impulsive psychopathic character) can be considered as a short-circuiting in a neurophysiologic sense and an acting out (characterological) from the psychoanalytic standpoint.

It is of some moment that contributions to the problem of constitution, predisposition, and innate endowment have come primarily from observations of infancy and childhood. Four

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main areas might be delineated: (1) sensation, (2) motility, (3) instinctual drives, and (4) the autonomic nervous system. In the sensory field, Bergman and Escalona[11] reported five cases which seemed to indicate a relationship between unusual early sensitivities and psychosis. They suggested that the "protective barrier against stimuli, 'Freud's Reizschutz,'" should refer to all data about the sensitivity or excitability of a newborn infant relating to either outer stimuli (sensorium) or inner stimuli (organic needs). They concluded that an organism insufficiently protected against stimuli by a "thin" barrier may need to develop certain ego functions precociously. These ego rudiments appear to break down under the impact of early traumata. Laufer and his associates,[86] using photo-Metrazol determinations in children with a hyperkinetic impulse disorder, characterized by hyperactivity, shorter tension span, and impulsiveness, showed a lower threshold to stimuli in the children.

Psychologists and psychiatrists have conducted series of interesting experiments on sensory deprivation. Hebb and his co-workers[12] have been studying the effects of isolation, with the aim of reducing the pattern of sensory stimulation to the lowest level. Lilly and his group[87] have carried on somewhat similar experiments reducing the absolute intensity of all physical stimuli to the lowest possible level. Both groups have been studying the effects of sensory deprivation on the reactions of individuals. Some of their findings indicate that, under sensory deprivation, the individual may become apathetic, aggressive, and even confused. In regard to motility, Fries,[49] in a series of publications, classified infants according to their congenital activity into three "normal" types—so-called active, moderately active, and quiet—and two pathological ones at either extreme—hyper- and hypoactive. The hyper- and hypoactive types were more vulnerable to the psychopathies. Mittelmann[97] has published a series of papers on motility and psychodynamics. He believes that the control of motility gradually becomes an important aspect of impulse mastery. The relationship of motility to tics has been demonstrated by Mahler.[89]

With reference to drive variations, Alpert, Neubauer, and Weil[7] have reported a series of studies on the unusual variations in drive endowment. They concluded that the ego, with its own autonomous potentiality of variation, interacts from the very beginning with the drive variations of a given individual and is influenced by these variations, and later the ego itself also modifies the drive expressions.

Regarding the autonomic nervous system from the standpoint of biochemistry, Grinker[64] states that there are many important constitutional differences in biochemical processes which are not clear, yet influence the child's needs and demands. In a clinical study he[64] showed how the ego development was influenced in a child who had celiac disease from infancy. Grinker[65] also remarked that the infant is born with a significantly variable hereditary or intrinsic visceral behavior pattern, which can be measured as a base line, on which subsequent influences impinge, producing alterations. From a study of three-day-old neonates, Richmond and Lustman[106] concluded that inherent autonomic endowment is one of the factors in the autonomous conflict-free sphere of ego development and, as such, participates in and markedly influences subsequent ego development. Studies have also been undertaken on ego variations. From clinical work with children Beres[10] has designated certain types of children as presenting ego variations and Gitelson[54] has described patients with ego distortions.

Greenacre,[63] combining considerations based on the analysis of particularly severe neuroses in adults and reviewing some experimental work and observations in infants and children, has thrown significant light on the general problem of predisposition to anxiety. For example, in a paper on "the biological economy of birth," she states:

> Important in the anxiety potentials in any human being, is the degree of tension existent, dependent on the sensory-motor balance, that is, the ratio between the sensory stimulation and the capacity (development and opportunity) to effect some sort of discharge.

In another paper on "the predisposition to anxiety" she stated:

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Severe suffering and frustration occurring in the antenatal and early postnatal months, especially in the period preceding speech development, leave a heightened organic stamp on the make-up of the child, . . . this organic stamp of suffering consisting of a genuine physiological sensitivity, a kind of increased indelibility of reaction to experience which heightens the anxiety potential and gives greater resonance to the anxieties of later life.

Stone[115] believes that the earlier and more profound the psychic disturbance in an individual (whether endogenous or experiential), the more liable it is to cause neurotic disturbances of growth, of sugar metabolism, of vascular tension, of cardiac rate and rhythm, and kindred fundamental pathologic changes. From the above reports we see efforts to study the constitution and predisposition pertaining to sensory thresholds, variations in motility, variations in drive endowment, autonomic endowment, ego variations, and the predisposition to anxiety.

I referred earlier to Freud's basic concept of the complementary series regarding heredity and environment. In concluding this section I should like to quote, from "Analysis Terminable and Interminable,"[35] one of his last formulations concerning constitution: "Three factors which determine the result of analysis are the effect of traumas, the constitutional strength of the instincts and changes in the ego."

¶ Sociological Aspects of Character Structure

It is interesting that we are freer to approach the so-called normal character types without ethical and moral value judgments, probably because they represent "good" characters in contrast to the neurotic impulsives who represent "bad" ones. This leads us to the question of choice of symptoms—why does one individual develop the "bad" character, another the "good"?

The problem of the choice of neurosis has not been solved; neither has the problem of the choice of symptom and of organ. The insight gained into the dynamics of neurosis led to the concepts of somatic compliance. The problem of the choice of character structure is a much more complex and difficult one, but, just as somatic compliance evolved in the study of the neurosis, the aspect of social compliance must be further delineated in the study of character structure. Hartmann[66] discussed the relationship of social structure to personality type and vice versa—the relationship of personality structure to social change. In fact, he introduced the concept of social compliance when he stated that "a given social structure selects and makes effective specific psychological tendencies and their expression and certain developmental trends."

The solution to the problem of somatic compliance requires the collaborative efforts of the physiologist and the psychoanalyst. The solution to the problem of social compliance requires the integrative efforts of the psychoanalyst and the social scientist. Such interdisciplinary collaboration carries certain dangers—if a psychoanalyst gets interested in the social sciences, he may become a social scientist; if a social scientist becomes seriously involved in psychoanalysis, he may become a psychoanalyst. The analyst might say that the social scientist who becomes an analyst is a better sociologist. When you question the social scientist about the analyst who becomes interested in social science, he will tell you that he is a better psychoanalyst.

The fact that there is an actual contemporary shift to a higher incidence of character problems (Ackerman[2]) compels us to observe more carefully the cultural influences which may play a significant role in this shift, Erikson's *Childhood and Society*,[25] demonstrates how psychoanalytic concepts can include the idea of social compliance. The specific concept which bridges the gap between the inner development of the individual and the impinging forces of culture is his meaningful construct of the idea "identity." The dynamic concept of phases of development, based on libidinal theory yet enlarged to include intimations of social values, is an integrating force. The concept of identity permits us to extend Freud's basic principle of the complementary series within the individual—i.e., the relative inter-

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action of constitution and environment—to the enlarged complementary series of the individual and society. Erikson[25] writes:

> The integration now taking place in the form of ego identity is more than the sum of the childhood identifications. It is the accrued experience of the ego's ability to integrate these identifications with the vicissitudes of the libido, with the aptitudes developed out of endowment, and with the opportunities offered in social roles.

An example of social compliance can be found in studies based on observations of men in military service. Porter and the writer[96] reported a high incidence—over 10 per cent—of psychopathic personality and a low incidence—0.3 per cent—of compulsive neuroses among soldiers with neuropsychiatric conditions admitted to hospitals or separated from the military service. The soldier with the compulsive neurotic character structure is able, in military service, to augment and strengthen his defenses, because the military services are vast compulsive organizations. On the other hand, the uninhibited tendencies of the impulsive psychopathic character lead to overt problems in such a closed, restrictive organization. Valenstein, Evje, and this author[119] presented further data which offer some confirmation of the positive relationship of certain personality types (compulsive) to a specific social structure (army).

With this as a background, how can we understand the "so-called normal characters" which Atkin[8] demonstrated were really not so normal? His patients appeared "normal" according to the usual criteria of being able to love, to work, and have satisfactory social relationships. If our culture accepts, as normal, material success, adjustment to reality, and money in the bank (with a premium on the ability to live within one's budget), we can see that the patient Atkin discussed, whose inner economy revolved around the "adding machine complex," balancing input and output with his culture, merely developed a character structure congruous with the current value system. These are aspects of an oral orientation within a social culture which fosters some of these elements. Thus, we see social compliance in this resonance of society with the inner needs of the individual. There is also a kind of inner somatization with an outer social somatization—the concern on inner organs being paralleled by the cathexis on external concrete things; neurotic hypochondriasis and a social hypochondriasis.

Viewing dispassionately the "adding-machine complex" of Atkin's patient, one would describe it as a philosophy in which his inner life is conducted as an efficient business organization—profit and losses are balanced—with an accounting always taking place. It does not require much imagination to find the external counterpart of his culture in the present business world, e.g., Fromm's[50] marketing orientation.

In Atkin's patient, a man's inner business life found its complement in the outer business culture. There are examples which reverse the process, in which a specific cultural pattern may resound on the inner life of an individual. I am indebted to Drs. John P. Spiegel and Florence Kluckhohn of Cambridge, who have given me their permission to use the data that they and their collaborators have obtained in their investigation of the impact of the cultural situation on Italian families, a study titled "Family Processes."[112] In most immigrant Italian families marriages are initiated through familial arrangement rather than on the basis of individual selection. In this Italian custom, the husband is loyal primarily to his family, the wife to hers, thus producing a certain degree of stress. Specifically, there is the constant tension created by the need for individual satisfactions, especially sexual on the one hand, and the need to satisfy the demands of the extended family groups, including aunts and uncles, on the other.

Spiegel and Kluckhohn have been making comparative studies of so-called normal Italian families and "disturbed" Italian families. The combination of loyalty to family, love, and duty gives the impression of an unusual degree of closeness and dependency—a sense of togetherness not only between the individual members of a family but also with immediate relatives. In a "so-called normal" family the only major difficulty observed was the depressive reactions of the wife which occurred dur-

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ing the summer, when her husband took his vacation with his brothers and left her at home. Her depression and unhappiness lifted when he returned home to her. The immediate precipitating factor was the separation and his seeming preference for his own family.

The presenting problem in a "disturbed" family was a boy of 8 years with a history of asthma, persistent enuresis, a food problem, and aggressive behavior. This family had three children, 3, 8, and 9 years old respectively, who were persistent enuretics; of some interest was the fact that the parents sought psychiatric help only after prolonged discussions with all the relatives. The father was quite narcissistic, suffered from migraine and hypochondriasis, and had a weight problem. The mother was phobic, refusing to leave her home. (This tendency is related to the cultural pattern of immigrant Italian families in which members stay close to home). She also was troubled with irregular menses, gynecological disturbances, and headaches. Her overt expressed wish and longing was for their family to move to another state where her mother lived and rejoin her mother's family.

When separations occur in a cultural pattern which tends to bind the extended family so closely, a disruption in the family pattern is significant. Conflict about separation seemed to occur in both families. In the so-called normal family, the depression of the wife developed when she was separated from her husband. In the disturbed family, although separation as an external event was not so evident, it is of some significance that there was such a generalized psychosomatic orientation. I would specifically emphasize the problems in the boy —eczema, asthma, a food problem, and persistent enuresis. We know that, in this type of psychosomatic problem, the factor of separation of the child from the mother is significant. It may be that I am reading too much into the above example in assuming a relationship between the effect upon the boy's mother of the separation from her own mother and the significance of the child's symptomatology, which seems to exhibit some aspects of separation effect. Nevertheless, although the relationship in this case may be obscure or nonexistent, reactions to the effects of separation in such a cultural pattern and the occurrence of individual psychosomatic symptoms may indeed show a relationship upon further investigation.

The sociological approach by Reiss in his paper, "Delinquency as the Failure of Personal and Social Controls," is quite interesting. He indicates that "primary groups are the basic institutions for the development of personal controls and the exercise of social control over the child. Delinquency may be seen as a functional consequence of the type of relationship established among the personal and social controls."[105] He further expected "that personal and social controls are less effective in governing the behavior of delinquent recidivists than non-recidivists." Thus, there is a common meeting ground in the significant phenomenon of control, as this author[93] previously demonstrated, though Reiss's approach is sociological rather than psychobiological.

Medicine is gradually abandoning the myth of the normal person—although we still think of a person as being healthy—"normal"—if he is not sick. The statistical yardstick is still the measure of all things. From an analytic point of view, there is no such animal as the "normal" person except as an ideal—we are all relatively neurotic. The basic tenets of psychoanalysis affirm that conflict is the essence of life and that instinctual renunciation is the price of being a civilized human being. Paraphrasing Pope's phrase "To err is human," we would say, "To be neurotic is human." If we accept the truth of these concepts, then we would not have to be on the defensive in regard to the criticism that we work only with abnormal people. The more psychologists and social scientists become enlightened to this reality, the less will they be concerned with the problem of normals and controls.

¶ Treatment and Summary

Classical psychoanalytic technique was evolved specifically for the treatment of the psychoneurosis, and, before the development of structural theories, the therapeutic emphasis was on the cure of symptoms. Reich[103] led the way to a therapeutic approach to the analysis of character problems. He showed how the

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initial transference resistance was expressed in a form which was characteristic of the patient's character. There was a consistent application of the newer method of resistance analysis to analysis of character, corresponding to the progress of analytic therapy from symptom-analysis to the analysis of the total personality. With the greater knowledge gained by the study of the ego and its defense mechanisms (particularly the work of Anna Freud),[32] the emphasis shifted toward characterological manifestations and the resistances which occurred in the character structure of the individual. Changes in techniques were evolved for the psychoanalytic treatment of children, delinquents, and psychotics. The variations in technique were especially emphasized by Eissler[21] in his statement that the basic model of psychoanalytic technique can be discussed with relative ease in the case of hysteria. More complicated cases in which there is a variation in technique—for example, in the case of a phobic who is advised to face the specific situation which gave rise to the phobia—are designated by him as parameters. This parameter is described as "the deviation—both quantitative and qualitative, from the basic model technique, that is, from a technique which required interpretation as the exclusive tool." It follows that, as a disorder increases in complexity, there will be a greater number and variety of parameters. Tartakoff[118] has done an illuminating study and review of recent books on psychoanalytic technique. A. Freud,[33,34] Glover,[59] and Stone,[116] among others, have written about variations of technique which apply especially to character problems.

A significant first step in the treatment of an individual with a character disorder would be to bring about a state in which the characterological difficulties are converted into neurotic symptoms. If the character disorder is of a serious, diffuse nature, where the patient shows little insight, experiences little suffering, and exhibits ego syntonic behavior, considerable preparation will be necessary.

In this chapter I have dealt largely with the impulsive type (neurotic and psychopathic) of character, inasmuch as this type has received less attention from the psychoanalysts. I hope that this delineation of the impulsive type in some detail may serve as a paradigm of the complexity of a specific type of character with its many facets. There is an enormous psychoanalytic literature on the other types of character[1,20,27,57,78] to which the reader may refer. Such character types as the phobic and hysterical, compulsive, cyclic, and schizoid are discussed by Fenichel.[26] Although, in this exposition, psychologic factors have not been elaborated extensively, I would like to stress that this should in no way minimize the great importance psychologic factors have in the development and formation of the character structure.

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CHAPTER 20

MINOR MALADJUSTMENTS IN THE AGED

Alvin I. Goldfarb

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THE ABSOLUTE AND RELATIVE INCREASE in the number of older persons in our society has turned the attention of psychiatrists to the ensuing social changes and to the individual problems arising in this age group. The psychiatric problems presented by aged persons are diverse, and the treatment methods—indicated or possible—encompass a broad range. This chapter will deal briefly with an orientation and attitude, stemming from psychodynamic theory and practice, useful in the psychotherapy of the aged. The operational concept discussed may be regarded as basic to the rational medical-psychiatric treatment of aged ill persons but is of especial value when psychotherapy is attempted. Many aged persons can be helped to acquire new ways through increased self-understanding, and even the very old and sick can benefit from reassurance and support. To initiate and maintain the controlled life experience called psychotherapy through which increased self-understanding or augmented confidence and self-worth can be gained, it is necessary to elucidate what reassures and supports the patient and how this may be offered. For this purpose a theoretical framework around which therapeutic action may be elaborated and on which the therapist and his assistants may lean for their own support and reassurance is proposed in this chapter.

¶ Historical Data

The number of published psychiatric works on old age and aging is too large to be listed here. Like philosophies, they appear to be "the products or expressions of the general conditions of society" and of their times. There was not a real scarcity of old persons in the past: in 1900, 1 in 25 persons was over 65 years of age, as compared to 1 in 12 in 1955. Until this decade, however, there appears to have been little interest in psychotherapy for the aged.

The lack of clear definition of what is meant by old age has resulted in some confusion. In

1919 Abraham,[1] for example, referred to persons in their 40's and 50's as being of "advanced age." Perhaps this is because he was himself at the time only 31 years old. He recommended psychoanalytically oriented therapy for older persons but was careful to point out that poor vocational and sexual past performance as well as early onset of symptoms were unfavorable prognostic signs. He emphasized the tendency of many older persons to regard the doctor as a father figure from whom will come suggestions and guidance. In 1925 Jelliffe[47] encouraged psychiatric interest in the psychotherapy of persons in the seventh or eighth decades of life. With only one exception, however, his illustrations of successfully treated persons are in the sixth decade of life. Of interest is the exception, a 72-year-old merchant whose temper improved, and whose hypertension appeared meliorated, through therapeutic sessions. He advocated treatment, saying, "Pessimism closes the door—optimism, even if an illusion, is worth the effort." Kaufman[54] and Atkin,[8] in 1940, appeared to regard the climacteric as the onset of old age, and they, too, referred to persons in their 40's and 50's as old or aged.

The importance of considering the older person in relation to the family and to the community was emphasized by Flügel in 1921; in his *Psychoanalytic Study of the Family* he made clear that it is for the well-being of society that there be respectful and helpful attitudes toward older persons, and that the success of a culture may be measured by the extent and quality of its provision for its aged. In an admirable paper, Kardiner,[51] in 1937, outlined the social forces which underlie attitudes toward the aged. The relationship of the subsistence economy to the ability and willingness of the family to protect and preserve the aged and the occurrence of child-parent reversal in attitude and action were cogently discussed by him. He gave an example of successful treatment of one older person which included manipulation of the social environment. Unfortunately, the ages of the persons used as illustrations were not given.

All the authors mentioned were concerned with aging and the aged. However, psychiatric difficulties of the fifth and sixth decades, to which most of them referred, are now better understood as problems of the middle years when many a person sees, or thinks he sees, his true trajectory in life and views it with disappointment, horror, or fright, without being able significantly to alter his course. Although this development probably has nothing to do with "involution," either physical or mental, it is nevertheless the possible beginning of chronic invalidism or of a mental state, which, even if not itself chronic, may create a social situation which steadily worsens. The disorders of middle life, or those developing in later years which are in all significant aspects like them, are dealt with in other chapters.

After World War II, however, a number of authors, notably Cameron,[15] Rockwell,[76] Wayne,[99,100] Herkimer and Meerloo,[45] Grotjahn,[43] Steru,[90-92] and Goldfarb,[32-40] reported specifically on the individual psychotherapy of the aged. Others, among them Zeman,[103-105] Ginzberg,[29,30] Allen,[2-6] Clow,[16] Linden,[60-65] Silver,[88] and Hollender,[46] reported on hospital, group, and milieu treatments. A number of reviews of theoretical and practical value have appeared, and a number of investigators, notably Busse and Barnes,[13,11] and Perlin,[70] are making sound medical-psychiatric contributions on which therapy can lean.

The fruitfulness of basic study of this age group is affirmed by the following findings in one institution for the aged. Klopfer[57] deduced that brief psychotherapeutic sessions would be effective; Perlin[70] noted that psychiatric interview was not always helpful in the proper selection of residents; Ballard[10] observed that certain types of older persons do not repeat suicide attempts; Shrut[87] noted that change of residence to an institutional type was related to increased anxiety and fear of death. The continuation of youthful attitudes and tendencies to remain active into old age, despite illness, was demonstrated by Oberleder.[67] Also, Kahn[48] noted that alert, assertive individuals seemed less prone to develop physical symptoms; and Pollack[71] reaffirmed the importance of good early socioeconomic circumstances and of at least minimal education in preserving intellectual ability with the progression of years.

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These authors have clarified some of the problems of psychiatric treatment of aged persons and have contributed to their solution. They have shown that, although some aged persons are in a position to review their patterns of behavior and gain insight into their dynamic determinants so as to make sweeping changes in themselves, most must be helped to regain or to utilize more efficiently their old effective patterns of action and to do so with a sense of purpose, restored interest, and pleasure. The psychotherapeutic interrelationship in which the older person regards the therapist as parent or child-parent and the utilization of this relationship for the patient's benefit has been demonstrated. The need for flexibility in the approach to treatment has been repeatedly emphasized. Appointments may be infrequent, sessions brief. Environmental manipulation and the role of ancillary personnel in treatment may be even more important than the sessions with the therapist. The need to work with the family or the persons who have assumed responsibility for the care of the relatively dependent person and the usefulness of the social worker in this respect have been emphasized.

¶ The Aged and Their Maladjustments

Who Are the Maladjusted Aged?

Chronologic old age, poor functional status, and the stigmata popularly considered pathognomonic of senility are by no means consistent correlates. However, for the sake of clarity, because it has some traditional and legal standing, and because so-called senile changes do not occur earlier with great frequency, we shall consider all persons 65 years of age and older as "the aged." This arbitrary definition has the combined merit of simplicity and of forcing our attention at once to the fact that we must avoid thinking in terms of a stereotype when we consider the aged human being. Individuals ranging from 65 to 90 or more years of age differ in strength, skill, endurance, appearance, intelligence, education, occupation, economic status, and social position; they have physical and mental disorders which cut across varied constellations of social, medical, and chronological characteristics.

Aged persons commonly referred to the psychiatrist are complaining, quarrelsome, restless, negativistic, depressed, agitated, or angry, and are regarded as threatening, on a verbal or physical level, of suicide or assault. Somatic complaints and paranoid ideas are common, and suicidal attempts are not infrequent. Less frequently than is popularly believed, sexual behavior unacceptable to the community is the reason for referral. This may vary from exhibitionism to not-unreasonable desires to remarry. In shelters for the aged, the most common reason for referral appears to be behavior which has "nuisance" value: noisiness, querulousness, physical complaining and somatic preoccupation which is unresponsive to the usual medical and nursing care available, and clinging, demanding, or hostile behavior. Quiet, subjective suffering on the part of older persons is often missed or neglected, even as it is in younger ones. Psychoneurotic behavior of all kinds is found in aged persons: dramatization, exploitation, and aggravation of disability or weakness are common, and obsessional characteristics are frequently troublesome. Among somatic expressions of emotional distress commonly encountered are headaches and vertigo, constipation, anorexia, sleeplessness, and early morning waking. A sense of heat and burning of the skin, intermittent sweats, flushing, and fatigability are frequent complaints. The loss of "loved" persons may result in accentuation of physical complaints or the appearance of new ones. Real depression, with guilt, self-depreciation, hostile and paranoid elements, and anxiety, does occur, but it may be less frequent than are states of pseudo-anhedonia characterized by social withdrawal, lack of interest, loss of purpose, and relative inactivity.

Frequently, the behavior giving rise to psychiatric referral is too quickly and too completely attributed to brain damage, although it is true that brain damage may contribute to these symptoms a coloring or flavor which often makes the disturbance appear, at first glance, to be more bizarre and more intense

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than more thorough study proves it to be. Careful note must be taken, however, of Rothschild's[78] careful documentation, in 1937, that the amount or extent of brain damage found at necropsy cannot be exactly related to the amount or intensity of the psychopathology or disordered behavior in life.

Psychosis, Psychoneurosis, and Disturbed Behavior

Seemingly similar mental disturbances in the aged, from the standpoint of nosology or the most relevant etiological factors, may require different methods of treatment because of individual differences and differences of the ecological situation. On the other hand, dissimilar disturbances occurring in a specific type of environmental setting, such as a shelter for the aged, or a mental hospital, may need, as a basis for treatment, the same general approach. It is the purpose here to discuss a general approach to aged disturbed or suffering persons. Clear-cut specific disorders occurring in the senium but common to younger persons are discussed elsewhere in this handbook.

The matter of differentiating between major and minor disturbances in older persons must be discussed briefly, because of the real difficulties in making such diagnostic decisions as well as because of the concern of the general public, the courts, and the mental hospitals about who belongs where and who should be treated or cared for by whom. Traditionally, psychoneuroses have been considered the minor, and psychoses the major, mental disturbances. An individual may be psychotic from the medical and psychiatric point of view and yet make a good, or at least passable, socioeconomic adjustment, whereas, on the other hand, many persons whose disorder is defined as psychoneurotic may undergo extreme suffering and may present great problems of disability requiring long-term care. Brought along into old age are many mental disorders which did not trouble the family or the community, or which were tolerated or even protected, because of special circumstances or the person's occupational adjustment or special skills. Psychoses, psychoneuroses, and behavior disorders of every variety may be revealed late in life when circumstances change or when attractive appearance, opportunity, skill, or position is lost. Such disorders, as noted above, may contribute to, or be accentuated by, brain damage which is characterized by evidence of defective memory and orientation and is ascribed to cerebral arteriosclerosis or to a little-understood process called senile deterioration. Also, an old person may be chronically or acutely ill or malnourished. Any one of these troubles, or a combination of them, adversely affects cerebral functioning. This adds to the problem of differentiating between what is to be considered a minor and what a major disorder. Symptomatic evidence of chronic brain syndrome, associated with cerebral arteriosclerosis or senile sclerosis, can be considered a major disturbance of mentation, because of its tendency toward inevitable progression, its disabling effects, and its association with emotional dyscontrol, personality change, behavioral disorganization, and the loss of productive capacity and social adaptability. Strong emotion, however, may result in exaggeration of defects of comprehension, orientation, memory, and judgment, and may lead to a mistaken impression about the severity of the disorder and to the belief that treatment is useless. Often, persons who appear to have moderate to severe brain damage, and whose behavior is grossly maladjusted, improve on the establishment of good patient-doctor relationships in a properly supportive environmental setting. This is in line with our knowledge that, except at the antipodal ends of the spectrum, actual brain damage and disturbance of mentation cannot be correlated.

Seemingly psychotic behavior of older persons with brain damage may differ from apparently similar conditions found in younger persons, in that there is fluctuation more or less in parallel with the general physical condition and with identifiable external situations provocative of strong emotion; there is also discernible improvement when the environment provides gratifications, a sense of security, and relief of physical or mental pain. Thus, it is very difficult to define the behavior of

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brain-damaged and chronically ill older persons in the usual terms of psychoses or psychoneuroses. When chronic brain syndrome is present, there is often a florid development of symptomatology having the characteristics of psychoses.

It is apparent from the foregoing that there are large numbers of persons who might, for one reason or another, be classified as suffering from a so-called major disorder who may, nevertheless, be surprisingly improved through the exercise of treatment methods commonly effective in minor disturbances. For these reasons, it is better to talk of *behavior disorders or disturbed behavior in older persons*, with or without chronic brain syndrome, rather than to attempt to make strict differences between psychoneuroses, psychoses, and organic symptoms. Traditional diagnoses are not to be discarded as useless. Evidence pointing to brain damage is a grave prognostic sign. However, from a practical point of view, whether or not evidences of chronic brain syndrome are present, there is much to be gained by determining (1) whether potentialities to harm self or others exist, and to what extent these are modifiable; (2) to what extent nuisance value is present, and how far this is modifiable; and (3), most important, the extent and quality of the patient's suffering, and how one may modify or eradicate it. In any case, a psychotherapeutic trial, in addition to good nursing and medical care, is indicated. A knowledge of the symptomatology is less important than information about the modifiability and the medical, environmental, or emotional changes required. The psychoses and psychoneuroses in older persons, in the absence of chronic brain syndrome, which are often indistinguishable from those seen in younger persons, respond about as well to equivalent treatment.

¶ Changing Attitudes Toward Psychiatric Treatment of the Aged

There is now widespread an expanding interest in active psychiatric treatment, especially psychotherapy, of aged persons with behavior disorders, whether chronic brain syndrome is present or absent. The great relative and absolute increase in the number of aged persons is not the only or chief determinant of this development. Civilized man has always desired to prolong life and to ensure strength, productivity, and the capacity for pleasure during life. Cultural and technical influences now favor a trend toward the psychiatric treatment of disorders previously considered irreversible or irremediable, and even of persons who, until recently, were generally regarded as having too short an expected life and too limited a capacity for worth-while activity or productivity to warrant the expenditure of any great amount of time and effort. For the sake of brevity, some of the influences favoring psychotherapeutic approaches to the aged are itemized below:

1. There is increasing understanding that the chief determinant of long-term illness and dependency upon shelter care is not physical disability but personality factors, and that mental disorder is often the major primary disability of those who require long-term medical or shelter care.

2. There is a growing conviction, based upon actual observation, that, as stated in 1956 by The Commission on Chronic Illness, "many patients having another primary diagnosis suffer also from mental illness; and most long-term patients have emotional problems sooner or later."[16]

3. The rapid increase in effective methods of prophylaxis and treatment for the many acute infections and some chronic severe illness has freed the physician for work with the so-called deteriorative and degenerative diseases of the elderly and has brought him face to face with the complex interweaving of psychological, emotional, and physical factors in disorders of aged persons.

4. The increased number of psychiatrists has favored the emergence of a number who have special interest in the elderly.

5. The rapidly expanding interest in sociologic factors in mental disorders as part of holistic or comprehensive medicine, as it has developed from psychobiology to psychosocial medicine, provides a theoretical base for treatment as well as a framework for investigation

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and research. With rational, consistent operational concepts, the previous medical pessimism and withdrawal can be replaced by optimism and interest.

6. An increasingly sound appraisal by psychiatrists of their position and their role as doctors whose obligation it is to meliorate where they cannot cure, and to relieve pain and suffering even when no basic alteration of the disorder can be expected, makes rational and reasonable the expenditure of time and energy with persons of limited life expectancy and potentialities.

7. There has been decreasing resistance to psychiatric concepts on the part of the general public. Real interest in and desire for psychotherapy has grown as increased freedom from preoccupation with ensuring subsistence has permitted the emergence of drives for gratification.

8. The incorporation of rehabilitation concepts into general medicine, as social workers, physical and occupational therapists, nurses, and other technical or nontechnical personnel have become integrated into teamwork approaches to individual patient care, has required the orientation of the team members, the use of psychodynamic concepts, and the help of psychiatrists with the patients.

9. Of considerable significance in promoting interest in psychotherapy for the aged is the great help persons who care for the aged derive from an orientation program. This aids them to realize that the aberrant behavior of their charges is motivated and can be understood as a complaint or plea for help, to which they can respond constructively.

10. Persons who attend the chronically ill, terminally ill, debilitated and dependent, or emotionally and behaviorally disturbed aged have found psychiatry and psychiatrists of assistance in the mitigation of the anxiety and anger which they themselves experience during the discharge of their duties. Situations frequently occur which provoke feelings of helplessness, either because they epitomize what may happen to oneself as one ages, appear to be insoluble problems, or tend to revive unresolved emotional problems in their relationship to their own parents or parental surrogates. Properly conducted group or individual conferences with staff members who are in any way concerned with the care of aged persons can lead to improved orientation and to significant changes in attitude which aid them in understanding and helping disturbed aged persons.

¶ The Predicament of the Aged Patient

The well-adjusted person of 65 or over appears to have emotional needs that do not differ greatly from those of younger persons. He desires friendships, of varying types and intensity of intimacy, with both sexes. He wants to keep busy at work, or a play equivalent, which is within his physical capacities, which is commensurate with his intelligence and background of training, and from which he derives a sense of accomplishment. He looks for, and objects to frustration of, opportunities for the relief of biological tensions such as hunger and sexual desire. In addition he may crave, in varying degrees, appreciation, marks of affection, and reassurance that he has made an impression upon this world by means of his words, his deeds, or by having reproduced himself. Thus his self-esteem, which in the past rested upon and was reinforced by his performance, can be maintained. In all this there may be some differences from youth, characterized by mellowness—a lack of haste, an inner patience, and a philosophic tolerance growing out of a satisfied curiosity. Obviously, emotional problems may be encountered among elderly well-adjusted people. They may meet these successfully alone or may require counsel, guidance, information, or even psychotherapy, as may any younger person under special stress. These persons may be found in their own homes, living with relatives, or, much less frequently, in old-age shelters.

In homes for the aged, nursing homes, and hospitals are a large number of aged persons who, like some others in their own homes or in a boarding-home arrangement, are less fortunate. In our society at the present time, large numbers of older persons tend to find

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themselves in roughly similar predicaments, from the physical, social, economic, and psychological standpoint. Not uncommonly they have lost the resources required for more or less comfortable survival. The loss of friends and relatives, work opportunity, and income leads to deprivations and frustrations on the levels of both subsistence and of gratification. Small quarters, the greater tendency of families to move about, economic inflationary forces, and the increase of population concentration in urban centers complicate and multiply the problems of survival and comfort for the older person. Moreover, there are declines in the efficacy of sensory function which contribute to isolation and decrease the steady stream of incoming stimuli which promote pleasurable action; there may be central-nervous-system integrative defects which impede communications with others and, in a manner of speaking, with oneself.

¶ Basic Concepts for Treatment

Decreased homeostatic efficiency limits function and may turn ordinary situations into minor or major emergencies, and effector inefficiency also severely limits the capacity for mastery and the unaided successful relief from tension. The chief resemblance of persons within the group we have defined as "aged" who come to psychiatric attention appears to be that they come to depend greatly on others. This dependency they may attempt to hide and may succeed in hiding both from themselves and from others. When their need, whether for medical care or because of inability to sustain themselves socially or financially, propels them or causes them to be propelled to a shelter or to others for aid, what the observer sees as their dependency is felt by the person as helplessness and is accompanied or followed by anxiety and a variable degree of anger. Each patient bears scars from early life—inhibitions or fears which have impaired his effectiveness in the past. New disabilities which occur in old age, however mild, may result in anxiety and anger, which go beyond alerting and organizing the individual and tend to disorganize and impair functioning.

The disturbed behavioral functioning of an aged person has as its core the early patterns of that person's behavior. These patterns of feeling, thinking, and acting are developed in a child-parent relationship which is the unavoidable biologic imperative for survival. Learning and mimicry reinforce or modify the behavioral patterns developed in the dependency period. One discovers, therefore, elaborate patterns of action which cluster about the emotional core of the personality developed in infancy. Among these patterns are tendencies, in variable degree, to exploit, exaggerate, or dramatize one's incapacity. The utilization of illness and inefficiency to punish oneself and others, to justify failure, to symbolize one's wishes, and to substitute for their fulfillment can be developed early and does not disappear with the accumulation of years. Disability, prolongation, and intensity of illness far beyond that warranted by the pathological structural changes may thus commonly occur in persons of advanced age. Disability may progress when emotional stress initiates or aggravates irreversible changes.

Fear and anger can prove disorganizing in the young and relatively intact person. Elderly people may even more quickly reach a point at which function becomes aimless, or efforts fragmentary and unsustained, when fear and anger arise. Emotional storms or immobilization may occur. More and more, we are coming to see how apathy can deepen, not only in the absence of stimuli adequate to maintain intrapsychic function and to promote adaptive contact with the world, but also in the presence of continuous severe stress beyond the person's powers, or his belief in his powers, adequately to master the situation or adapt to the change. This apathy appears to be an inhibition of function, an active process of damping out or overcontrol. When it is eliminated, the potential abilities of the person may once again assert themselves.

In many older persons, self-reliant, goal-oriented, problem-solving activity may have been at a low level to begin with; when it is further decreased by new functional losses,

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then previously precariously balanced or already low self-esteem suffers and falls progressively, as failure follows failure. As failures occur, a sense of helplessness arises. With feelings of helplessness, fear is provoked and mounts. Fear, an ever-growing sense of ineffectuality, and feelings of worthlessness accentuate each other in a vicious cyclical manner. With failures to master change, to act effectively so as to relieve tensions growing out of social, personal-environmental, and intrapersonal relationships, there is discomfort. Moreover, gratifications are not achieved, nor can substitutes or compromises for them be made. The sense of frustration and feelings of deprivation grow, anger supervenes, fear of retaliation and guilty fear may arise, and the personal suffering increases in a complicated tangle of emotional overreaction, behavioral disturbance, and physical disorder. In this helpless, disorganized state, the patient's behavior is patterned along lines of the culturally acceptable manifestations of dependency as previously internalized through learning and mimicry. The behavior is motivated by his need for help and clusters about his specific propensity for the development of a child-parent type of relationship. In some, this is of an affectionate character; in others, it clusters about attitudes of domination and submission.

¶ Approaches to Treatment

Phenomenologically, there appears to be greatly diminished cortical reserve in many elderly persons. They are prone to develop behavioral disorders with anoxia, and often are overly sensitive to neurodepressants and neural stimulants. They may develop confusional states with infections, with pain, and in response to minor environmental or social changes. Often, they are hypersensitive with respect to their own ruminations, and they react stormily to their own fears and angers. An injury or illness, a disappointment, a death, or a separation, may be followed by galloping progression of puzzling bewilderment and memory loss. Even in aged persons with loss of memory, stress often yields a depressed-apathetic, clinging-fearful, noisy-abusive, or frantic person. Illness in the aged is characterized, as Zeman has felicitously phrased it, by "multiplicity, chronicity and duplicity."[104]

The psychiatrist must be a member of a treatment team, each of whom is on the alert for signs about which the others should be informed. In an elderly or aged person with disturbed behavior, the symptomatic or specific treatment of a physical illness—measures instituted to correct drug intoxication or infection or to relieve a painfully distended bladder, a troublesome phlebitis, a painful ear, or an impairment to vision—may contribute to marked improvement. In the absence of reassuring "organic" factors which we can tackle with pharmacological or physical methods, however, we may feel overwhelmed. There seem to be very few resources with which to work. The frustrations we feel, when confronted by the patient who poses this problem, provoke anxiety. This may lead us to fruitless pity and harmful excesses of compassion, or to self-defensive anger against the patient's threat to our self-esteem; our anger and the guilt which accompanies or follows it may lead us to hostile acts disguised as kindly measures. We may refrain from doing essential operations because of the patient's age, or we may overtreat them in a backward somersault away from such negligence; we may protect and coddle them into apathy or overstimulate them into panic. Misguided protective treatment or undue neglect augments the fear and anger of one who already feels helpless and vulnerable; such attitudes worsen the psychological difficulties, increase the patient's inefficiencies, and further disorganize his overt behavior. This fact makes it imperative that the family, or those who act in nursing and attendant capacity, be properly oriented to the patient's needs and that they have a working concept which can sustain them by providing them with a belief in their own capacity to master the problem. One cannot overemphasize the importance of a cooperative social environment when psychiatric treatment of the aged is attempted. Of equal importance is the existence of good general medical care for the patient. In the absence of efforts in these directions, the psychiatrist

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works in a vacuum. This does not mean that psychiatry can offer nothing except where the environment is ideal and medical care is perfect; on the contrary, psychiatric influences can act to improve both the patient and his lot.

¶ Aims and Techniques

The aim of treatment in aged ill persons is to decrease the disorganizing fear and anger; to reduce the amount and intensity of unreasonably aggressive behavior, which provokes exacerbation of guilt and, at times, invites environmental retaliation; to increase comfort and satisfaction; and to restore and enhance the sense of worth and dignity. In selected cases the restoration of productivity of even a minor degree may be an aim. Artists, scientists, professionally trained persons, and others with special aptitudes, skills, or interests, may occasionally be assisted toward rewarding avocational—if not vocational—pursuits. Restoration or increase of dignity, self-esteem, or worth may, in fact, be the method rather than the goal of treatment, and may be the maneuver which decreases fear and anger, with subsequent improved behavior.

The sense of worth appears to depend not only upon attitudes toward oneself, developed early in life by way of internalization of parental attitudes and the organization of self-image around early successes and failures, but also upon one's view of oneself as currently capable of mastering problems and gaining pleasure. Pleasure cannot be forced upon people and does not necessarily accrue from having one's dependent needs catered to, nor does it even follow upon the provision of luxury. Pleasure appears to arise out of two conditions of the organism: first, the adoption or the existence of a sense of purpose or direction of effort; and second, the sense of solving problems, mastering change or difficulty, or winning over threatening forces. The two may be subsumed under the term "mastering," and pleasure may be considered as that affect which arises in a setting of successful, or effective, effector synthesis accompanying or leading to actions of mastery. Treatment efforts may therefore be directed toward augmenting the patient's ability to master problems and to obtain pleasure for himself, or toward inflating his belief that he can and does master current problems, as well as toward changing his views on what constitutes success and decreasing the hostile action of critical internalized attitudes.

Even in a setting of cerebral damage, anxiety may have an organizing effect by increasing alertness and promoting action. Anxiety may be followed by anger which exerts an organizing action, and which, in addition, tends to enhance the individual's sense of strength and pride. The rise of fear or anger in a withdrawn or disorganized person may lead to attempts at problem solving. This, especially if successful, may result in increased self-esteem, a decreasing sense of helplessness, and the establishment of a more or less continuous pleasurable state. Consequently, it is often of therapeutic value to permit the arousal or augmentation of anxiety or anger to occur. This may favor successful action and be accompanied by a double gratification—that of tension relief and that which accrues to the mastering action. Patients are not provoked or "baited" to develop anxiety or anger when it is desirable that these emotions be permitted to arise; rather, this tends to take place spontaneously, as when the patient is referred to the psychiatrist (because of what is implied by being sent to a doctor). Where this appears to work in the patient's best interest, premature efforts to meliorate the emerging emotion should be avoided. "Preparation" for the interview may be unwise. An offer to the patient of specific medical attention initiates a situation in which fear and anger play prominent parts. It is the propensity of all ill and troubled persons to regard a doctor as a person of power with potentialities to help or to harm, and to anticipate an appointment, and look on the doctor himself, with fear and anger. The patient, in his helplessness, which we see as dependency, elevates the physician to parental status and delegates to him the tasks which were naturally assumed by the parent in the original child-parent relationship. The necessity for recognizing this and making intentional, consistent use of it has been recognized for centuries and was neatly

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recapitulated in 1904 by Freud[25] in his paper "On Psychotherapy."

The spontaneously arising relationship which is based upon the early child-parent interplay can provide a lever for psychotherapy. This relationship can be developed and maintained in relatively brief and widely spaced sessions. Formality of appointments is often to be eschewed, in the interests of the most helpful interrelationship and of enlisting the cooperation and attention of the family and/or the institution concerned with the patient's care. An able therapist maintains his position in the aged patient's eyes not by actual role playing, as does an actor interpreting his part, but rather by not doing or saying anything which is incompatible with the role the patient wishes to have fulfilled and which he has the doctor fulfill in his fantasy. This can be done if the psychiatrist reacts appropriately to the face value of the situations that arise, but within the limits defined and with the restraints prescribed by a proper grasp of the associational flow of the patient's conversation and by comprehension of his nonverbal, self-revealing communications. The patient's needs for punishment, respect, affection, protection, approval, etc., are met not so much by what is said or done by the psychiatrist as by the patient's own interpretation of the therapist's attitudes and behavior in the transaction. The patient's private interpretations fulfill his criteria for having re-established the relationship he seeks. He becomes convinced that, in the therapist, he has found a suitable substitute for the lost relationship in which he felt strong and secure, and he may say so in moving language which not only tends to convince himself but also appears to be an attempt to convince the therapist and to be a signal or set of instructions for the therapist, for example: "You are like my son but kinder." "Not since my husband died have I had a chance to talk to someone like you." "You're not like the others, you understand." "My husband was a doctor, my father was a very fine man, with you I feel the same." The therapist, by these clear signposts, recognizes that the patient has thrust him into a role, and he needs no magnifying glass to discern the outer lineaments of that role. The sick person distorts, exaggerates, or scotomizes what he must, and as he must, to maintain the therapist in the role the patient has thrust upon him. That the patient may run through a dozen different figures before finding one who will do is because of the blindness of those he elected. There are limits to the person's capacity to distort, exaggerate, or scotomize. A patient who provokes, demands, or practically begs for punishment must receive some harmless token along these lines or be lost; if he demands proof of interest by means of the therapist's intervention, then a token stand must be taken for him, or he will be lost and go on to search for another person who does not destroy his illusion of having found the longed-for parental figure.

¶ Illustrative Cases

Each person shows special difficulties which must be considered in the therapeutic relationship. The following is an example of the kind of patient who may be seen in private practice, in this case one who shows little of the so-called "organic" syndrome but demonstrates the reversibility of seemingly severe psychological disorder in an aged person.

An 85-year-old woman was referred for consultation because of markedly delayed convalescence from an abdominal operation. She was, by the usual criteria, physically recovered. However, she complained of weakness, ate poorly, and did not gain weight appropriately; she was apprehensive about leaving her small apartment and could not tolerate remaining alone. A prominent complaint was that the mild sedative ordered by the physician was a poison. She was critical and suspicious of her nurses, although markedly dependent upon them. She expressed ideas that her family wanted her to die and was, therefore, neglecting her. It was frequently necessary to demonstrate to her that items out of her sight had not been stolen.

Her heartsick family feared she was progressing to an irreversible paranoid senile state, because these symptoms did not respond to the excellent

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treatment of their long-time family doctor, a very capable internist, or to their own solicitous attentions. They were fearful that a psychiatric consultation would complicate and aggravate matters by frightening and antagonizing their already obviously apprehensive, angry, and distrustful mother. Tentative overtures to the psychiatrist were made; appointments discussed, made, put off, made again, and canceled. A visit to the patient's home finally crystallized, and a daughter hovered protectingly over the patient during the consultation.

The associational trend of the patient, in at first hesitant but finally friendly conversation, revealed that she was greatly concerned about whether so old a woman could really recover from a major operation. There were also doubts that she had been told what was really wrong. She suspected that the care shown her constituted the last courtesies of old friends and faithful relatives in view of an inevitable fatal end. It became obvious to her that the physician called in consultation was a psychiatrist, and as this became clear she indirectly "gave proof" of her sanity by telling a detailed story which an old acquaintance, now mentally ill, was never able to get straight. She responded with apparent pleasure to the psychiatrist's interest in this account as well as to his obvious respect for her accomplishments, which were considerable. The sedative about which she felt concern was, after discussion with her doctor, discontinued, and a very mild cerebral stimulant was prescribed instead.

In the next few days the patient showed marked improvement. She felt subjectively stronger, discharged her night nurse, began to eat well, and came willingly to the psychiatrist's office for her next appointment. In the second conversation what had occurred became clear. To this woman the fact that the family should call in a psychiatrist was proof that she must be having a nervous breakdown. This kind of action proved, therefore, that she was not truly physically ill and consequently was in no danger of dying very soon. She was willing to enter into an arrangement with the psychiatrist to explore why she had become so apprehensive. She remains improved after a year, in which period she has been seen five times.

Comment: Obviously, the threatening surgical experience was not alone the determinant of this patient's reaction; the intensity of her psychological disturbances was meliorated, however, with the arrival on the scene of someone whose status or whose approach was able to decrease her sense of helplessness. The arrival of a psychiatrist made the problem or the situation appear to be one with which she could grapple and solve, either by means of her own or with someone else's strengths. It is not infrequent for persons who fear they are seriously ill with a so-called "organic" disorder to be reassured when they discover it is truly a psychological or mental disorder; the converse, that people with physical symptoms of a psychological disorder welcome the diagnosis of physical illness, which presumably will respond to medicine, surgery, or manipulation, is even more frequent. Attempts openly to reassure by way of "psychosomatic" explanations, to comfort those exaggeratedly frightened by the prospect of physical illness, are, however, usually ineffective; the unvarnished administration of placebos or mock treatment is also liable to provoke more anxiety in the patient than to relieve him when he needs reassurance about his psychologically determined symptoms. The means of reassuring and supporting our patients is not based upon intuition alone; it is a skill, perhaps unwittingly acquired and unintentionally used by many, but nevertheless subject to understanding, description, and controlled application.

Those who welcome a diagnosis of physically treatable disease, when their disorder stems from anxiety, are the persons to whom nonphysical treatment of seemingly physical symptoms is incomprehensible, and who may have considerably more to lose than they can foreseeably gain from recognition of their real problems. For them, whose economic condition may be very bad, the best vehicle for psychotherapy may be medical examination, regular observation, and symptomatic treatment, whether it be pharmacological, physical, or that of a regimen.

Within shelters for the aged, many persons become acutely distressed and are disturbing to

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other residents and staff. The patient described below had evidence of a moderate degree of brain damage.

A 74-year-old childless widow, whose late husband was a doctor, became unmanageable in the infirmary where she was being treated for cardiac failure. Her attitude to the psychiatrist was one of friendly, apologetic, ingratiating compliance. She made certain to inform the psychiatrist of her late husband's occupation. Her flow of conversation clearly indicated her dependence upon the fatherly protection of an interested physician whom she equated with her husband and her father. With both her husband and her father she had been a "good girl"—compliant, ingratiating, believing her care to be contingent on her good manners, mid-Victorian ladylike virtues, intellectual interest, and feminine submissiveness. When the psychiatrist instructed the staff to tell her that the diet and regime she objected to was given specifically on his order, she became, for the time, a model patient.

Six months later she was again referred to the psychiatrist because of memory defect, disorientation, obnoxious and unmannerly behavior, and slovenliness at the dining table. She seemed unfit for apartment residence and appeared to be a candidate for transfer to custodial care. In the course of treatment, she became querulous and seemed on the verge of relapse. In discussion, she complained about pain. Examination revealed beginning herpes zoster. Her rather stormy, painful course was weathered with no greater incident than in a more youthful, less debilitated person.

She was seen from time to time, and a few months later, by way of a dream, she informed the therapist that in her adult lifetime of lavish entertaining in a suburban home, she never was certain whether she was loved for herself or for her goods and accoutrements, both material and intellectual. When, in a few well-timed words, the therapist made clear to her that it was she who was endearing and not her gifts, she made sudden startling improvement, over and above the previous slow but steady progress, and could be discharged from regular treatment. She regularly sent the therapist sentiment-filled cards on Valentine's, Mother's and Father's Days.

A year and a half later she was hospitalized for cardiac failure and one night threatened suicide. She had paranoid delusions that the attendant was influencing her by means of voodoo and causing her heart disease. Direct reassurance and manipulation of the environment probably helped, but the chief reason for improvement in this episode was clearing of the cardiac failure. A few months later she died.

Comment: In the aged one, as in the youth, private motives are not put on public display; moreover, age alone does not decrease our propensity to hide from ourselves the motives that may direct our thoughts and actions. The therapist recognized this woman's hidden desire for an admiring, protective, powerful parent and her delegation to him of this role. By not discouraging her illusion that he was such a person and that she had won her place with him, he helped increase her pride, her sense of strength and confidence returned, and she functioned better.

In this woman, as in the previous patient, well-automatized patterns of social behavior and well-established mechanisms of psychological adaptation could be revived. Good early education pays dividends in old age. This patient's dissolution was heralded by the loss of memory and disorientation which persisted even in the absence of infection or cardiac decompensation. She died six years after coming to psychiatric attention.

Persons with severe brain damage do not live a long time, and, even though marked improvement in their behavior and in their subjective state may be achieved with adequate supportive care, there are limits to the length of time this can be maintained, as in the case which follows.

Mr. T., 80 years of age, a native of Germany, who never married, had been a lifelong seclusive misanthrope and a chronic alcoholic. He was considered a misfit in the family and left home when 18 years old because of a scandal involving a young woman. He came to the United States by himself in 1890 and worked in various restaurants and hotels as room clerk and cashier until 1943, when he underwent a prostatectomy, gave up work, and subsequently decided to enter the Home for Aged and Infirm Hebrews. He was

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admitted in 1946, at the age of 74. For three years he made a choleric, marginal social adjustment in the Home. In 1949 cerebral thrombosis caused right hemiparesis which confined him to the infirmary. There he became a serious problem because of explosive angry outbursts, with threatening and assaultive behavior, set off by the doctors' and nurses' attention to his severe conjunctivitis. He was relatively immobile, and sulkily refused to make efforts which could help the staff determine the true extent of his disability. He was referred for psychiatric help, and therapy was instituted in 1951.

In the first two very brief sessions, he was questioned about his angry behavior in such a way as moderately to reinforce his preconception of the therapist as an injunctive, prohibiting, and threatening parent. In the third interview he angrily denounced the therapist and the Home staff for implying that he was mentally ill. He went into a lengthy diatribe about how his eyes had been spoiled by an incompetent doctor before he came to the Home, and how the trouble was being perpetuated by the incompetent Home physicians who prevented him access to better ones. His hemiparesis he attributed to a trifling insult which the physicians aggravated by neglect and inept therapy, for example, the rehabilitation procedures which he violently opposed. In the session he was encouraged to vent his anger on the medical and nursing staff and especially toward the therapist, who appeared suitably distressed, cautiously self-defensive, and semiapologetic without ever admitting that the patient was actually correct.

At the end of ten minutes it was tactfully agreed that the patient could leave the interview. He departed with an air of righteous indignation triumphant. For the next few days he was relatively silent and cheerful, and there were no angry outbursts; his attitude was that of one who has bearded the lion in his den and emerged victorious; he was contemptuous of the harmful potentialities of those about him and submitted to their ministrations without protest. A further opportunity for him to vent his anger and emerge triumphant was offered in another five-minute interview about a week later.

In the fourth interview, two weeks after the first, there was a change in his attitude. The patient seemed to feel safe with the "defeated" therapist, who seemed none the worse for wear. He spoke angrily of the staff and his plight, but as though to an ally. He came to this session, for the first time, in street clothes which he had demonstrated he could help put on himself. The therapist listened sympathetically, suggested that the patient could probably do a great deal despite the opposition which he felt existed, and offered to have a medication added, which was done. Following this, in a series of interviews for backsliding on the part of the patient, there was, according to the needs of the patient, a shifting of role playing between that of the strong parent who can be vanquished and that of the strong parental ally. After eight interviews over a period of four months, there was some improvement which was sustained for eighteen months. The patient altered his status from one of angry immobility to relatively peaceful but limited ambulation.

His dependence on the therapist was subsequently assumed, without incident, by a social worker whom the patient identified with the therapist. When she "abandoned" him for a vacation, he subsided into depressed and sullen immobility, and then reacted with episodes of assaultive rage of such violence as to require transfer to a psychiatric hospital before opportunity for further therapy. Mr. T. died one year later.

Comment: This man, whose lifelong feelings of helplessness were reinforced by hemiplegia and the concomitant effects of brain injury, handled the anxiety thus generated by an angry show of force. This was ineffective in overcoming his fear and, in fact, increased his retaliation fear. In this setting he was depressed, immobile, and had explosions of anger. The therapist stepped in to provide him with an illusion of omnipotence through triumph over a powerful, threatening physician. Some of the omnipotent feelings could only be short-lived, but they were later replaced by acceptance of the "defeated" therapist as a powerful parental ally. Safely entrenched with him, the patient's helplessness decreased, his anxiety diminished, and reparative rage was unnecessary, so that there was simultaneous improvement in behavior and decrease of his suffering.

Not all persons who have brain damage do

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badly, as is testified by many prominent figures alive today. One patient, who achieved some fame in her later years subsequent to the incidents described below, is such a person.

Mrs. N., a vivacious, witty, 72-year-old woman of masculine appearance and dress, was admitted directly to the Home for Aged and Infirm Hebrews from a hospital where she had spent sixteen months after cerebrovascular accident with no significant residual signs. She had considerable hypertension. While hospitalized, she had a few episodes of "somnambulism." She had apparently reveled in the institutional environment, where she had found many people admiring and affectionate.

Her past history revealed that she was reared in a large, congenial, but rigidly Victorian, "stiff-upper-lip" English literary family, in which complaining was anathema and expressions of anger were unforgivable. She was orphaned early, met financial reverses, felt obliged to care for a younger sister because of a maternal injunction, and was widowed at the age of 24 after three years of marriage in a country strange to her. She then traveled widely, working variously as a probation officer, teacher, and finally as housemother in a girls' detention home, in seeming constant denial of her frustrated desire for the early loving atmosphere of her childhood but almost always in an institutional atmosphere which was, in many ways, reminiscent of the large-family life of her girlhood.

On admission to the Home she at once assumed a position of leadership, denied her discomfiture on various occasions when this was obvious, but clearly expressed her dissatisfaction and anger by manipulation of other residents and by her trenchant wit. She appeared to regard her roommate as especially troublesome. In this setting, three weeks after admission to the Home, she began to have almost nightly episodes of "somnambulism" which, in this woman with a history of brain damage, could not clinically be distinguished from psychomotor epilepsy.

Therapy was instituted, and she welcomed an opportunity to aggrandize and equalize herself with the therapist, whom she at once identified as an affectionate, interested protector who was like her well-educated, loving father. The social worker simultaneously made it possible for her to work along lines which gave her prestige status in the Home. The "somnambulism" disappeared. Sudden return of these fuguelike episodes, one of which terminated in rigidity and frothing of the mouth, was correlated with injunctions from a new resident physician, and from a doctor in the clinic she went to for ancillary neurological study, that she was "after all not as young as you used to be and should take it easy." To this woman, who suppressed and repressed large amounts of rage, this medical injunction (as a parental prohibition, absolute) meant restraint, curtailment of aggressive leadership, and relinquishment of office-holding, or mothering, and the control of others—in short, loss of prestige and social dominance. This restriction resulted in increasing anger without room for its expression. Resumption of therapy, in the course of which she disclosed these feelings, and removal of the injunction were followed by complete disappearance of the nocturnal fugues.

Behavior disorders of the aged are so complexly interwoven with physical illness and socioeconomic difficulties that they seem to present insoluble problems of care. The gratification of particular needs, so as to create for the patient the illusion of having achieved a situation of secure dependency, may quickly dissolve the behavioral difficulty.

Mrs. T., a native of Germany, came to the United States in 1941 with her husband when she was 64 years old. She had supported herself by work as a domestic with her husband and his first wife for many years. Two years after her employer was widowed late in life, she married him in opposition to the wishes of his grown children. Shortly after the family came to the United States, Mr. T. died. Estranged from her stepchildren, Mrs. T. continued to work as a domestic until 1949 when she was 72. She then entered the Home to make provision for her financial and physical care; she indicated also that she wished to be with contemporaries who might be more cordial than her stepchildren.

She was a seemingly independent, aggressive, tense, and dominating woman who, after admission, had trouble with a succession of roommates because she could not share or compromise about room arrangements. She complained of intense head pains and of nervousness which she attrib-

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uted to chronic tinnitus, seemingly based on arterial central-nervous-system changes related to diabetes. After a year in the Home, she was referred to the psychiatrist upon complaint that her tinnitus was so annoying that unless relieved she would "go through the window."

This woman had looked to the staff of the Home for protective care. In two brief interviews the therapist made it clear that there was real interest in her and concern for her welfare, and that, while ventilation of anger was permissible, nevertheless tantrumlike, suicide-threatening behavior must lead to the opposite of the desired affectionate care. At the same time that this "punishing" disapproval was offered, implicit assurance of forgiveness was tendered. Mrs. T. made rapid recovery from the depression, and, after five sessions in twelve months, treatment was discontinued. A year later she was seen by another psychiatrist because of complaints by her roommate, who was a psychiatric patient. It was found that Mrs. T. had been the *provocateur*, and a short injunctive psychiatric session, followed up with evidence of interest in her by the social worker, served to control her.

There were no complaints of tinnitus at this time, nor have any new episodes of upset behavior been reported. If Mrs. T. has been troubled by tinnitus since, this has been her closely guarded secret. Now, eight years after the first incident, she remains cheerful and active and always singles out the therapist when he is within sight to greet him happily and thank him profusely for his aid and interest. The patient's "warmth" is obviously her means of sustaining a protective alliance.

What the sick people seemed to need above all was to maintain their conviction that there was hope and help. The therapist's job was to see to it that the person should not become disillusioned about the powers of the person to whom he turned. It was important that he not be discouraged in his particular way of believing in the doctor as a person who is in a position to help him and over whom he had some control. Disillusionment would simply lead to further anxious search.

The need to find a convincingly helpful figure is a trend hidden from oneself as well as from others. It is not consciously embarked upon and carried out. The manner in which the campaign is conducted can deceive the delegated assistant as well as the frightened patient. A person, viewed as potentially helpful, to be dominated, manipulated, or maneuvered, is what the patient appears to be searching for without appreciating the fact, or even while consciously denying it. This may be mistakenly regarded as a search for love or for understanding. Actual domination or manipulation of another, however, is not essential for these patients to gain benefits from a relationship. Rather, it is the unverbalized conviction or belief that they are doing or can do so which serves to reassure them. To remain in the good graces of such persons, patients will perform seemingly miraculous feats, such as employing long-unused muscles or performing intellectual tasks considered no longer possible. Moreover, the patients' belief that such a person has been found and the initiation of efforts to bring their selected protector's powers to bear on their own problems constitutes a sense of purpose. "Joy's soul lies in the doing . . ." for ". . . man prizes the thing ungain'd more than it is." Wooing, beseeching for the ungained prize, brings to the attention of the participating, previously inactive, person the unrealized extent of his own powers. It is these efforts and these real or illusory successes which reassure and support, not the pats on the back or the words of the physician.

¶ Summary of Effective Factors in Treatment

Age, other things being equal, is no barrier to treatment. When, with advanced age, there is a loss of resources required for the meeting of social and material problems and a profound sense of helplessness in the patient (as may also occur in younger persons), a therapeutic transaction begins with the delegation to the doctor of great powers. The patient appears to select the physician to play a part in a personal relationship from which the patient will gain gratification and a sense of security. On the simplest level this may lead to fear or anger which exerts an organizing effect upon be-

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havior. The patient often perseveres, as long as nothing is done to disenchant him, in believing that the therapist has increasing interest in him. With this belief comes a rise of satisfaction, of pleasure. The pleasure is derived from the conviction that this interest guarantees continual "care" and that the "care" has been gained through the patient's own efforts. Because he feels that interest is displayed in him, the person comes to believe that he has won, charmed, tricked, forced, or otherwise personally gained this social advantage. The receipt of medicine, assistance in environmental manipulation, or specific advice within acceptable ranges is often taken as a token or symbol of having gained the therapist as ally, friend, or protector, and, simultaneously, as proof of having triumphed over, of having dominated him. This sense of triumph, of having won the therapist's powers and of owning them, may be carried out of each session; a parent figure has been incorporated. There is sustained gratification from feeling favored in what may constitute a sibling-rivalry situation. When these events take place in a hospital or shelter where other aged persons reside with whom the patient feels in competition, he "lords it over the others." He not infrequently behaves as though he were endowed with the therapist's imagined powers.

Real success, motivated by the desire to please the doctor—the making of a rug or an ash tray as a gift for the doctor, for himself, or for another—which the doctor can be shown or about which the doctor may be told by the patient or may hear from others, provides gratifying elevation of self-esteem. The real success may take place in improved social relationships. Some persons obtain a special sense of satisfaction by withholding information of such success from the doctor; keeping it as their secret is felt as virtuous, and the pride is redoubled. The withholding of information about illness, pain, or trouble from the doctor may be a potent source of pride for the patient—self-praise for the virtue of being uncomplaining, undemanding, and long-suffering. This occasionally leads to the neglect of treatable illnesses and is a reaction for which the physician must be on the alert.

Visits to the doctor arouse both fear of punishment and guilty fears in some patients, with consequent decrease of their aggressivity in the family or in community situations. Conversely, disorganizing guilty fear may be decreased because the physician's behavior is viewed as permissive, forgiving, and accepting of the patient. Once some of these bonds of relationship have been established, a sense of purpose is derived from sheer continuation of the transaction which is easily transferred from one therapist to another, or even to the "department," as symbolized by nonmedical personnel within it or its delegated representatives.

¶ Results

In the author's experience with aged patients who do not suffer from fairly well-defined psychoses of schizophrenic, paranoid, manic-depressive, or involutional type, but whose behavior disorder can be classified as psychoneurosis or personality disorder in the absence of brain damage, psychotherapeutic efforts appear to be rewarded either by improvement or stabilization, a halt in progression of the disorder, in about half the patients. In cases of chronic brain syndrome with disordered behavior, about one third of the patients improve, stabilization occurs in about a third, and the remaining third grow worse. In many cases the behavioral state improved despite progression of the physical disease.

¶ Conclusion

Too often, there has been a social, medical, and psychiatric attitude that people must learn to accept their limitations, must resign themselves to their disabilities, must stop their struggling and fighting so that, possibly with skilled help, they may find peace in the recognition of their deficiencies and limitations. This attitude and the treatment based upon it encourages feelings of failure, hopelessness, depression, or apathy in the patient. When therapy based upon such ideas works well for the patient, it appears to be because the sick

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one learns to discard the therapist and gains strength from this maneuver. Still alive and with mechanisms for survival, motivated to life, persons who are disabled, depressed, and frightened live in a world which has taught them to measure themselves and others in terms of performance, power, and prestige, with which they interact even when disoriented. To encourage acceptance of limitations and disability is to foster self-recrimination and loss of self-respect; it encourages regarding oneself as crippled and weak. If we take cognizance of, rather than disregard, the tremendous pleasure an individual can derive from a relationship which takes simple shape in a special way, we can find a lever for therapy, a means of encouraging growth and expansion of purpose and of interest, in short, of energy and activity.

Once reconciled to the idea that we are not magicians and that our efforts may be welcomed as a comfort by many aged and chronically ill persons, by their families, their friends, and the community, we can approach the problem without a sense of misspent time and talent. Then we may come face to face with our own feelings of dread, helplessness, and anxiety about age, illness, death, and the care of those who are old enough to be, or to remind us of, our parents. Quite possibly these attitudes—a combination of our own fears, acquired habits of thought, and individual fantasy—contribute to our pessimism. Certainly, the task appears overwhelming, yet an unimpassioned view of older persons' psychiatric needs may reveal much room for a doctor to heal, to meliorate, or to comfort.

In 1916 Byrne* opened a lecture with the following words:

> In spite of the fact that its methods have long since been reduced to principle, it is amazing to find scientific psychotherapy so little utilized by the profession in the treatment of old age and chronic invalidism. This is all the more shocking when one considers the not inconsiderable success obtained without and within the profession by individuals who realize the value of optimism and healthful suggestion, even though they know practically nothing about the scientific application of even these psychotherapeutic measures.

* This neglected paper was eventually published in the *Hospital Bulletin* of the New York City Department of Charities, Vol. I, pp. 103–107, 1951, under the title "Psychotherapy of Old Age and Chronic Invalidism."

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CHAPTER 21

THE BORDERLINE PATIENT

Melitta Schmideberg

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THE BORDERLINE REPRESENTS, in my opinion, a clinical entity (with the due reservations applying to the concept of any entity) bordering (1) on normality, (2) on the neuroses, (3) on the psychogenic psychoses, and (4) on psychopathy. It contains elements of any, and sometimes all, of these entities. It is not just quantitatively halfway between the neuroses and psychoses; the blending and combination of these modes of reaction produce something qualitatively different. This combination of different reactions is characteristic for all borderline cases. Thus, the paranoid character and the schizoid are not just attenuated forms of paranoia or schizophrenia but possess a fair degree of normal functioning which enables them to live in reality to a sufficient degree.

¶ Concept of the Borderline

One reason why the borderline should be regarded as a clinical entity is that the patient, as a rule, remains substantially the same throughout his life. He is stable in his instability, whatever ups and downs he has, and often even keeps constant his pattern of peculiarity.* As the borderline condition rarely

* No psychiatric entity is absolutely rigid, and patients may both deteriorate or improve: neurotics sometimes do cross the border into psychosis or psychopathy and vice versa. Although it is easy to diagnose a condition ex post facto and call it "prepsychotic" it is much harder to diagnose it in the present unless it is already a case of pseudo-neurotic schizophrenia.[7]

In the same way, though borderline seems to be an entity per se, some patients cross the border into psychosis or psychopathy, become drug addicts or alcoholics, whereas others might stabilize into a neurosis or relative normalcy. The manifold factors that precipitate such changes have not been studied sufficiently, but social conditions certainly enter. According to Hollingshead and Redlich[8,9] there are thirty-one times as many schizophenics among the poorest classes as there are among the upper and upper-middle. They explain this discrepancy by the fact that in the middle classes psychosis is discovered and treated earlier. However, this is only part of the answer: since the borderline's problem is essentially one of object relation and relation to reality, it seems therefore likely that if reality treats him better, and more leeway is given to his peculiarities, he manages better to maintain an object relation and live

ushers in a schizophrenia, it should not be regarded as a prepsychotic condition (a diagnosis usually only made ex post facto!), as latent schizophrenia, pseudoneurotic schizophrenia, etc. While some schizophrenics in remission may resemble borderlines, the latter are different, because they have not been and are not likely to become schizophrenics. The borderline concept should also be distinguished from psychotic episodes, temporary or partial schizophrenic reactions to stress, etc. The characteristic features of the borderline are not his symptoms. He certainly lacks the more obvious psychotic ones, the delusions, far-going disorganization, or regression of the schizophrenic, and though he may have marked ups and downs, he lacks the manic elation or the melancholic depression. Though he is often suspicious and collects grievances, he has no true paranoiac symptoms, nor has he the dramatic symptoms of the hysteric or marked obsessional ones. Depression, anxiety, and other painful feelings may accompany any disorder and are even experienced by normal people under stress, and borderlines often suffer from them also. More interesting is their frequent lack of normal feeling.

Many disturbances cannot be regarded as either psychotic or neurotic and have sometimes been described as "transitional" (Glover).[5] Various offenses, sexual perversions, homosexuality and prostitution, alcoholism, drug addiction, hypochondriasis, eccentricities, peculiar behavior, querulousness, and vegetarianism are often found in borderline patients, but these symptoms are not invariably the hallmarks of the borderline. Alcoholism may be found in anybody from the near normal to the gravely disturbed; exhibitionism may be found in sexually inhibited neurotics but also may be combined with many other perversions as may be a symptom of psychosis, epilepsy, feeble-mindedness, or even in fairly normal persons under stress or temptation.

Characteristic of the borderline is the severe disturbance of the personality. The differentiation between a simple neurosis and a full-blown psychosis or psychopathy is easy; the diagnostic problem is to differentiate it from the normal person under stress (especially if we happen to dislike his personality), the milder forms of simple schizophrenia, and the character disorders. Borderlines should be broken down into major subgroups, such as depressives, schizoids, paranoids, querulents, hypochondriacs, antisocials (representing attenuated forms of psychopathy), mixed cases, etc.* It is preferable that the classifications should be in terms of clinical concepts, rather than in descriptive or dynamic ones. Thus, the "emotional unstable drifter" (in German, *haltloser Psychopath*) is usually a schizoid with some depressive or paranoid traits.

¶ Dynamics

Borderlines suffer from disturbances affecting almost every area of their personality and life, in particular, personal relations and depth of feeling; identification and empathy; their attitude to society and reality; volition and self-control; sublimations; activities and capacity for work; capacity for enjoyment and need for pleasure; sex life; the experiencing of and control of emotions; phantasy life; ideals, values, and aims in life; and a fargoing lack of integration in their personality. Their object relations are shallow and weak, and they lack depth of feeling, steadiness, empathy, and consideration for others.

Experienced psychiatrists diagnose borderlines by the clinical impression rather than by any particular symptom or trait of behavior.

within reality. In other words, he does not become psychotic. Psychosis is so often the solution of despair.

It is well known that there are many more offenders among the poor than among the rich, and it is not merely a question of apprehension and conviction against which the rich are better protected. In the middle classes more scope is given to delinquents while at the same time a great deal of pressure is used to socialize them. The way social factors affect mental reactions and hence further or hinder adjustment and deterioration must be studied in greater detail.

* As Kraepelin remarks, "there are innumerable types of psychopathy." Klages enumerates 4,000 words in the German language alone, descriptive of character traits, each of which could be used as basis for classification of character types. "Numerous authors have described systems of classification, which are difficult to compare, because sometimes for similar meanings different names are used, and sometimes for different meanings similar ones." (E. Trillat[15])

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This impression is gained from the lack of genuine contact or its very short-livedness, the blankness of facial expression, and other indications of lack of feeling.

Some patients are aware of their inability to experience genuine emotion and suffer from it; others are unaware of it (probably because they never experienced it and hence do not miss it). Psychiatrically, if the patient is aware of and perturbed by his inability to feel, it is classified as a depersonalization phenomenon—a very frequent characteristic of borderlines. Patients who suffer from their inability to feel sometimes work themselves up into hystericlike scenes and overemotional reactions, or take drugs or alcohol, commit offenses, or have pathological sexual reactions to escape both their painful feelings and their lack of feelings.[14] Much of their acting out and emotional outbursts constitutes an attempt to break through their insensitivity. But though they often quite consciously long for the experience of genuine emotion, they are unable to tolerate it, and react very badly to any expression of it. They often break with the person toward whom they displayed affection, or they react with hostility. Others protect themselves against feeling by managing to keep their personal relations superficial or by frequently changing their jobs or abode. This largely accounts for their instability.

Borderlines are fundamentally nonsocial, and some are openly antisocial. They are severely disturbed in their relation to people, to reality, and to society. They cannot visualize the future in any realistic manner and cannot tolerate emotional continuity. They have a great deal of underlying hostility and negativism. The querulents in their self-righteousness and insistence on law and order cause untold trouble to others.

Schizoids and depressives are nonsocial by default and withdrawal; they drift, fail to work, stay in bed the greater part of the day, etc. Schizoids with psychopathic traits use their withdrawal to hurt others. One such patient, whenever he was severely depressed, usually as an aftermath to failure, would stay in bed for days and would count with a sort of fascinated horror how often the phone rang, which he failed to answer, well knowing that it was his mother or me calling him.

Paranoid reactions may sometimes cause aggressive behavior, but more often they cause withdrawal and disrupt personal relations. An adolescent of this type would leave his job on the spur of the moment, without waiting for his pay, if he did not like the way somebody looked at him; he would change trains for the same reason and travel in another direction. One left his ship during the war and became a deserter because he did not like the way the captain looked at him. Because the anxiety determining such behavior is not always obvious, such patients are often merely called drifters, or emotionally unstable psychopaths, or the like—a description that lacks understanding.

As adults, our main relation to reality and society is via our work and employment. Working, cooperating with others, getting on with fellow employees and the boss implies well-adjusted social behavior. Earning money honestly and planning to spend it realistically requires foresight, self-control, and the facing of reality. Thus, it is not surprising that the borderline is disturbed over work and that attempts to get him to take and keep a job constitute a large part of his treatment. Though some borderlines are of superior intelligence and perform occasional feats of brilliancy, they can rarely keep it up, as they lack powers of concentration, perseverance, and the willingness to make a steady effort. Often their memory is poor as far as work and studying is concerned. They have a particularly low tolerance for frustration, are oversensitive to criticism, react to the setbacks they bring on themselves with excessive self-pity, grievances, hostility, and withdrawal, and make little attempt to mend matters realistically. Because of their poor performance and unsatisfactory personal relations, they are frequently fired, or they throw up the job. They have underlying ideas of grandeur, actually resent having to do anything at all, and, in any case, expect praise and recompense out of all proportion. These attitudes also interfere with their acquiring any real knowledge. They cannot tolerate the frustrations and narcissistic hurts of the efforts and

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setbacks inherent in the process of learning. Learning presupposes the admission of one's ignorance, and this is a painful experience.

More important still than their intellectual difficulties is their inability to accept rules and routine, their underlying or open defiance, their not wanting to be like others, their resenting having to get up in the morning, to take the subway, to do tedious work. There are many vicious circles and chain reactions involved. Their poor performance stops them from getting or holding good jobs, and the resentment over this frustration throws them back further upon their narcissism.

Some change their jobs constantly; some just manage to hold one; others sponge on their families; many drift into unemployment, crime, alcoholism, and go down further because of their inability to hold a job. Whether they are able to hold a job, though with difficulties, depends not merely on their state of mind but on their intellectual ability, charm, social connections, or whether they have a family willing and able to get them a job or at least give a spurious reference. Many just manage to hold a job in times of prosperity, but if a depression comes, they are the first ones to become unemployed, and then their degeneration is hastened.

Their thinking disturbances, as a rule, do not attract much attention and are not as pronounced as in the psychoses, but there is, in almost every case, a disturbance of judgment, memory, observation, empathy, understanding of others, of connecting cause and effect, of foreseeing consequences, and, in particular, of what is called "common sense." The primary processes of cognition are intact, but, owing to strong denial mechanisms and the ensuing disturbance of normal associative processes, their faculty of observation and memory is often poor. However, these failures are selective, emotionally conditioned, as indicated by the fact that such persons sometimes remember a trivial grievance for twenty years.[13]

Logical thinking and observation are rooted in reality, and, at the same time, bring us nearer to it, and this situation the borderline tries to avoid. Again, failure to learn and to observe necessarily leads to a lack of knowledge—practical, social, scholastic—and this intensifies their emotional difficulties.

Their difficulties in work and learning are largely due to their failure to judge what is relevant. Many factors contribute to this failure to think properly. An important one is the inability or reluctance to identify, and thus, to learn from others. Here, again, important chain reactions are taking place. The difficulty over identifying is due to a poor development of object relations, but the failure to understand others and to consider them inevitably leads to friction with these persons. This, in turn, induces the patient to withdraw or to react with hostility, and the ensuing retaliation, on the part of others, makes him still more reluctant to have contact. Identification with others implies a consideration for them and a curbing of one's own reactions. Because the borderline is reluctant to impose on himself this amount of self-control, he refuses to identify. Also, he is narcissistically self-centered and does not want to get involved.

We learn much, even without being aware that we are doing it, by identifying with others. This applies, in particular, to what is usually described as common sense. The borderline, owing to his inability or reluctance to identify, has often failed to learn the most elementary matters, and, in particular, to understand other peoples' mentality and to anticipate their reactions. Unable (because unwilling) to foresee the reactions to his behavior, he is naturally insecure and hence is full of grievances, anxiety, and sensitivity. But he also likes to cultivate his sense of being wronged because it justifies his nonsocial attitude. His ignorance and lack of logic and foresight are largely selective.

He is capable of denying, to an amazing degree, the most commonplace knowledge in order to avoid the involvements arising from it, because these involvements might lead to action he wishes to avoid or might cause hurts or anxiety to him. After all, the disturbances of volition affect mainly activities and situations that involve his relation to reality, and it is this that the borderline tries to avoid.

These patients function poorly, suffer from severe disturbances of volition, and are reluctant to assume responsibility. The withdrawn type

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seems to lack drive and even strong enough incentives for any type of action. However, if such patients change during the course of treatment, they suddenly show very strong needs and impulses, leading either to acting out or to rational acting. This indicates that what originally seemed a lack of drive was not primary but merely served to avoid the chain reaction of wanting, being frustrated, having to struggle, being involved in reality, being vulnerable. The acting-out type seems to have, at times, too much drive, but he is unable to keep it up in a steady manner. His acting-out behavior is largely a compensation for his failure to act—an abrupt reaction to his procrastination and inhibition—and alternates with periods of deep depression, anxiety, and withdrawal. Also, these patients spend so much energy on getting themselves into trouble, and out of it again (as a patient said "not only in going round in circles, but in arabesques"), in making the most complicated efforts to avoid work, or to face a problem realistically, that they have no energy left for normal thinking and remembering.

The borderline is thoroughly unhappy, even when he does not suffer from acute depression, because he is disturbed in both important and in unimportant areas. The average person gets quite a lot of pleasure out of trivial situations and even his day-to-day duties. The borderline, with ideas of grandeur at the back of his mind, jeers at these, spoils them for himself, and is then left with nothing to enjoy or to identify. The ensuing sense of dreariness and loneliness creates an excessive need for pleasure, greed for money, sex, food, spectacular situations, ostentatious spending, etc. It may also lead to the craving of the addict or alcoholic, the lawbreaking of the offender, the despair of the suicide. Such patients find routine and ordinary duties or social consideration too much to bear, because they have no capacity for enjoyment to compensate for the displeasures of delay or self-control.

Borderline patients may suffer from impotence and frigidity, or from excessive sexual needs and promiscuity, and, in the case of frigid women, from both. Their attempts to break through their depersonalization may lead to excessive sexual activities, and they need the sexual pleasure to compensate for the lack of affectionate feelings. Similar mechanisms apply to the excessive greed frequently found in delinquent children, and in alcoholism, addiction, and perversions. The immediate pleasure is to take the place of the personal relation, and it must be immediate and excessive because there are no happy memories and little hope or sense of continuity or forepleasure.

The lack of satisfactory personal relations may create a fanatic idealist as well as a criminal. Sometimes both extremes can be observed in the same person—an ascetic contempt for worldly possessions and the pleasures of the flesh combined with excessive sexual needs, uncontrollable ambition, possessiveness, envy, and greed, alternately and almost simultaneously. The borderline is a study in contrasts. He has characteristically inconsistent extremes of standards and behavior. A woman might get up in the middle of the night to clean the kitchen with obsessional thoroughness, but neglect to clean the room in the daytime; a bank robber might lie awake at night worrying about a debt of twenty cents; a patient could feel haunted by guilt and worry over not doing his job well, but would do nothing realistic to improve his work.

The extreme contrasts in borderline personalities are only partly due to a lack of integration. The normal person undergoes, in the process of growing up, a slow and steady blunting of his impulses, and he learns to compromise and to accept inconsistencies and shortcomings in himself and in the outside world. Borderline patients have failed to do so. Many offenders have told me that, as they could not live up to their ideals, with a feeling of despair they just gave up their ideals or religions and became criminals.

These patients are also particularly aware of and sensitive to any social injustice or inconsistencies, unless they go to the other extreme, figuratively close their eyes to the world, and withdraw. One such patient described his mentality as that of the "hyperbole." (This geometric figure is constructed by the positive and negative opposites on both sides of the axis.) The strong negativism and sadomasochism are

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further factors in creating these extremes which reflect their ambivalence. It is important, for therapy, to be aware that the patient is dominated by such contrasts, because he can only be influenced therapeutically if both sides are reached almost simultaneously. It is necessary to be inconsistent in handling them and to contradict oneself in almost the same breath: to discuss their hostility, we have to mention their affection and appreciate simultaneously their idealism and antisocial attitude, their overvaluation of materialistic things, and their ascetic withdrawal.

Some borderlines—mainly schizoids and depressives—have not only an empty and vacant expression but seem to have a blank mind. Their main reason for not speaking is because they have nothing to say; there is really nothing in their minds. This emptiness is the result of repression, condensation, and denial mechanisms and is often a defense against very sadistic, frightening, peculiar fantasies, but it may, to some degree, be primary. Other types of borderlines, however, have very peculiar and abnormal types of fantasies quite consciously. They withdraw from reality for fear of turning their fantasies into real deeds and because their sadomasochism colors their concept of the world. The excessive living in fantasy interferes with their coping with reality, which intensifies, in turn, their anxiety and hostility.

Further characteristics are their querulousness, collecting of grievances, and hypochondriacal complaints. The latter concern not only the body but the mind; they describe worriedly and repetitiously their complaints, painful feelings, and peculiar reactions. Their fear of going crazy is akin to the fears of the bodily hypochondriac. Their querulous grievances and overawareness of social injustices and wrongs are also a sort of hypochondriasis concerning the outer world: the wrong (like the pain) should not exist, something must be done to stop it immediately—like a child who would still, at the age of ten, yell for his mother when defecation was painful. Such hurts to their narcissism they cannot tolerate; the world, as well as their own bodies and minds, must be perfect.

But these reactions serve a secondary purpose as well. One patient said he collected grievances like others collect butterflies, and who could expect him to give up the most precious pieces of his collection? If others are in the wrong, or if something hurts him (mental or physical hypochondriasis), this diverts attention from all he has done wrong or failed to do; it is a defense against guilt.[18] For that reason, proving the querulent wrong usually only makes him worse. Also, he clings to abstract standards and extreme ideals because he lacks security. He has no easy give and take, his parents usually were harsh and unforgiving, he could, at best, hope for rights but not for kindness and forgiveness.

While the classical neurotic symptoms are due to an excess (and secondary failure) of repression mechanisms, hypochondriasis, querulousness, and similar conditions are largely due to insufficient repression. The patient cannot forget and forgive, he cannot repress his hurts, the injustices he suffered, the little aches and pains he felt, as would the ordinary person and also the neurotic. This failure of the repression mechanisms to function adequately in the right place and way is one of the hallmarks of borderline patients, and this observation is of great therapeutic importance. Not only should we be careful not to remove indiscriminately their repression mechanisms, we also have to teach them how to repress and provide the motivating force for so doing. Many patients dwell on their grievances to prove that they are no cowards, assuming that forgetting a wrong is cowardice. Actually, they usually suffer more from anxiety than does the average person, and they have often acted cowardly. Teaching them to deal with anxiety-provoking situations or threatening persons in a social and realistically adequate manner helps these reactions a great deal.

¶ Therapy

The borderline patient poses a serious therapeutic problem, as the accepted methods with which we approach both the psychoses and the neuroses are inadequate. Medication may sometimes be used as an adjuvant but generally

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serves little purpose; the same holds true for shock treatment; institutional treatment is, as a rule, undesirable, and ambulatory treatment full of difficulties; simple re-education, suggestion, or hypnosis are of very limited value; orthodox analysis is usually contraindicated or ineffective. Thus, new methods must be developed. In the last twenty-five years, I have treated several hundred patients belonging to the above type, including offenders, and I have long follow-ups on many of them. I have, for these patients, increasingly modified the orthodox Freudian analysis to meet clinical exigencies, utilizing an ego-directed and reality-directed analytic method combined with much re-education and education.*

The aim of therapy is to strengthen the more desirable or, at least, less pathological mechanisms and to counter the more abnormal ones. In other words, therapy must be selective, directive, and clinically purposeful. Undirected classical analysis is counterindicated, as the analytic process produces regression which the well-developed ego of the classical neurotic carefully selected for analysis can tolerate, but which the poorly developed ego of the borderline and the antisocial personality is unable to withstand. As Freud always stressed, orthodox analysis was devised for the classical neuroses only,[1] and in applying it a transference neurosis develops, but with a borderline psychotic, a transference psychosis is likely to take place (or a transference delinquency, drug addiction, etc.), and we can by no means be certain that we can make it disappear again. We cannot, as in classical analysis, remain detached onlookers, allowing the therapeutic processes to unfold. We should not allow even a temporary regression or deterioration, as this might lead to a serious disorganization or dangerous acting out. Free association furthers autistic thinking and withdrawal from reality, which is opposite to what we want to achieve with the borderlines. The detached and passive attitude of the analyst has a bad effect on the patient for various reasons, which I will discuss later. Carefully selected and worded interpretations are often helpful, but ill-advised ones may be dangerous. We should not give an interpretation without anticipating what effect it will have on the patient. The mere fact that it is correct does not justify giving it. Analytic knowledge is of great value in assessing the dynamics of the case, for handling the patient, and for judging progress or deterioration during treatment, but we must distinguish between the knowledge the analyst has and the one he conveys to the patient.

According to Freud, in the psychosis the ego is overwhelmed by the id,[4] which detaches it from reality.[2] Hence, our aim in therapy must not be to bring the unconscious indiscriminately into consciousness (Who is more dominated by his unconscious than the schizophrenic?) but to strengthen the ego and its control over the id, and develop its relation to reality. Thus, therapy must be directive and ego- and reality-oriented.[12] Treatment must improve the borderline's relationship to people, develop his reality sense, judgment, sense of continuity, forethought, and awareness of the consequences of his actions; in short, socialize him and develop controls.

If we regard neurotic mechanisms and symptoms in borderline cases as defenses against psychotic conditions, it is obvious that we must be very careful not to activate or intensify the underlying psychotic condition, but strengthen the existing defenses rather than break them down. This is achieved by selectively increasing repression, giving values and higher standards, furthering object relations and the relation to reality, while selectively and with discrimination undoing the effect of repression in other areas.

A therapist treating borderline cases has a serious responsibility. His prime duty is to pre-

* I want to stress the fundamental difference between Ferenczi's "active therapy"[2] (Rosen's "direct analysis"[11] and other similar methods) and the ego-oriented directive analytic method I developed. Ferenczi departed from the passive listening attitude in order to get more material and libido into the analysis. He was concerned only with the effect of his maneuvers on the patient's unconscious, and, incidentally, as he stated in later papers, was disillusioned with the result. I, on the other hand, depart from the passive listening attitude for clinical reasons, not to evoke interesting analytic material but to consider the patient's feelings, state of mind, behavior, and the effect of the treatment on the patient's life situation. I sometimes use devices to stop him from producing interesting material if it is pathogenic or clinically undesirable.

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vent the patient from getting worse, to watch for danger signs or the beginning of disorganization or dangerous acting out, to prevent emergencies arising, and to cope with them if they do. Depressives may become potentially or actually suicidal, psychopaths potentially or actually criminal, and schizoids may easily regress into a full psychosis. Just as we will do all in our power to prevent a latent tuberculosis from flaring up into an open one, it is all important not to allow a latent psychosis to develop into an open one, or, at least, to limit it as much as possible.

For this reason, treatment of borderline cases must be planned, and the goals of therapy must be based on an evaluation of the patient's personality and dynamics, his environment, and his chances in life, with a minimum of the therapist's personal bias. Some aspects of the personality or certain reactions should be intensified, or modified; others should be minimized or underplayed. Certain people should become more aggressive, others less; sometimes, they should become more aggressive in some areas and less so in others. Usually, the goal is not so much to "get the patient's aggression out" as to make him more effective. Irritability and bad temper springing from helplessness or aggressiveness to bolster one's self-esteem are not desirable aims.

The purpose of the treatment is to diminish the patient's abnormality and increase his normality. As his normality increases, he becomes more receptive to normal strivings; as the area of this normality widens, he will be more ready to give up his abnormality. The more he is capable of socializing, the more other people begin to have a beneficial effect on him. The influence of others in normalizing the patient, whether it is done in a planned manner by the parent and probation officer or spontaneously by friends, is of great value. Improvement is like a stone thrown into water, creating ripples that are wider and wider. The therapist can utilize both good and bad situations that arise in the patient's life; and sometimes, try to bring about both kinds. Bad situations can be utilized to point out to the patient the consequences of faulty behavior or reactions or to teach him how to handle and accept them rationally. Good situations are, of course, encouraging and he should be reminded of them when things go wrong again or when he gets depressed. Also, sometimes it is useful to point out that he brought about the improvement himself by more socially desirable behavior.

Every possible device should be used to cajole, push, or let the family push the patient into normal situations, and afterward to make him aware of having acted normally. The strongest factor in socializing a patient is the fact that he has acted normally and socially and gained satisfaction from so doing; the knowledge that he is capable of being social and that he enjoys it is the strongest inducement for similar behavior in the future.

Improvement should be stepwise. Setbacks must be expected; they are not only inevitable but may be utilized for therapeutic purposes in motivating the patient for further effort and insight, teaching him what brought on failure, and desensitizing him to disappointments. With some patients, too much emphasis on "whys," too much dwelling on causes and on the past, counters their facing immediate problems and coping with present-day reality, and stops them from developing volition and ego controls and accepting responsibility.

Much has been written about the weakness of the ego, but little has been said concerning the specific therapeutic measures that develop ego strength. Two rather contradictory ideas are current: (1) that analytic treatment develops ego strength; (2) that ego weakness makes analytic treatment impossible. What, then, is to develop the ego?

The ego develops largely through its identifications, and, hence, identification with a therapist who has a strong personality is desirable. For that, however, the therapist must avoid a mirrorlike, objective attitude and must not be afraid to be himself, take responsibility, voice opinions and values, and show initiative. This is yet another reason why the too great detachment and self-effacement of the classical analyst is ill-advised for borderline patients. Much of this detachment is defensive on the part of the therapist and is unnecessary if we are capable of coping with the patient. We should not be too afraid of being maneuvered by the patient,

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as this is, for many, the only means of establishing contact, but we should be able, on the contrary, to maneuver and, when necessary, stop the patient. The therapeutic relation consists, to some degree, in allowing the patient to test and even to take advantage of the therapist, and once a relationship is established, the patient should be molded with therapeutic ends in view.

The borderline patient with weak object relations has little capacity to identify in a favorable manner; hence, simple re-education is rarely effective. Before educating the patient, we must make him educable, and before we can achieve lasting favorable identifications and relations, we must make him capable of identifying. We must utilize his flimsy attachments, immediate needs, and passing interests and build on these. We must get him to accept many unpalatable insights, controls, and changes of attitude, which he will do only if he gets positive satisfaction and support from the therapeutic relation.

Therapeutic detachment is largely due to the fear that there is danger in making the patient dependent on the therapist. Naturally, there are possible dangers in any effective therapeutic device, whether it be medication, surgery, or psychotherapy. To change the patient, he must be influenced, and he becomes amenable to influence only through dependence. Obviously, the therapist should not only be ethical but should handle the situation with common sense, and the dependence should be for clinical purposes only. The patient's dependence should be utilized to solve his problems, to develop social adjustment and better relations, and to help him be more successful. As this happens, he will automatically become more independent. Thus, there will be no problem in stopping the therapeutic relation. Excessive dependence on the therapist (or anybody else) over a prolonged period is an indication of therapeutic failure.

To establish contact, we have to meet the patient on his own ground—socially, intellectually, and emotionally. We must show some understanding for the feelings of the depressed, for the withdrawal of the schizoid, for the situation of the former convict. Contact must be made with both the normal and the abnormal part of the personality; contact with the former alone is not likely to be lasting in a very abnormal person; contact with the latter alone is not curative. Once contact is established, it must be used to change the patient.

Going down to the patient's level must be done with the therapeutic purpose of eventually moving him into other directions. Merely to have a good relation with the therapist is rarely therapeutic in itself, though it may sometimes work with milder cases, provided the environment uses its pressure in a desirable way. For the more abnormal patient a good relationship, with a too forgoing or prolonged tolerance for his pathology, does more harm than good. The relation with the patient is no end in itself but a means toward clinical aims, and these must be carefully chosen. Hence, the need for a directive ego- and reality-oriented therapy.

In handling the patient, one should distinguish between long- and short-term aims, and often one may state this distinction to the family and patient as well. The short-term aim is to establish contact, bring some relief, make the situation tolerable for the patient and others, and, in particular, limit his acting out or withdrawal. Then we can gradually proceed to socialize him. Without initial improvement, treatment is likely to be broken off. I rarely aim at a systematic anamnesis or diagnosis in the first interview, but try to establish immediate contact. One always can get more detailed information later. I talk spontaneously, and often make a point of appearing nonprofessional. If a patient finds it difficult to talk, I ask questions or talk myself, attempting to put him at ease. Sometimes, I may start talking about myself or my interests, with controlled spontaneity, or I discuss subjects in which he might be interested. I occasionally offer a cigarette, have coffee with the patient, lend him a book, etc.

An experienced therapist should be able to give interpretations on the basis of little verbal material, drawing conclusions from the patient's behavior and character, his history, his symptoms, and his general pattern; from information received from the environment; from

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analytic theory; and by putting himself in the patient's place and imagining what he himself would feel.

With a shy or distrustful patient, the therapist must take the initiative and show understanding and sympathy; once a relation is established, he can then help the patient to straighten out some of his practical problems. If the therapist takes the time to show personal interest in him, the patient becomes convinced of the therapist's genuine desire to help. Only then does he begin to identify. The relation should be essentially a friendly one, with controlled spontaneity on the part of the therapist, containing elements of both tolerance and authority.

The one thing that has a bad effect on a borderline patient is weakness and detachment; we need authority to have influence over him and his environment. Sexual and aggressive impulses, if they arise in the transference, often should be minimized and diverted rather than analyzed, and it may sometimes be better not to bring them into consciousness. If these impulses manifest themselves openly and strongly, it may be desirable to trace them to their source. By stressing the past, we also divert the patient from the immediate situation and make him less tense. Altogether irrational reactions should be discouraged, and, on occasion, definitely stopped or utilized for more normal purposes.

It is essential to clarify the difference between self-control and inhibition. Self-control is essentially conscious, a function of the ego, though it is aided by unconscious mechanisms. Failure of self-control, or failure to trust one's ability to self-control, exposes one to many anxieties—the fear of being overwhelmed by uncontrollable impulses and of the ensuing social and practical consequences. Patients who do not trust their capacity for self-control will avoid situations of temptation (sexual needs, greed, etc.) or hurt (which provoke uncontrollable aggression) and thus limit their lives.

The aim of therapy is not, as some therapists currently seem to feel, to remove inhibitions indiscriminately and to lower standards, but, as Freud always stressed, to replace the automatically functioning and unconscious mechanisms, which often realistically hamper the patient, by conscious self-control which is deliberately planned and directed. Thus, with a better developed ego the patient begins to cope with situations and to desensitize himself. Self-control, like any other faculty, is developed slowly and stepwise and is stimulated by overcoming difficulties. If no difficulties are encountered, the individual fails to learn to desensitize, to develop defenses and self-control, like a child who, if never exposed to bacteria, would fail to develop antibodies. Development of self-control is closely related to personal relations, reality sense, foreseeing of consequences, and development of the ego, and hence it goes hand in hand with modification of the narcissism.

Borderlines are excessively hurt by things other people regard as an ordinary part of life, yet they are remarkably thick-skinned, in many respects, to other peoples' feelings and demands. This oversensitivity is largely due to their excessive narcissism and feelings of grandeur—hurts and frustrations should not happen to them.

The borderline does not fit into any rigid treatment situation. His intolerance of emotional continuity and of steady object relations, his excessive changes of mood, and his defiance of routine often interfere with regular attendance. His inability to relax, his fear to lose hold on reality, his paranoid (or, in the case of delinquents, realistically justified) apprehensions hamper free associations; alternating between withdrawal and being overwhelmed by intense upsets, prone to dangerous acting out, he often needs contact between his regular sessions, though he may not attend the latter. Such patients are only little influenced by insight and tolerate silence badly. They need a very elastic technique and much latitude. Yet the latitude should not spring from weakness. After a while, when the patient normalizes, he should learn to show consideration for the therapist, and, in return, for what the therapist gives him, to make an effort. The therapist should sacrifice his comfort when necessary—as does every medical doctor—but he should not allow the patient to take too much advantage of him in the long run. These patients, even after they have normalized and

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are at their best, are still no subjects for classical analysis or for any method that has taken over its ritual.

The relationship between the therapist and the patient should not be the intensive, exclusive kind, reminiscent of a possessive, dominating parent. It must be such that it does not interfere with other relationships in the patient's life. A good relationship with the therapist is one of the strongest socializing forces; the therapist should use the patient's attachment to induce him to change and adjust. But the relation—often the first relation the patient has been capable of—also acts as a pattern for other relations. Adjustment to please the therapist is not necessarily of temporary value only, as it sets up many beneficial chain reactions. The patient learns to deal with his impulses by better ego controls and hence will be happier and less anxious; he learns to get on better with people—in short, he learns to gain satisfaction from living more successfully in reality and will, therefore, have an inducement to continue to do so, even after the therapeutic relation stops.

The patient should feel that the therapist has his interests at heart, but that is not tantamount to condoning everything he does. Mere assurances that the therapist is "his friend" carry little weight; if the patient feels that he is receiving genuine sympathy or practical helpfulness, he will himself come to this conclusion.

There is a trend to disparage early improvements, because they may not last or may represent a "flight into health." They may or may not be lasting, but if the therapist disparages them, they are sure to be crushed, and sometimes the patient does not recover from this disappointment, so that no further improvement takes place. Improvement gives hope and stimulates effort, and it is on the initial and often fleeting improvements that the more permanent ones are built. It is up to the therapist to intensify, stabilize, and utilize the initial and passing improvements. True, a very abnormal patient should not be allowed to get so elated over an initial improvement that he breaks off treatment. If the elation must be countered by pointing out all that is still wrong with him, it should be done so as not to kill his confidence. The therapeutic goals one holds out to and expects for the patient should be realistic, based on one's clinical experience and the therapeutic results one has achieved with similar cases. Too-extreme concepts of normality crush the patient. It is like giving him too high a wall to scale.

Analytic psychiatrists are often uncertain in their own minds as to whether it is desirable for symptoms to disappear. Characteristically, while we speak in medicine of the "relief from symptoms," in psychiatry we often speak of "losing" them. But they are certainly no loss to the patient. They constitute suffering, maladjustment, and failure. If the therapist is ambiguous in his own mind as to whether he wants symptoms to disappear, or feels uneasy if they do, they are not likely to disappear, or they will return. Analysis has taught us that symptoms are expressions of an underlying conflict and, in the borderline, often a defense against psychotic reactions. However, we must evaluate the importance of a symptom clinically as well as dynamically. Some symptoms are relatively unimportant in the patient's life, even if he is unduly concerned about them, while others seriously interfere with functioning.

As to the former symptoms, it may be desirable to get the patient to accept them, at least for the time being, to minimize them, to divert his attention from them. We must, however, try to curb symptoms that seriously interfere with adjustment, and the ensuing relief and better adjustment are of great therapeutic value. I usually go first for the symptom that is either easiest to influence or is most disturbing, because the resultant improvement is a main factor in establishing a relation. At the same time, we should try to deal with underlying conflicts and strengthen the patient's personal relations, which is the best antidote to possible psychotic reactions. We can deal with the underlying conflict even without revealing it to the patient; for example, if it concerns his unconscious hostility toward his father, we can find other acceptable outlets for his aggression, make him less sensitive to guilt, improve realistically his relation to his father and to father substitutes, make him

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more independent, and remove some of the causes of his resentment.

The main difference between classical analysis and psychotherapy is that the former works from the depth to the surface only, while the latter attacks in many direction. Normality is not tantamount to rigid stability, but, like the dynamic equilibrium of the physiologist, is the outcome of innumerable chain reactions and checks and balances. Psychotherapy can attack any of these chain reactions, and the more it influences, the more effective it will be. It can affect the environment through the patient, the patient through the environment, and every member of the family through each other. Dynamically too, it can work from the surface to the depth, and vice versa; it can increase repression and decrease it (often simultaneously in different areas), attack the infantile origin of a symptom or its present-day meaning, or influence it by environmental manipulations, by increasing or decreasing pressures, by giving or denying outlets, etc.

Psychotherapy is the combination and integration of many therapeutic devices affecting many chain processes in a planned manner for attaining clinical goals. Not only are there these constant chain reactions, but the mind is not really compartmentalized; it has only been described in compartments by the scientific observer. The subject himself, unless he is scientifically trained, is not aware of volition, cognition, emotion, etc., as separate entities, as they constantly merge into each other. Such distinctions are necessary for scientific description, but they are artificial and do not exist actually.

It is important to make the patient aware of his disturbances in thinking and judgment in a way that does not undermine his self-confidence, and to teach him in concrete terms how better to handle any of these situations and how to think more realistically. We can, afterward, analyze the reasons for these disturbances, but it is more important to point out the malfunctioning in great detail with a view to correcting it step by step. This is one of the most important aspects of the patient's re-education (or often education). Here again, there are constant chain reactions. If we can teach the patient forethought, he will think about the consequences of his actions and develop a greater measure of control; a better understanding of other people leads to more consideration and this, in turn, to more control. Some patients require vocational or scholastic training. Apart from its practical usefulness, the process of learning teaches the patient that steady effort is required to gain one's ends. Thus, the "pleasure principle" of the small child (for whom there is little difference between wishing and having, naming something and knowing it) is countered, his ideas of grandeur and his living in fantasy are curbed, and his adjustment to reality is furthered. The psychological value of learning and of steady effort consists largely in the way it attacks primitive narcissism and modifies it into a more realistically justified self-esteem based on actual achievement.

It is essential that the therapist develops the patient's judgment and acts as an organ of his reality sense until such time as he himself can function adequately. The borderline is narcissistically centered, though he may be full of self-hate. It is important to make him gradually aware as to how others see him and by what means he provokes favorable or unfavorable reactions in others. If the patient understands the cause-and-effect relation and ceases to feel like a pawn in events, and knows that he can produce desirable reactions in others, feel more confident, he will have less anxiety, and become more social.

As stated before, the acting out of borderline patients should be curbed and their antisocial or dangerous activities stopped. But what about making them act normally? How can therapy initiate activity and develop will power? It has been argued that a patient cannot become independent if he acts because of dependency on the therapist. But changes in character and personality are a stepwise process. First, we must get the patient to be more active and successful, and then he will gradually find new people and interests in his life, and thus become increasingly independent. The main thing is to get him moving. He has been in a rut for many years, maybe all his life. Often, his lack of experience and his helplessness add to his anxiety. Merely to point out to him his anxieties and inhibitions will

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effect a change too slowly or even make him feel none. The failure to act is not always due to inhibition; sometimes, it is a primary failure of not having learned how to act, and therapy then has to imply education rather than re-education and develop something that has hardly existed heretofore.

To get the patient moving, we have to utilize any incentive inherent in his life situation or pressure emanating from his environment. If it is impressed upon him at the right moment and in the right way that he is more likely to find a nice girl, or that he will make a good impression on the probation officer of whom he is afraid, if he finds himself a good job, he is likely to want to look for one. And only when he wants a job, should the therapist offer his advice on how to go about it. Then, once the patient has embarked on looking for a job, we can discuss his difficulties, anxieties, and inexperience. It makes little difference how the patient is originally motivated as long as he embarks on an activity that in the long run is to his advantage, because the gratification he derives from it acts as an incentive to proceed.

Naturally, the patient is aware that it is to his advantage to have a good job, or that certain hobbies are pleasant, but the mere knowledge that something is desirable produces remarkably little effect unless emotions are evoked. Students are usually more motivated to study by the fear of exams than by the knowledge that this studying is essential to their future. Psychologically, we become aware of the outside world only through the emotions it evokes, and it is essentially emotions that provide the drive for action. Thus, any disturbance of emotions, or of the linkage between stimulus-emotion-volition, leads to disturbances of volition and action. The emotions acting as incentives may be positive (desire, pleasure, greed, sexual needs, ambition) or negative deterrent ones (fear, guilt, shame, disgust, etc.). Usually, we are motivated by a combination of positive and negative incentives. These considerations are of therapeutic importance. We must arouse emotions and desires, direct these incentives into the right channels, and link them with the desirable course of action. We can utilize or reinforce any emotion inherent (or potentially inherent) in the patient's life situation, for example, use fear of the court as deterrent, or stimulate desires as positive incentives. We can also create new associations or reinforce or redirect existing ones. Moreover, we can channel generalized or irrational emotions so that they act as levers for normal behavior. If the patient's generalized anxiety can be focused onto his fear of the police, he will stop committing crimes; if his bad feelings can be concentrated onto guilt toward his wife, he might act better; if his good feelings can be connected with the awareness of having acted well, he is likely to continue to do so. We must connect emotions with volition, create the desired associations, and in this be led by clinical and social values. We can influence the patient directly as well as indirectly. It is often stated that suggestion is ineffective or short lasting. This depends on the influence we have over the patient, and that is why therapeutic dependence is essential. True, the patient does not accept everything he is told, and it has to be repeated often, in many ways. One patient said he does everything I tell him—but a year later. Many patients do not even know that they are acting on what I told them long ago. Whether a change is lasting or not depends largely on whether it is ultimately in the patient's interest: The rewards inherent in the change are a strong motivating force to make it permanent. Patients usually change stepwise, with setbacks, but after repeated partial improvements, these tend to become permanent.

An excellent device for channeling feelings and creating or modifying associations is by means of clinically tendentious interpretations. According to E. Glover, inexact interpretations are more often therapeutic than correct ones.[6] To interpret to the patient, "you unconsciously thought" is usually more effective than any direct suggestion.

While analytic psychiatry has paid a great deal of attention to emotions, not too much has been written as to how they should be handled therapeutically. Indiscriminate abreaction or intensifying of emotions is undesirable with borderlines, and, while an occasional abreaction in an inhibited patient or one under great stress may be of value, repetitious abreac-

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tion easily turns into an undesirable conditioning. Sometimes, it is good to evoke emotions but, as a rule, only up to a point; in other cases the patient should acquire more self-control. We must teach the patient how to cope with his painful feelings, and, to some degree, he will copy his therapist's reactions—an experience he foregoes if the therapist remains continuously detached. One way of coping with emotions is, for example, to bring out some anxiety, discuss it for a while, then minimize or divert the patient from it. The patient must also be conditioned how better to tolerate unpleasant feelings and it is reassuring for him to hear that others, too, suffer from painful feelings. It is a hurt to everyone's narcissism to be exposed to painful emotions, but the borderline resents this especially. He builds complicated spirals around the initial painful feeling, takes it as an indication that he may be going crazy or is inferior, and then is worried about his state of mind. If these secondary spirals can be reduced, the patient learns to tolerate better the primary bad feeling, and this usually goes hand in hand with some modification of his narcissism. Also, painful feelings can be channeled and therapeutically utilized or even be given a narcissistically positive value. It is easier for the patient to tolerate anxiety if it is lessened, especially if it is impressed upon him that it is now different from his former pathological reaction. We must appeal to his sense of responsibility to develop volition and self-control and convey to him that the effort is up to him. He must be told directly as well as by implication that he is capable of coping with his emotions himself. At the same time we must have succeeded in reducing his bad feelings to a degree where he really has some control over them. To give one example, in a severe depression the patient has lost all hope that he will ever feel otherwise, and he will fight even a momentary improvement for fear that after a brief spell he will again feel depressed, and then, by contrast, experience the depression more. He will refuse to make any effort as long as he has no hope of feeling better, and he cannot feel better unless he has hope. We must break through his depression by any means at our disposal—by medication, diversion, getting out some aggression (an often very helpful factor in depressed patients), by somehow building up his self-esteem or just pouncing on a spontaneous change of mood and reinforcing it. Once the patient feels better, even if only for a few moments, we can draw his attention to this improvement, and capitalize on it. If we can plausibly (whether it is actually justified or not) connect it with therapy, this is all to the good, as it gives the patient more trust in therapy, and he will then be more ready to make the necessary effort. By describing to the patient in detail how a depressed person feels, contact can sometimes be established which might form the basis of attachment. Once we get some attachment, the patient is likely to feel better, and thus, a favorable chain reaction develops.

To influence the patient, we must approach him both intellectually and emotionally; the two cannot be separated. Reasoning evokes emotions, and emotional contact makes the patient more receptive to reasoning. To evoke emotions in withdrawn patients, we must, ourselves, show emotion and spontaneity, and this is yet a further reason against a detached analytic attitude. Most borderline patients are not motivated the way the psychiatrist may wish them to be. Often, they come for treatment only under pressure of their families, or, if delinquent, they are sent by the court. But even if they come on their own, they come because they feel unhappy or do not have a job, or have trouble with those around them, and they would like this to change. However, that does not mean that they really want to change themselves or that they realize that the cause of the trouble lies within themselves. Even if they have some insight, it rarely lasts or is a sufficiently strong motivating force. It is the task of therapy to motivate the patient for therapy, and that is done more by getting attachment and giving help than by reasoning. If the patient feels and functions better, he feels gratitude which helps to cement the therapeutic relation. But as soon as the pressing need lessens, his motivation also tends to wane, and we must motivate him again and again. Motivating is a continuous process; not only is it necessary to make him cooperate, but

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it stimulates and parallels the development of his reality sense. Insight is a particularly weak tool for influencing borderline patients. They are narcissistic; their super-ego and judgment are poorly developed; they have weak motivations, marked disturbances of volition, and their relation to reality is disturbed. They are reluctant or unable to connect consequences with their behavior and make excessive use of projection and denial mechanisms. They have much more effective ways of warding off insight than do the neurotics; they fail to attend regularly, come only when they are in trouble, and then want an immediate solution of their immediate difficulties. They alternate between feeling indifferent and desperate, and in both of these states are difficult to reach. When they are indifferent, they are not interested in the treatment, and when they are desperate, they are too preoccupied with feeling desperate even to discuss intelligently what brought on their situation. They do not listen to what the therapist says, or they disparage it. They are able, to an amazing degree, to forget any insight they may have shown on occasion. They dwell on their grievances and the shortcomings of others, or of society, and do not see realistically what is wrong with themselves. Even their self-deprecation is a defense against genuine insight involving change. They accuse themselves excessively or suffer from extremes of depression to ward off possible criticism. In other words, they use all their energy, intelligence, and conscious and unconscious defenses to ward off the most elementary common sense. Trying to reach such a patient by insight is like battering the walls of a castle with a tin spoon. We must get under his skin and devise methods of gaining influence over him and, more important, get him into such a frame of mind that insight becomes tolerable. For instance, as long as the patient feels too guilty or unhappy, or is behaving very badly, he cannot accept interpretations that increase his guilt, but once the therapist has made him act better, he is more able to tolerate the realization of his faults.

Some interpretations reassure the patient while others upset him. This depends not only on the form of the interpretation but also on the content. If we want to reassure the patient, interpretations should be given so that they are not interpreted as reproach. At the time of, or even better, before, interpreting antisocial impulses, it is good to draw attention to his affection. With some patients, a generalization, such as "It is only natural that you resented . . ." is preferable to a straightforward interpretation of his hostility. The patient is more willing to admit that he felt angry for a brief moment in a justified situation than that he has sadistic ideas. If the patient does not tell, one can make safe guesses. It is likely that a girl, who has been in an institution, feels resentment against the matron. But the girl may insist that the matron was nice and treated her well. "Surely," I say, "she does sound like a nice person. But you know, nobody is perfect. Sometimes something must have annoyed you." Then she starts talking, and after fifteen minutes the matron does not sound like a nice person at all. In testing out interpretations, one should go cautiously and watch the patient's reactions, starting on comparatively safe topics. Sometimes, it is better to give interpretations phrased as questions. A boy is less likely to feel guilty about hostility toward his teacher than toward his own father. The order of interpretations is important, and it may make a difference whether a certain interpretation is given five minutes earlier or later. One has to watch the patient's reactions to the interpretations. If he is upset, one can either analyze the upset or reassure him, or do both, or to a certain extent, take back the interpretation and divert him. This step-by-step method makes it possible to control the effect of interpretations.

Even correct interpretations may have ill effects. Withdrawn or obsessional patients may dwell on insight in order to avoid action; interpretations may provoke regression, acting out, or intense anxiety. The fact that the analyst knows what goes on in the patient's mind may evoke paranoid fears of his omniscience. A psychotic may fit the insight into his paranoid ideas, a psychopath use interpretations to justify his antisocial behavior; they may also intensify a depressive's self-accusatory reactions or induce a further schizoid with-

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drawal from reality. My first antisocial patient, a schizoid prostitute, became homosexual and a thief in the course of being analyzed. The analysis consolidated her latent homosexual trends into manifest homosexuality, and her previously vague antisocial tendencies into definite law-breaking activities. This effect was undesirable, and I have never since analyzed borderlines without balancing interpretations by very careful countermeasures. In current psychiatric thinking, the impression prevails that defenses are something undesirable or even pathological. On the contrary, they are as essential for mental functioning as is any vital organ of the body.

As the aim in treating borderlines is to strengthen the ego and its control over the id, we must be careful not to weaken the existing defenses by interpretations, by encouraging the unconscious material to emerge indiscriminately as in free associations and uncontrolled fantasying, or by being unduly tolerant of pathological manifestations and impulsive behavior. Moreover, we should develop the existing defenses and build new ones, utilizing our understanding of dynamics for this purpose. Anything that develops the ego also strengthens its defenses. In particular, setting limits, developing volition, forethought, responsibility, and consideration for others, stressing consequences, socializing the patient, and giving him values force him to develop defenses. Values and standards are of positive emotional significance; they are as important for normal development as the fulfillment of material or sensual needs. They fashion the personality and form an important part of it. Values, ideals, and standards act as levers that check primitive impulses, and thus further repression and other defense mechanisms, but they also give positive satisfaction that compensates the instinctual frustration.

In the same way, standards are not something negative, to be combated; they give security, direction, are of positive emotional value, and supply a sense of belonging to the community. Confusion of, or lack of, standards makes for insecurity. Lack of ideals and hope causes dissatisfaction and increases the need for material pleasures, which, if excessive, is bound to lead to competitiveness, hurts, unhappy experiences, and pauper emotions.

Real achievements, social acceptance, and greater self-control lessen anxiety. Guilt is effectively diminished by stopping the patient from doing guilty deeds and inducing him to do positive things that satisfy his conscience. For normal adjustment it is just as important that the woman clean her rooms in daytime as that she stop her obsessional cleaning at night, or that a patient not only give up his neurotic worries over work but become more efficient. If the patient has extreme ideals and standards, and the latter fail to influence his behavior, we have both to modify his standards and make them more effective. With others, their standards are ineffective, simply because they are too low, and we must set higher ones. Each patient must be treated individually, according to need, and even differently at different times. Sometimes, he needs more instinctual freedom, sometimes more control; in some areas his standards may be too high, in others, too poor, and we must use our influence in an elastic manner. We must, on occasion, sensitize the patient toward his own impulses and ideas if we want him to control them better; sometimes, desensitize him toward them if he is unduly afraid of them. Analytic interpretations are important tools toward achieving this, and we should evaluate interpretations more from the point of view as to whether they sensitize or desensitize, than according to their content. This sensitizing or desensitizing effect is to quite a degree achieved by the wording, tone of voice, comparisons used, etc.

The treatment of borderline patients is fraught with difficulties and possible dangers. That is why many psychiatrists refuse to treat them outside institutions. The main dangers lie in extreme withdrawal reactions or in acting out, such as suicide or impulsive or criminal acts. But even apart from serious dangers, impulsive or aggressive behavior must be limited. The longest analysis will not help a marriage if, in the meantime, the marital partner has filed for a divorce. Loss of a good job, expulsion from medical school, or breach with the family should be prevented. Hence, some im-

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provement must be achieved quickly, and the treatment conducted so as to lead to a minimum of upset in the patient's daily life.

The main method of preventing dangerous acting out lies in a positive relation to the therapist. I encourage difficult patients to phone me in an emergency, and I will either talk to them on the phone or see them outside their regular session, if necessary. The patient often tells more on the phone than face to face, partly because he appreciates the trouble the therapist goes to for him, and partly because the emergency usually makes him more talkative. One can give interpretations on the phone, reassure him, or merely encourage him to talk. It is important, however, to reduce these emergency contacts as time goes on, and to get the patient more adjusted to therapeutic routine. Although the therapist feels and shows concern for the patient, he should not transmit his anxiety to him. To prevent dangerous acting out, one must cope early with the situations that are likely to cause the patient to get upset, and must limit and channel his painful feelings.

The chief reasons for dangerous acting out are despair and revenge; if life is made more tolerable and the patient is given hope, he is less likely to do anything desperate. It is bad if the transference relation is too intense and the therapist is the only one he has to fall back upon. The patient should be able to act out his ambivalence to some degree and turn from the therapist to others when he feels angry or hurt. Any personal relations the patient has should be encouraged, and even unfavorable ones only reluctantly broken up until there is something better to take their place. One can introduce new persons into the patient's life, get a social worker, probation officer, or medical practioner to take an interest in the patient, or, if he is well-to-do, engage a companion or nurse, find the patient a job or some occupation, or get the family to take more interest in him. I, myself, have a psychiatric assistant, but I have, on occasion, used my maid, or, in the London clinic, the caretaker. Many persons, professional or nonprofessional, can be utilized for therapeutic purposes. It is possible, and often necessary, to create an institution outside an institution, to regulate the patient's day-to-day life and routine, and even have him under supervision or restricted. Sedation, sleeping drafts, and placebos are often useful. It is essential to teach patients how to cope with their loneliness, mainly over the week ends and how to deal with anxiety or upsets. In advising the patient to plan his day, or in deciding what interests to encourage or discourage, we should not be guided just by common-sense considerations as to what a normal person in such a case would do. We must utilize our knowledge of dynamics to assess the likely psychological effect of any occupation or situation on the patient (or sometimes on his environment). For instance, a patient with overintense guilt reactions or one suffering from a severe depression often reacts badly to the things that normally would give pleasure. Hence, he is made worse by them, and, in such a case, it is better to advise occupations that entail hardship but satisfy his super-ego and, by keeping him busy, divert him from thinking about his depression. This is one value of work and routine. Sometimes, with oversensitive patients, we have to find something that is as far away from their real interests which would evoke conflicts, as possible. (I made one patient take courses in Greek philosophy and ceramics for this very reason.)

Because it is essential to avoid a too-sudden increase in guilt reactions, indiscriminate encouragement toward sexual activity or pleasure may be dangerous. Some borderlines react in a psychotic manner to the realization of their sexual desires and, in a few cases, the impending marriage or permanent sexual relation seems to have triggered off open schizophrenic breakdowns. While with certain inhibited schizoids, it is desirable to encourage sexual and permanent relations, there are others where one should do all in one's power to discourage and postpone it. Sometimes, a year or two later, if the patient has normalized in other areas, he can tolerate such relations. The careful handling of the patient, based on the constant analytic evaluation of his reactions to stimuli and stresses, is the key to the treatment of borderline patients, rather than interpretations, and the handling has to differ according to how the patient himself changes or the environmental situation fluctuates.

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While it is safe to encourage certain patients who change only slowly, there are others who change too quickly from a depression into an elation—even if there has been no manic episode in their history—and dangerous acting out or psychotic reactions may ensue if the elation is not stopped in time. Depression is more painful to the patient, but apart from the possibility of suicide, it is rarely dangerous. Elation may trigger off the freeing of oneself from controls and the limitations of reality, leading to manic reactions, schizophrenic ideas of grandeur, delusions, and even to catatonia. This development is an important factor in the cases where analytic psychotherapy has led to an open psychosis.

The orthodox analyst takes only classical neurotics who come on their own volition, have insight, and on whose cooperation he can rely. He avoids contact with the family, as this might interfere with the transference situation. Many borderline patients, irrespective of their age, are not self-supporting; in other respects also they are very much dependent on the environment, because they cannot cope with life. Moreover, such patients often attend irregularly, and keep the most relevant things to themselves; but we must know what goes on as they are still our patients, whether we see them or not. For that, we need the family to cooperate, or at least to keep us informed. I encourage both patients and members of the family to phone me, though I may limit the number of calls or the time I speak to them. Sometimes I phone the patient or family myself. I have, in emergencies, gone to the patient's home or sent my assistant. If there is a serious possibility of suicide, one has, of course, to take careful precautions.

One must have a relation with the family (1) to get information from them currently, though not necessarily frequently; (2) to be able to influence their behavior and advise them how to handle the patient in specific situations, tell them what is important, what not, and teach them the danger signs; and (3) to sympathize with their side of the picture and help make life bearable for them while the patient is being treated. Of course, one should not have too many illusions about the family's cooperativeness. Abnormal patients usually have difficult families. But we have to work with them as they are. The therapist must assess the amount of cooperation he is likely to get, determine in what areas the family can help, and decide which member will be most useful. On the other hand, the therapist must get some improvement or, at least, better behavior from the patient, so that the family is willing to continue making an effort. It is impressive to note the degree to which very abnormal parents have changed when a son or daughter improved. While, originally, the parent sets up a pattern of abnormality in his child, after a while the child's abnormality imposes a terrible strain, and, in turn, produces abnormal reactions in the parent.

While I do not hesitate to remonstrate with a parent over some aspect of behavior, I will not hold him wholly responsible for the child's abnormality. I will convey to him that I know he had tried his best, even if he did the wrong thing. When I criticize parents or want them to change their behavior, I do not discuss their unconscious attitude or ambivalence. Analytic interpretations should be restricted to the analytic situation; they tend to evoke guilt and, if combined with definite blame, may provoke excessive and unfavorable reactions.

We should not take away or break up anything in a patient's life before he has something else upon which to depend. Simply because a patient is abnormal and his home life is unsatisfactory is no reason to encourage him to leave home. Often, he is so abnormal that nobody but his family will put up with him. Then, again, breaking away may produce a loneliness that is worse than family quarrels. Leaving home should never be too glibly recommended by the therapist, but a great deal of thought should be given as to how and when it should be advised and how it should be carried out.

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PART THREE

The Functional Psychoses

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CHAPTER 22

MANIC-DEPRESSIVE PSYCHOSIS*

Silvano Arieti

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As VARIABLE as its clinical picture is, as unconfirmed as its dynamic interpretation remains today, as controversial as its etiology continues to be, manic-depressive psychosis nevertheless strikes the student of psychiatry for its relative simplicity and for the facility with which its nosologic concept is grasped even by the beginner.

It is therefore appropriate to start the section on functional psychoses with the study of this condition, for it can serve, in part, as an introduction to the study of more complicated disorders.

¶ Introductory Remarks and Historical Notes

Already, at this point, several questions may have occurred to the reader, on account of the fact that we have labeled the disorder a "functional psychosis." Why a psychosis, and why functional? Since many cases of manic-depressive psychosis are very mild, and the percentage of these mild cases seems to increase in relation to the total incidence of the disorder, it would seem logical at first to call the condition a psychoneurosis rather than a functional psychosis. The term psychosis, however, does not indicate only an actual or potential severity of the disorder (a severity which may be reached even by some psychoneuroses) but also connotes the fact that the psychopathological way of living is, in a certain way, accepted by the patient. No matter what transformation

* In this chapter is included the study of the disorders which, according to the official nomenclature of the American Psychiatric Association, are called:

000-X10—Affective reactions (301.2)
000-X11—Manic-depressive reaction, manic type (301.0)
000-X12—Manic-depressive reaction, depressive type (301.1)
000-X13—Manic-depressive reaction, other (301.2)
000-X14—Psychotic depressive reaction (309.0)

The number in parentheses at the right is the code number from the International Statistical Classification (from Committee on Nomenclature, *Diagnostic and Statistical Manual: Mental Disorders*, 1952).

the psychotic patient has undergone (either a predominantly symbolic transformation as in schizophrenia, or a predominantly emotional transformation as in manic-depressive psychosis, or a predominantly cognitive defect as in organic conditions), that transformation becomes his way of relating to people and of interpreting the world.

The manic-depressive patient does not fight his disorder, as does the psychoneurotic, but lives in it, and therefore is psychotic. In this respect he resembles persons who are affected by character neuroses, and who do not even know of the pathological nature of their difficulties. The distortions of the character neuroses, however, are susceptible of at least partial adaptation to the demands of society, whereas in psychoses such adaptation is not possible.

Several psychiatric authorities sharply oppose the use of the word "functional" on the grounds that each condition is at the same time organic and functional, since an organ must always be there to mediate a function. Stanley Cobb,[21] for example, states that "every symptom is both functional and organic."

In the neuropsychiatric frame of reference, this statement is perfectly valid: Every symptom is functional inasmuch as it consists of a physiological function of the organ, and organic inasmuch as it requires the organ that mediates it, either in its anatomical integrity or in its pathological alterations. The statement carries the implicit admission that such states as the functional and the organic do exist. Neither state, however, can exist without the other; we may conceive them separately as abstract concepts, but in the physical world they are always together.

How is it then that the term "functional" has been retained in American psychiatry and is so widely used? According to the present writer, its use is not maintained merely through semantic inertia. Like many other words in every language, it has enlarged some of its meanings and lost some others, and has come to convey a group of concepts which, at the present stage of our knowledge, may still be useful.

A functional point of view about a psychiatric disorder does not exclude the possibility of a hereditary or constitutional predisposition that makes the functional transformation possible. It does not exclude recognition that any function is accompanied by a physical, molecular substratum. It does not even refer to the fact that functions are generally transitory and reversible, whereas organic alterations are not, because this is not true in every case. A memory trace may be permanent, and an anatomical alteration may reverse completely. The functional point of view focuses on the fact that, no matter what the complex causality of the disorder may be, it is the particular form of functioning (or of operating) with its content that constitutes the predominant and primary (although not exclusive) essence of the disorder and leads to secondary sequels, both organic and functional.

It also implies that the dysfunction is predominantly determined by, or connected with, an emotional maladaptation, which, in its turn, is at least partially provoked by a human environment. For instance, it is obvious that functional cases differ from psychoses occurring with tumors of the cerebral hemispheres. Here the normal functionality is secondarily expelled by the histologic alteration.

It is certain that the last word has not been said on this important subject; for the time being, however, the concept of functional disorder is found useful by many, and therefore retained in the classification adopted in this handbook.* In the European literature functional psychoses are generally called endogenous. This classification implies that these psychoses are based primarily on hereditoconstitutional factors or causes within the nervous system, in contrast to the disorders which are exogenous—that is, originating from causes outside of the nervous system. This classification is no longer acceptable to the majority of American psychiatrists.

The following definition of manic-depressive psychosis is based on the fundamental Kraepelinian concept, and we shall use it only as a preliminary statement in order to proceed in our study until, toward the end of this

* The present author would prefer the designation "psychosomatic" to functional. See Chap. 24, p. 491.

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chapter, we shall attempt a more complete one.

By manic-depressive psychoses is meant a group of mental disorders characterized by periodic attacks of melancholia or elation of rather marked proportions, accompanied by retardation or hyperactivity.

Historical Notes

The reader who is particularly interested in the historical perspective of the concept of manic-depressive psychosis is referred to the excellent article by Jelliffe[44] and to the monograph by Zilboorg[94] for the prepsychoanalytical literature; for a historical survey of the analytical literature, the reader is referred to Lewin's monograph[61] and to Roi's article.[82] In this volume we shall restrict our discussion to a brief exposition.

Ancient Times

As Zilboorg[95] aptly says, manic-depressive is a condition which has been known since antiquity and which seems to have changed comparatively little in its symptomatology—much less than other mental disorders. According to Jelliffe,[44] the disorder is "the only form [of psychosis] whose chief features may be unequivocally recognized down through the ages." According to Koerner,[51] the earliest record in Indo-Germanic cultures is that of the melancholia of Bellerophon in the Homeric epics. In the writings of Hippocrates, we find many references to mania and melancholia. He considered manic and melancholic states to be chronic conditions, although he admitted the possibility of recovery in some cases. He distinguished various forms of melancholia and swings of mood, although it seems certain that he did not make any connection between the elation of the manic and the melancholia of the depressed patient.

Not until several centuries later, when Aretaeus appears on the scene, was any additional contribution made to this subject. According to several authors, Aretaeus lived in the second century of the Christian era, but other authors, such as Cumston and Zilboorg, think that he lived toward the end of the first century. Aretaeus was born in Cappadocia, a kingdom in a region of Asia Minor. The kingdom of Cappadocia was part of the Roman Empire, and it is possible that Aretaeus practiced most of his life in Imperial Rome. He was particularly interested in the condition that we call manic-depressive psychosis. His observations are so exact and deep as to be comparable to the modern views on this disorder. He not only described the symptomatology of manias and melancholias but also saw a connection between the two states. He observed that young people are more susceptible to mania and older people to melancholia, and that, although the two states are related, mania is not always an outcome of melancholia. He seems thus to have anticipated for at least seventeen centuries the contributions of Kraepelin. In certain ways he went even further than Kraepelin, for he felt that spontaneous remissions were not reliable. The intermittent character of the illness was clear to him. He also described very well the religious, guilt-ridden, and self-sacrificing attitudes of the melancholic and the gay and overactive behavior of the manic. He reported how a severe case of melancholia, about whom many physicians were pessimistic, recovered fully after the patient had fallen in love.

Classical Period of Psychiatry

The teachings of Aretaeus were soon forgotten or ignored, and not until 1851 did a French psychiatrist, Falret,[30] again describe the condition and grasp its intermittent and circular character.* Kahlbaum's attempts in 1863 to consider mania and melancholia as two simple states of *vesania typica* (the general form in which he included all functional psychoses, with the exception of paranoia) were not successful.

Kraepelin, who was obviously influenced by the works of Falret and Baillarger (another French psychiatrist who made important studies of this condition, at approximately the time of Falret), studied many patients and conceived the concept of manic-depressive

* According to Cameron,[18] earlier authors grasped the intermittently manic and depressed character of the psychosis. Bonet in 1684, Schacht in 1747, and Herschel in 1768 (all quoted by Cameron).

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psychosis as one syndrome which, in its many varieties, included simple mania, most cases of melancholia, and the periodic and circular insanity. It included also "some cases of amentia" and some affective moods, which, although not of such severe proportions as the previously mentioned disorders, were regarded by him as "rudiments" of the latter. Kraepelin's reason for including all these syndromes in a large nosologic entity was based on the fact that these syndromes, in spite of many external differences (1) have common fundamental features, (2) not only cannot be easily differentiated but may replace each other in the same patient, and (3) have a uniform prognosis. The outcome was thus, for Kraepelin, as important a nosologic characteristic for manic-depressive psychosis as it was for dementia praecox. Kraepelin worked in the field of manic-depressive psychosis for many years, but it was only in the sixth edition of his *Lehrbuch der Psychiatrie*, published in 1899, that he used the term "manic-depressive insanity" and only in the eighth edition (1913) that he fully expanded this nosologic concept.

At first, Kraepelin's concepts were not unanimously or universally accepted. (See, for instance, Tanzi.[91]) Later, however, his concepts were generally accepted, although attempts continue to be made even today to separate the single or recurring depressions from the complete manic-depressive circular syndrome.

THE PSYCHOANALYTIC SCHOOL

We must turn to the psychoanalytic school to find an attempt to go beyond descriptive and nosological concepts. Exceptionally, it is not Freud himself who introduces manic-depressive psychosis into the field of psychoanalysis, but his pupil Abraham. In 1912 Abraham had the original idea of comparing melancholic depression with normal grief. Both conditions are due to a loss that the person has suffered, but, whereas the normal mourner is interested in the lost person, the depressed patient is tormented by guilt feelings. The unconscious hostility that he had for the lost object he now directs toward himself. Abraham also assumed that there was a regression to an ambivalent pregenital stage of object-relationships, that is, a return to an anal-sadistic stage.

Freud,[32] in a paper titled "Mourning and Melancholia," accepted Abraham's ideas that there is a relation between mourning and melancholia and pointed out that, whereas in mourning the object is lost because of death, in melancholia there was an internal loss because the lost person had been incorporated. The sadism present in the ambivalent relationship is then directed against the incorporated love-object. This concept of introjection helped Freud to develop the concepts of ego-ideals and, later, of super-ego. In a subsequent work published in 1921 (*Group Psychology and the Analysis of the Ego*), Freud advanced the idea that in mania there is a fusion between the ego and the super-ego. Thus the energy previously used in the conflict between the two parts of the psyche is now available for enjoyment. Freud also pointed out that this fusion between ego and super-ego may be based on biologically determined cycles (something similar to the cyclic fusion of the ego and id, which periodically occurs every night during the state of sleep).

In later works Abraham[1] confirmed Freud's findings and clearly postulated the factors which are prerequisites for manic-depressive psychosis: (1) a constitutional and inherited overaccentuation of oral erotism; (2) a special fixation of the libido on the oral level; (3) a severe injury to infantile narcissism, brought about by disappointments in love; (4) the occurrence of this disappointment before the Oedipus complex was resolved; and (5) the repetition of the primary disappointment in later life.

After Abraham and Freud, Rado and Melanie Klein have, perhaps, made the most important psychoanalytic contributions to this subject. For Rado,[76,77] "melancholia is a despairing cry for love." The ego tries to punish itself in order to prevent the parental punishment. The patient attempts to repeat the sequence—guilt, atonement, forgiveness—which, according to Rado, is connected with a previous sequence occurring in the infant—wakening rage, hunger, appearance of the mother's breast, and ensuing satisfaction. The excite-

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ment of being nursed by the mother is compared to a sexual orgastic experience, and mania is compared to an oral fusion, an equivalent of the breast situation.

Freud's and Abraham's theories about the incorporation of the object receive further elaboration by Rado. He believes that there is a splitting of the incorporated object: The good part of it, by which the child wants to be accepted and loved, remains in the super-ego, whereas the bad part of it, which the child despises and even wants to kill, becomes part of the ego.

Melanie Klein[50] sees in the infant baby the mechanism which may develop later into full psychosis. She describes the paranoid position and the depressive position. Whereas the first consists of mechanisms by which the child "spits out" or eliminates or projects to others what is unpleasant, the second or depressive position occurs at the time of weaning, that is, around the sixth month of life. The child has an innate fear of death, and the "positions" are defenses to guarantee the survival. Thus, for Melanie Klein, this depressive position is a normal event in the life of every child.* It is the inability adequately to solve this position that presumably leads, later, to the disorder. The mother who before was seen as two persons (one good and one bad) according to Klein is seen as one person; she continues, however, to be internalized as a good or bad object. The child is afraid that his instinctual aggressive impulses will destroy the good object, and interprets the loss of mother's breast and milk at the time of weaning as the result of the destructive impulses.

The Existentialist School

It is difficult in an American textbook to give, within the limits of the assigned space, an adequate account of the contributions of the new existentialist approach to manic-depressive psychosis. Any account presupposes a familiarity with existentialist philosophy, and especially with the works of Heidegger, which most psychiatrists do not have.* Moreover, the interpretation of these writings is not an easy task for those who are not well acquainted with the intricacies of the German philosophical language. A brief resumé will, however, be attempted here.

In the existentialist school, manic-depressive psychosis is not, as a rule, studied as a unit; mania and melancholia are the objects of separate studies. Contrary to what we find in the other schools (particularly in the psychoanalytic schools, where melancholia receives the main consideration), it is mania which has attracted the interest of the existentialists. Binswanger has devoted six long articles to mania. He asks himself the usual existentialist question: What, for the manic, is the way of being in the world? It is a world of festivity, of the victory of the instinct over restraint and inhibitions. It is a world that tends to abolish logic and real difficulties; it is a direct and immediate world, the world of optimism itself. Optimism is a special style of thinking and living. In this way of living the patient becomes big and the world small.

In the flight of ideas, we have three factors —the regression, the play of words, and the logorrhea. Because of the regression, language ceases to be a means of communication and ends by becoming an end in itself, a kind of play at the service of the existential joy (*Daseinsfreude*). Playing has invaded the whole human structure of the manic, and play of words is part of it. The logorrhea manifests a *grossmauling* way of existence.

The ambivalence of the manic-depressive is different from that of the schizophrenic. Whereas the latter may hate and love at the same time, the manic-depressive, at certain periods of time, may only love or hate, although alternately he does both.

Binswanger[14, 15] attributes to the flight of ideas

* This point of view has been sharply criticized by Spitz,[88] who has found infantile depressions (which he calls anaclitic) only in pathological conditions and determined by the fact that the mother was removed from the child between the sixth and eighth months for an approximate period of three months.

Several of Klein's conceptions seem only adult personifications of the infantile psyche. Although these conceptions are thought-provoking, there is nothing to indicate that they relate to the processes or activities of the infant's cerebrum.

* See Chap. 66 of this book for a succinct, comprehensive presentation of the existentialist approach. See also the recent article by Kahn.[45]

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the following characteristics: (1) an affective tone of optimism, (2) a particular way of experiencing space and time, (3) a volatile and confused character of thought and meanings, and (4) the prevalence of projections.

Existential studies of depressions have been made by Le Mappian[59] and by Ey.[28] For these authors, as well as for other existentialists, the depressed state is constituted by an arrest or insufficiency of all the vital activities. It is a "pathetic immobility, a suspension of existence, a syncope of time" according to Ey. As a consequence, the patient experiences a feeling of incompleteness, of unreality, and of impotence; a special, inhibitory way of living then ensues. Most authors emphasize the particular attitude of the patient toward time. Only the past counts; it extends into the present to torture the patient and to remind him of his guilt, his unworthiness, and his inability to accomplish. "Time was lost," the future is not even contemplated. Sommer,[88] quoted by Roi,[82] points out how the patient, although self-accusatory, does not want to repair; he wants to be punished.

The studies of the existentialist authors give us a more accurate account of the uniqueness of the subjective experiences of the patient, permitting us to become more aware of their particular ways of living and offering an enrichment of the understanding obtained by the dynamic, sociocultural, and formal approaches.

¶ The Manifest Symptomatology of Manic-Depressive Psychosis*

Manic-depressive psychosis manifests itself with recurring attacks of depression and of manic elation in various forms and cycles. We shall take into consideration (1) the depression, (2) the manic attack, (3) the course of the disorder, and (4) the diagnostic criteria.

* This section will be relatively short in comparison to corresponding sections in other textbooks of psychiatry. Kraepelin devoted 206 pages of his monograph to the description of all the varieties of the disorder. This is not feasible any longer in a modern textbook of psychiatry, where an attempt is made to focus the interest of the reader also on other aspects of the problem.

Depressions

Depressions are characterized by the following triad of psychological symptoms: (1) a pervading feeling of melancholia; (2) a disorder of thought processes, characterized by retardation and unusual content, and (3) psychomotor retardation. In addition, there are accessory somatic dysfunctions.

The pervading mood of depression at times has its onset quite acutely and dramatically, at other times slowly and insidiously. The patient generally had previous attacks of depression which, because they were mild in intensity, passed unnoticed or were considered by the patient and his family as normal variations of mood. Even the psychotic attack is misunderstood at first. An unpleasant event, such as the death of a close relative or a grief of any kind, has occurred, and a certain amount of depression is justified. When, however, a certain period of time has elapsed and the depressed mood should have subsided, it seems instead to become more intense. The patient complains that he cannot think freely, feels unable to work, cannot eat, and sleeps only a few hours a night.

As the symptoms increase in intensity, the patient himself may request to be taken to a physician; often, however, the illness is advanced to such a degree that the patient is no longer able to make such a decision and he has to consult a physician at the initiative of the members of the family. When the patient is seen by the physician, the latter is impressed by his unhappy, sad appearance. He looks older than his age, his forehead is wrinkled, and his face, although undergoing very little mimic play, reveals a despondent mood. In some cases the main fold of the upper lid at the edges of its inner third is contracted upward and a little backward (sign of Veraguth).

In most cases the examiner is often taken astray by the complaints of the patient, which consist of physical pain, a feeling of discomfort, digestive difficulties, lack of appetite, and insomnia. The physician may interpret these complaints as simple psychosomatic dysfunctions; in the majority of cases, however, the

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mood of melancholia is prominent and leads to an easy diagnosis.

The patient is often at a loss in describing the experience of melancholia. He says that his chest is heavy, his body is numb; he would like to sleep but he cannot; he would like to immerse himself in activities, but he cannot; he would even like to cry, but he cannot. "The eyes have consumed all the tears." "Life is a torment." There is at the same time a desire to punish oneself by destroying oneself, and at the same time to end one's suffering. Suicidal ideas occur in about 75 per cent of patients, and actual suicide attempts are made by at least 10 to 15 per cent. Often the suicide attempt occurs when it is not expected, because the patient seems to have made some improvement, as the depression is less pronounced (see p. 438). In a minority of suicide attempts, the suicidal idea was carefully concealed from the members of the family. The desire to end life applies only to the life of the patient himself, with one important exception, to be kept in mind always: young mothers who undergo psychotic depressions often plan to destroy not only themselves but their children, who are presumably considered by the patient as an extension of herself. Newspaper reports about mothers who have killed themselves and their little children in most cases refer to patients suffering from unrecognized attacks of manic-depressive psychosis.

The other important symptom of depression concerns the content and type of thinking. As far as the content is concerned, the thoughts of the patient are characterized by gloomy, morbid ideas. In some cases, at the beginning of the attack, ideas occur which cannot be recognized as part of the ensuing picture of psychotic depression. They seem to be neurotic obsessions, phobias, what the patient calls "unclean thoughts." They are followed by discouraging ideas which acquire more and more prominence. The patient feels that he will not be able to work, he will lose his money, something bad will happen to his family, somebody is going to get hurt, or the family is in extreme poverty. There is no great variety in the patient's thoughts. It is almost as if the patient purposely selects the thoughts which have an unpleasant content. *They are not thoughts as thoughts; they are chiefly carriers of mental pain.* The distortion caused by the unpleasantness of the mood at times transforms these melancholic thoughts into almost delusional ideas or definite delusions. They often represent distortions of the body-image and hypochondriasis. The patient thinks he has cancer, tuberculosis, syphilis, etc. His brain is melting, his bowels have been lost, the heart does not beat, etc. Delusions of poverty are also common. Ideas of guilt, sin, and self-condemnation are very pronounced, especially in serious cases. At times these self-accusatory ideas are so unrealistic that the name "delusion" seems appropriate for them. "It is all my fault," "It is all my responsibility." In some cases the tendency to blame oneself reaches the absurd; the patient blames himself for being sick or for "succumbing to the illness." In some cases he feels that he is not really sick but acts as if he would be sick. This impression is almost the opposite to that which we find in some schizophrenics. In the latter there is the idea that what happens in the world is an act, a play, the world is a big stage. The depressed patient, on the contrary, feels that he is acting the part of the sick person. This idea, incidentally, occurs generally when the patient starts to recover from the depressed attack.

These delusional ideas cannot always be traced back to an exaggeration or distortion of mood. In cases that have a mixed paranoid and melancholic symptomatology, the delusions are more inappropriate and bizarre and are in no way distinguishable from those of paranoid patients.

Together with this peculiar content of thought, there is retardation of thinking processes. The patient complains that he cannot concentrate, he cannot focus his attention. At first he can read but cannot retain what he reads. Writing is more difficult for him because composing a letter requires tremendous effort. If the patient was a student, he cannot study any longer. Thoughts seem to follow each other at a very slow pace. Talk is also slow. In a severe state of stupor the patient cannot talk at all.

Hallucinations are described by many authors in manic-depressive psychosis, especially

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in the old textbooks. According to the experience of many psychiatrists, however, they are much less common in manic-depressive psychosis than they used to be. This difference is not apparent, in the sense that patients who hallucinate are now diagnosed as schizophrenics. According to the present author, hallucinations do occur in some severely depressed patients. They have the following characteristics:

1. They are relatively rare in comparison to their occurrences in schizophrenia.
2. They do not have the distinct perceptual and auditory quality that they have in schizophrenia. The patients often cannot repeat what the voices say; they sound indistinct. The patients describe them as "as if rocks would fall," or as "bells which ring," etc. Often they seem more illusions than hallucinations, or as transformations of actual perceptions.
3. Much more easily than in schizophrenia, they can be related to the prevailing mood of the patient. Their secondary character, that is, secondary to the overall mood, is obvious. They are generally depressive in content, and denigratory, often commanding self-destruction or injury.
4. More frequently than in schizophrenic patients, they seem to occur at night; more seldom during the day. The manic-depressive, who is more in contact with external reality than the schizophrenic, possibly needs the removal of diurnal stimuli in order to become aware of these inner phenomena.

The third important sign of depression consists of retarded hypoactivity. The actions of the patient decrease in number, and even those which are carried out are very slow. Even the perceptions are retarded. Talking is reduced to a minimum, although a minority of patients retain the tendency to be loquacious. Solving of the usual small daily tasks of life is postponed or retarded. The patient avoids doing many things but continues to do what is essential. Women neglect their housework and their appearance, discontinue the use of lipstick and powder, and always wear the same dress. Every change seems a tremendous effort. Interpersonal relations are cut off. In some mild cases, however, the opposite seems to occur at first. The patient, who is prone to accuse himself and extoll others, becomes more affectionate toward the members of the family and willing to do many things for them in an unselfish manner. Later, however, when the disorder increases in intensity, he becomes indifferent to everybody.

The accessory physical symptoms that accompany depressive attacks are reduction in sleep, decrease in appetite, and considerable loss in weight. These symptoms do not seem to be due to a specific or direct physiological mechanism, but rather are related to, or a consequence of, the depression. Many patients complain of dryness of the mouth, which is to be attributed to decreased secretion of the parotid glands.[90]

Other frequent symptoms are backache and amenorrhea. There is a definite decrease in sexual desire, often to the point of complete impotence or frigidity. In many patients sugar is found in the urine during the attack. The basal metabolism tends to be slightly lower than normal. Kennedy[49] believes that in many patients the symptomatology consists almost exclusively of these somatic dysfunctions. He calls these syndromes "manic-depressive equivalents."

The above are the fundamental symptoms found in depression. The early authors have described with great accuracy and at great length several varieties of depression. It will be sufficient to give a brief description here of the main types, which are still accepted.

Simple Depression

Simple depression is characterized by a relative mildness of the symptoms. Neurotic symptoms may be prominent and may make the diagnosis of psychosis difficult. Delusions and hallucinations are absent. Although retarded, the patient is able to take care of the basic vital needs. Suicidal ideas and attempts, however, occur in this type too. In recent years cases of simple depression seem to have increased in number, relative to the total incidence of manic-depressive psychosis.

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Acute Depression

In acute depression the symptoms are much more pronounced. Self-accusation and ideas of sin and poverty are prominent. Some depressive ideas, bordering on delusions, are present. Hallucinations may occur in some cases. The loss of weight is very marked.

Paranoid Depression

In paranoid depression, although the prominent feature remains the depressed mood, delusional ideas play an important role. The patient feels that he is watched, spied on, or threatened. Somebody wants to hurt him. Hypochondriacal delusions with pronounced distortion of the body-image may occur. As in the case of hallucinations, these delusions seem secondary to the prevailing mood of the patient. They disappear easily when the mood changes. Hallucinations may also occur.

Depressive Stupor

Depressive stupor is the most pronounced form of depression. Here there is more than retardation: the movements are definitely inhibited or suppressed. The patients are so absorbed in their own pervading feeling of depression that they cannot focus their attention on their surroundings. They do not seem to hear; they do not respond. They are mute, with the exception of some occasional utterances. Since they cannot focus on anything, they give the impression of being apathetic, whereas they are actually the prey of a deep, disturbing emotion. These patients cannot take care of themselves. Generally, they lie in bed mute, and have to be spoon-fed.

Unless they are successfully treated during the attack, physical health may suffer severely. They lose up to a hundred pounds in certain cases; they are constipated, and their circulation is enfeebled.

The Manic Attack

In the manic attack, as in depression, the symptomatology is characterized by: (1) a change in mood, which is one of elation; (2) a disorder of thought processes, characterized by flight of ideas and happy content; and (3) an increased mobility. Accessory bodily changes also occur.

It is difficult in many instances to determine the beginning of an attack. The patient is often in a lively mood. His personality is described as that of an extrovert, active individual who likes to talk a lot and do many things. At the time of the attack, however, the overjoyousness of the patient seems somewhat out of proportion, occasionally even inappropriate, as, for instance, when he easily dismisses things which should make him sad and continues to be in his happy mood. The patient seems exuberant, very sociable, and, at times, even succeeds in transmitting his happiness to the surrounding persons. This mood, however, does not seem to be a constant or solid one. We are not referring here to the alternations with depression but to the fact that this euphoric mood may easily change into one of irritation, or even rage and anger, especially when the patient sees that the environment does not respond to his enthusiasm or does not react in accordance with the exalted opinion that he has of himself.

The thinking disorder is prominent and reveals itself in the verbal productions of the patient. The patient talks very fast, and cannot concentrate on any subject for more than a few seconds. Any marginal idea is expressed; any secondary distracting stimulus is allowed to affect the patient. The thoughts expressed are not disconnected but maintain some apparent ties. We can always determine that the individual ideas are connected by the elementary laws of associations, but the talk as a whole is verbose, circumstantial, not directed toward any goal or toward the logical demonstration of any point which is discussed. The ensemble of these thought and language alterations is what we call "flight of ideas."

Actually, this type of verbal behavior has a goal—that of maintaining this superficial effervescent euphoria and of escaping from intruding thoughts which may bring about depression. In not too-pronounced cases the patient realizes that he unduly allows details to interfere with the original goal of his conversation and tries to go back to it, but again he is lost in many details.

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In this incessant logorrhea, the patient makes jokes. The propensity toward associations leads to repeated clang associations, which the patient uses to make jokes, puns, etc.[5] In some rare cases the lack of thought inhibition facilitates a certain artistic propensity, which does not, however, lead to achievement because of the lack of concentration.

Lorenz and Cobb[64] and Lorenz,[63] who have made an accurate study of speech in manic patients, report that in manic speech there is a quantitative change in the use of certain speech elements, namely: (1) a relative increase in the use of pronouns and verbs, (2) a relative decrease in the use of adjectives and prepositions, and (3) a high verb-adjective quotient (that is, the proportion of adjectives is decreased). These authors found no gross disorganization at the level of structural elements and postulated that the defect in manic speech occurs at higher integrative levels of language formulation. They conclude that, "If the assumption of a correlation between emotional states and verb-adjective quotient is correct, the manic patient's speech gives objective evidence of a heightened degree of anxiety."

The rapid association ability that the manic possesses enables him to grasp immediately some aspects of the environment which otherwise would pass unnoticed. The patient is in the paradoxical situation in which his ability to observe and grasp environmental stimuli has increased, but he cannot make use of it because of his distractibility.

The content of thought often reveals an exalted opinion of himself. The patient may boast that he is very rich, a great lover, a famous actor, a prominent businessman, etc. These statements receive flimsy support. When asked to prove them, the patient attempts to do so but is soon lost in a web of unnecessary details. If he is reminded of the goal of the conversation, he may become excitable. Disturbances of the sensorium are generally of minimal intensity and are caused by the exalted mood or distractibility rather than by intellectual impairment.

The motor activity is increased. The patients are always on the go. They are in a state that ranges from wild motor excitement to incessant activity. They talk, they sing, they dance, they tease, destroy, move objects, etc. In severe states these actions or movements remain unfinished, purposeless. In spite of this constant activity, the patients do not feel tired and have tremendous endurance.

Accessory somatic symptoms consist in loss of weight, generally not as pronounced as in depression, decrease in appetite, and constipation. Insomnia is marked. The blood pressure is generally lowered. Menstruations are irregular. Sexual functions, although apparently increased in hypomanic states, are generally decreased or disturbed in various ways.

As in the states of depression, many forms of manic states have been described by the early authors. Following is a brief description of them:

HYPOMANIA

In hypomania the symptoms are not of a marked intensity. As mentioned before, it is difficult, at times, to say whether what the patient shows is his usual "extrovert" personality or the beginning of the illness. He seems full of pep and in a good humor. He wants to do a lot of things. His verbal abilities are accentuated. Although he always had a talent for foreign languages, now he speaks many of them without hesitation, unconcerned with the mistakes he may make. Some of these patients increase their activities to such an exaggerated degree as to show very poor judgment. Actually, they do so compelled by their inner excitability and by their exalted mood. They may walk for miles and miles. Generally, they have a goal (for instance, to reach the next village) but not a necessary one. They may send out hundreds of unnecessary letters or greeting cards and make a large number of lengthy telephone calls. They often go on spending sprees, with disastrous economic consequences. The sexual activity is increased, and lack of control may bring about unpleasant results. Illegitimate pregnancies in hypomanic women and venereal diseases in hypomanic men and women are relatively common.

The excitability, richness of movements, and euphoric mood give a bizarre flavor to the behavior. A female patient, in order to show a

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sore to a physician, completely undressed in front of him. Occasionally, even thefts and fraudulent acts are committed. The patient retains the ability to rationalize his actions, at times to such an extent that the layman is confused and believes in the patient's sanity.

Acute Mania

In acute mania the symptoms are much more pronounced. They may have become marked gradually, from a previously hypomanic state, or rapidly, from a normal condition. The patient is in a state of such extreme restlessness that his behavior may be very disturbing and difficult to control. He may disrupt theatrical audiences, sing or scream in the street, or ring bells. If an attempt is made to control him, he may become belligerent. The mood is one of such exaltation that spontaneous thoughts of self-aggrandizement are immediately accepted. The patient believes herself to be the Virgin Mary, a new personification of Christ, etc.

A subtype, which Kraepelin differentiated from acute mania, is delusional mania, characterized by an abundance of grandiose delusional ideas reminiscent of those found in the expansive type of general paresis.

Delirious Mania

Delirious mania represents an extreme stage of excitement. The patient is incoherent, disoriented, restless, and agitated. He may easily injure himself and others in his aimless activity. Restraint, chemical or physical, is an absolute necessity to avoid exhaustion which may lead to death. Hallucinations and delusions are frequent.

Mixed States

In addition to the above-mentioned types, Kraepelin has described "mixed states" which are characterized by a combination of manic and depressive symptoms. He distinguished the following six principal types: (1) manic stupor; (2) agitated depression; (3) unproductive mania; (4) depressive mania; (5) depression, with flight of ideas, and; (6) akinetic mania.

The names given to these types indicate the combinations of the chief symptoms. Of the six types the most common is, perhaps, agitated depression. In this condition a motor restlessness, more typical of a manic excitement, is superimposed on a markedly depressive symptomatology.

Course

Although the various types of manic-depressive psychoses have been described as if they were separate entities, all the types are related, as Kraepelin saw when he formulated the large nosological concept of manic-depressive psychosis.

The melancholic attack and the manic, which at first sight seem so different, have an intrinsic similarity. In fact, the same mental functions are altered, although the alterations are, in a certain way, opposite. Whereas in depression the mood is one of melancholia, in the manic attack it is one of elation; whereas in depression the thought processes and motor activity are retarded, in the manic attack one finds a flight of ideas and increased motility.

One of the main characteristics of manic-depressive psychosis is the recurrence of the attacks, which has conferred to the disorder the designation, often used in Europe, "intermittent psychosis."

The attack may occur in different successions, which old books of psychiatry described at great length and with many illustrations (which represented the manic attack as a positive wave and the depression as a negative wave). If we have a sequence of a manic and a depressed attack (or an attack of depression followed by a manic one) we have the typical circular psychosis. We may observe, however, that the attacks of depression far outnumber those of mania. Some patients may undergo a conspicuous number of depressions without ever having a manic attack.

There seems to be no relation between the duration of the attack and the normal intervals. At times, short attacks recur several times in short succession, but not seldom the series is interrupted by a long interval. I have seen several cases in which an attack of depression in the early twenties was not followed by a second one until the patient had reached his middle sixties or even the seventies. Many

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attacks of depression, which occur later in life and which by many authors are considered as a subtype of senile psychosis, must be considered, instead, as late occurrences or relapses of manic-depressive psychosis, as Kraepelin illustrated. This fact has been confirmed recently by the recovery that these patients make as a result of convulsive electric treatment; the genuine senile patients do not improve.

According to Pollock, 58.1 per cent of patients have only one attack; 26.1 per cent have two attacks; 9.3 per cent have three attacks, and 6.5 per cent more than three. Occasionally, one finds a patient who had even 25 or more attacks.

The age at which the first attack occurs varies. It may happen in childhood in rare cases. By far the largest number of first attacks occur between the ages of twenty and thirty-five. Manic attacks are slightly more frequent between ages twenty and forty. After forty their ratio to depressive attacks decreases further. Women are more susceptible to this psychosis than men. (About 70 per cent of patients are women.)

The illness generally results in recovery as far as the individual attack is concerned. Repeated attacks usually cause very little intellectual impairment. Death, however may occur in two instances: suicide in depression, and exhaustion, or cardiac insufficiency, in cases of delirious mania. Another situation, which seems to increase in frequency and which we shall discuss again later, is the change of the manic-depressive symptomatology into a schizophrenic one, either shortly after the onset of the illness or even after many years of hospitalization.*

Prognostic criteria as to the future course of the condition are very difficult when the patient is examined only from the point of view of the manifest symptomatology. Contrary to what happens in schizophrenia, the manifest symptomatology of manic-depressive psychosis will rarely permit prediction as to whether the patient will have only the present attack, a few, or many in his lifetime. The prognosis is almost always good as to the individual attack but is uncertain as to the possibility of recurrence. Rennie,[78] in an accurate statistical study, found that the prognosis is worse when attacks occur after the age of forty. He found that 79 per cent of all patients have a second attack, 63.5 per cent a third, and 45 per cent a fourth. The more frequent the attacks, the worse is the prognosis.

* There are many psychiatrists who would deny such a statement. They feel that if a manic-depressive seems later to become schizophrenic it is because the right diagnosis (schizophrenia) was not made. At the present time, the prevalent opinion of people who have worked for many years in the same hospital is that some patients who once presented what appeared to be a typical manic-depressive symptomatology later disclose a typical schizophrenic symptomatology. This point of view, of course, does not exclude the possibility of wrong diagnosis being made in some cases, especially during the first psychotic attack.

Diagnostic Criteria

Typical cases of manic-depressive psychosis are generally easy to diagnose, even if the examination is limited to the study of the manifest symptoms, although the beginner may have some difficulties in some cases.

An elderly man, who has lost a lot of weight, is depressed, and complains that he may have cancer, may be mistaken for a manic-depressive when actually he really has some sort of malignancy with reactive depression. An accurate physical examination will determine the condition. In psychiatric practice, however, the opposite occurrence is more common: an elderly patient has lost weight, has many hypochondriacal complaints, fear of cancer, and is depressed. Negative physical findings, retardation, and insomnia, as well as the past history will generally determine that he is suffering from a depression.

Some patients, who are very retarded, have lost accessory movements, and present a mask-like expression of their faces, are occasionally confused with postencephalitics. Manic states may be confused with the following conditions:

1. Psychomotor epilepsy. Epilectic exaltation is impulsive but is deprived of elation. Furthermore, the electroencephalogram will lead to an easy diagnosis.
2. Toxic deliriums (or amential states). The wealth of disconnected hallucinations and the poverty of external perceptions (or of reactivity to the environment) will lead to recognition of the delirium.

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3. General paresis. The physical symptoms of general paresis, and the serological findings, will lead to a diagnosis. Moreover, in the paretic the sensorium is more defective and the actions and thoughts are more incongruous than the degree of exaltation would permit, and superficial delusions more numerous.
4. Catatonic excitement. The excitement precedes or follows the catatonic state. The actions are more aimless and absurd and deprived of any feeling of guilt, the mood is more incongruous and inappropriate, and hostility toward others is more pronounced.
5. Attack of exaltation occurring in any mental diseases, including mental deficiency. The subsequent course will reveal the correct diagnosis.

For a differential diagnosis with involutional psychosis, see Chap. 26; with reactive depression, see Chap. 18.

¶ Psychodynamic Mechanisms

The characteristics that we have described in the previous section constitute the obvious or manifest aspects of processes of a much more subtle nature which were going on for a long time.

Because relatively few patients are found in those areas of the world where there is a considerable number of psychodynamically trained psychiatrists who are willing to study these cases (see pp. 440–443) and because psychotherapy of a manic-depressive patient presents great difficulties in a large number of cases (even greater than those presented by schizophrenic patients), our knowledge of the psychodynamics of these cases is still fragmentary. Some fundamental factors, however, seem to stand out sufficiently to permit us to explain grossly some of the most common mechanisms.

The Childhood of the Manic-Depressive Patient

From the information obtained by this author and others from patients and their families, it seems a fairly well-established fact that the early childhood (at least the first year of life) of the future manic-depressive patient has not been so traumatic as those of people who tend to become schizophrenics or even seriously neurotic.

The future manic-depressive is generally born in a home which is willing to accept him and to care for him. The word "accept" has a special meaning here: the mother is duty-bound and willing to administer to the baby as much care as he requires; she is willing to provide for him everything that he needs. This willingness of the mother is, in turn, accepted by the child, who is willing to accept everything he is offered; that is, early in life the child appears very receptive to the influence (or giving) of the significant adult (parent). There are no manifestations of resistance toward accepting this influence, as, for instance, autistic manifestations or attempts to prevent or retard socialization, as one finds in schizophrenia.[4] If we use Martin Buber's terminology, we may say that the "Thou," that is, the other, is immediately accepted and introjected. The Thou is at first the mother, but this receptivity to the mother enhances a receptivity for both parents and all the important surrounding adults and promotes a willingness to accept them with their symbols and their values. It promotes also a certain readiness to accept their food (either the milk of the mother or regular food) and thus predisposes some people (but by no means all) to overeating, obesity, and the seeking of compensation in food when other satisfactions are not available.

This receptiveness to the others and willingness to introject the others determines, at this early age, some aspects of the personality of the patient. He tends to become an "extrovert"; at the same time he tends to be a conformist, willing to accept what he is given by his surroundings (not only in material things but also in terms of habits and values) and to rely less than the average person on his own resources or on his own interpretation and evaluation of the external world. This readiness to accept, this psychological receptivity, will predispose him also to pathological (or exaggerated) introjection.

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In the second year of life (earlier, according to some authors), a new attitude on the part of the mother drastically changes the environment in which the child was growing and exposes him to a severe trauma. The mother will continue to take care of the child, but considerably less than before, and now she makes many demands on him. The child will receive care and affection provided he accepts the expectations that the parents have for him and tries to live up to them.

This brusque change in the parents' attitude is generally the result of many things: predominantly, their attitude toward life in general tends to evoke in the child an early sense of duty and responsibility—what is to be obtained is to be deserved. The parents are generally dissatisfied with their own life and harbor resentment, at times, toward the children, who represent increased work and responsibility. This hostility, however, is seldom manifested openly; generally, it is manifested by the fact that the parents increase their expectations too much.

Thus, the child finds himself changed from an environment which predisposes to great receptivity to one of great expectation. These dissimilar environments are actually determined by a common factor: the strong sense of duty that compelled the mother to do so much for the baby is now transmitted at an early age to the child. Generally, the families of manic-depressive patients have many children, and often, when the future manic-depressive patient is in his second year of life, a sibling is already born and the mother is now lavishing her care on the newborn with the same duty-bound generosity that she previously had for the patient. This, of course, makes the change in the environment more marked for the patient.

This displacement by a younger sibling seems to be important in the dynamics of manic-depressive psychosis, although, again, no statistical proof of it can be given.* Statistical studies have so far concerned themselves more with the order of birth (that is, whether the patient is the first-born child, second-born, etc.).*

For many patients, but not for all, the abrupt change that we have described has already taken place at the time of weaning. Premanic-depressive patients are generally breast-fed in their infancy and then suddenly deprived of mother's milk. No bottles, no rubber nipples, and no pacifiers are used. There is a sharp transition from the breast to the glass. In a minority of manic-depressive patients, this loss of the breast plays an important role, as we shall see later.

How does the child try to adjust to the new threatening situation? The predominant mechanism by which he finds security is acceptance of parental expectations. He does not reject the parents emotionally, or avoid them (as the schizoid often does), but consciously accepts them. He must live up to their expectations no matter how heavy the burden. It is only by complying, obeying, and working hard that he will recapture the love or state of bliss which he used to have as a baby, or will at least maintain that moderate love which he is receiving now. Love is still available, but not as a steady flow. The flow is intermittent, conditioned, and therefore does not confer security. The child feels that if he does not do what he is supposed to, he will be punished: mother may withdraw her love totally. At the same time that the anxiety of losing mother's love sets in, hope is given to the child that he will be able to retain this love, or to recapture it if and when it is lost. The child is thus given the illusion that he has a choice, that he has the freedom of retaining the parental love or not. There is also the implication that mother is not bad, in spite of her appearance, but, on the contrary, that she is good. She is good even in punishing him, because

* I have observed this displacement by a sibling to be an important factor also in the psychodynamics of milder depressions, which cannot be classified as cases of manic-depressive psychosis.

* Some statistical works seem, however, to indicate that the first-born child is more liable to manic-depressive psychosis. Of course, the first-born is more liable also to be displaced. Berman,[13] in a study of 100 manic-depressives, found that 48 were first-born, 15 second, 10 each third and fourth, and 17 fifth or later. Pollock and co-workers[79] found that 39.7 per cent were first-born and 29.7 per cent were second-born. Malzberg[68] and Katz[48] could not find any relationship between birth order and manic-depressive psychosis.

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by punishing him she wants to redeem him, make him again worthy of her love. Thus the mechanism is different from that occurring in many preschizophrenics; although the pre-manic-depressive has an image of himself as bad, he does not feel that he is beyond the possibility of redemption, as, instead, the preschizophrenic often feels. The anxiety about being unable to fulfill parental expectations changes into guilt feelings. If affection or forgiveness is not forthcoming, the child feels that it is his own fault; he has not lived up to what was expected of him, and he feels guilty. When he feels guilty, he again expects punishment. He wants to be punished, because punishment is the lesser of the evils. He'd rather be punished than lose mother's love. If he is not punished, he often works harder in order to punish himself.

A little later, but still at a very early age, many of these children assume responsibilities such as the support of the family. If they engage in a career, it is often in order to bring honor and prestige to the family. In a relatively large number of cases, the family belongs to a "marginal" group of society because of religious or ethnic minority status, and the child feels that it is his duty to rescue the family with his own achievement.

In addition, in several patients incestuous wishes toward parents and, as frequently, toward siblings of opposite sex elicit strong guilt feelings which the patient feels must be atoned.

Other facts make the picture more complicated and difficult to understand, for instance the impression often received that the parents of several patients seem not strict but overindulgent. This is due to the fact that, in this second stage of childhood, the parents do not need to enforce any rules with their actions. The rules, the principles, have already been incorporated by the patient. As a matter of fact, some of the parents now regret that the children take rules with such seriousness.

The parents of the patient generally give a picture of cohesiveness and stability. There is no serious talk of divorce; the family seems on stable ground, reinforced by the conventions of society. Those family conflicts or schisms described in schizophrenia are not seen as frequently in the family of manic-depressive patients.

In addition to the mechanism of accepting parental expectations, two other mechanisms occur. The second is just as common as, and in a certain way a part of, the first. At the same time that the child accepts the parent or parent-substitute and tries to live up to her expectations, he harbors a strong resentment against this parental figure who has made so many impositions. Such resentment manifests itself in attacks of rage, rebellion, or even violence. Generally, however, these feelings are promptly checked and repressed, not only in childhood but throughout the life of the patient. Sadistic thoughts and impulses are, at times, very pronounced but seldom acted out. Together with the consequent guilt feelings brought about by these impulses are feelings of unworthiness and depression. The patient soon learns that rebellion does not pay; on the contrary, it increases the atonement he must undergo later. The stronger his sadistic impulses, the stronger become the masochistic tendencies. He soon desires peace at any cost; any compromise is worthy of peace. The mechanism which will permit him to maintain a certain equilibrium is the repression of this resentment. The resentment is, however, retained unconsciously, as it appears from dreams and occasional outbursts which reach consciousness.

A third dynamic mechanism which is found in many, but not all, cases of manic-depressive psychosis is the following:

The child senses that the acceptance or introjection of parents is too much of a burden and, without realizing it, shifts the directions of his incorporations: other adults in the environment (much older siblings, uncles, aunts, grandparents, friends, etc.) tend then to be internalized instead of the parents. Not only is the common tendency of children to introject adults here exaggerated, but peripheral adults become parentlike figures. The child unconsciously resorts to this mechanism in order to decrease the burden of the parental introjection, but in many cases this defense does not prove useful. As Fromm-Reichmann[35]

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remarked, there will be no single significant adult to whom the patient will be able to relate in a meaningful way. The relationship with these other grownups again is determined by a utilitarian purpose, duty, or role. The introjection of such adults eventually fails to provide what is needed and may end by confusing the child (how can he satisfy all the adults?) and increasing his burden and feeling of guilt.

Here again, it is interesting to note the difference from the psychodynamics of schizophrenia. The preschizophrenic does not try to introject other parental figures but, on the contrary, often projects to these substitute parental figures (who later will become the persecutors) the bad qualities of the parents.

Prepsychotic Personality

This strong tendency of the premanic-depressive to introject parental figures will also produce strong feelings of patriotism, religiosity, and loyalty to a political party, to the church, to the country. Patients often wish to have a military or ecclesiastic career. These organizations are not parent-substitutes but additional parents. Group loyalty and *esprit de corps* play an important part in the psychological constellation of these people. Actually, under the pretense of belonging to a group, to a close-knit family, or to an organization, the individual hides his loneliness.

In many cases we find a self-conscious individual, always motivated by duty, of the type of personality Riesman[81] has called "inner-directed." He is not a creative person, because he is too much of an imitator, but what he tries to do, he does well. He has deep convictions, and his life is motivated by principles. He must be a dedicated person. He is generally efficient, and people who do not know him too well have the impression that he is a well-adjusted, untroubled individual. On the contrary, he is not a happy man. He selects a mate not because he loves her but because she "needs" him. Later, he will never divorce the mate because she is in terrible need of him. At the same time, he blames himself for being so egotistic as to think that he is indispensable. The necessity to please others and to act in accordance with the expectations of others, or in accordance with the principles that he has accepted, makes him unable really to get in touch with himself. He does not listen to his own wishes; he does not know what it means to be himself. He works incessantly and yet has feelings of futility and emptiness. At times, he conceals his unhappiness by considering what he has accomplished, just as he conceals his loneliness by thinking of the group to which he belongs. But when he allows himself to experience these feelings of unhappiness, futility, and unfulfillment, he misinterprets them again. He tends to believe that he is to be blamed for them. If he is unhappy, if he finds no purpose in life, it must be his fault, or he must not be worthy of anything else. A vicious circle is thus established which repeats itself and increases in intensity, often throughout the life of the patient, unless fortunate circumstances or psychotherapy intervene.

The patient often has partial insight into his own mechanisms but does not know how to solve them. For instance, he is willing to accept the role in the family and in society which has been assigned to him, and yet later he scolds himself for playing this role, for not being spontaneous. But if he tries to refuse the role, he has guilt feelings. The conclusion is that no matter how he tries to solve his problems, he will feel he has made the wrong choice. A female patient told me that she "felt like a little girl who pretends to be grown up but is not. I am acting." But she must live in that way; that's her duty. It is her fault that she "acts" and does not accept social behavior as spontaneous or real life.

The patient also tends to put his superiors or teachers in a parental authoritarian role. Again, and quite often, he feels angry at them as they seem to expect too much, or they themselves have been found at fault. The patient does not know how to act: Should he continue to accept the authority of these people and the burden that this acceptance implies, or should he remove them from the pedestal? But if he removes them, a void will be left. His authorities are part of him, of

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his values, and of the symbolic world upon which he sustains himself, and to do without them is impossible. Furthermore, he would feel very guilty. The patient often realizes (as Cohen and co-workers have clearly illustrated[22]) that he tends to underestimate himself. It is his "duty" to "undersell" himself. On the other hand, he tends to blame himself for underestimating himself and giving himself no chance to develop his own talents and potential abilities.

Another variety of prepsychotic personality is the dependent type. Contrary to the persons described above, this type includes people who, even at a superficial examination, appear maladjusted. These patients have never forgotten the bliss of the first year of life and still expect or demand a continuation of it. They demand and expect from others, feel deprived and sad when they do not get what they expect. They are demanding but not aggressive in the usual sense of the word, because they do not try to get what they want through their own efforts; they *expect* it from others. Somehow, they have not developed that complex of duty and hard work typical of the accepting, introjecting patient.

These patients alternate between feeling guilty and having the desire to make other people feel guilty. They generally find one person on whom to depend, and they make this other person feel guilty if he does not do what the patient wants. The sustaining person (generally the spouse) is empowered with the capacity to make the patient happy or unhappy and is supposed to be responsible for the despair and helplessness of the patient. Relatively often we find in this group women who depend entirely on their husbands, who are generally much older.

A third type of prepsychotic personality, the forerunner of the manic, is lively, active, hearty, and friendly. On closer scrutiny, the apparent health and liveliness are found to be superficial. In a certain way the patient actually escapes into actions or into reality but remains shallow and dissatisfied. If he happens to be engaged in work in which not concentration but action is required, he may do well and maintain a satisfactory level of adjustment; otherwise, he may sooner or later get into trouble. He claims that he has many friends, but, although the interpersonal relations seem warm and sincere, they are superficial and lack real kinship. One patient said, "I joke, I laugh, I pretend; I appear radiant and alive, but deep down I am lonely and empty." This type of person is, only in certain respects, the opposite of the duty-bound individual. He tries to escape from his inner directions, but he does not correspond to what Riesman has called the "other-directed" person. Imitating Riesman's terminology, we could call this hypomaniclike person "outer-directed" but not "other-directed." He does not escape into others, he escapes *from* his inner self (because the inner self has incorporated the burdening others).* He escapes into the world of superficial reality where meditations, reflections, or deep emotions are unnecessary. Such an individual may, at times, seem so free as to be considered psychopathic. Actually, his deep concern with conventional morality often necessitates this pseudopsychopathic escape. Some of the pseudopsychopathic hypomanics have shown asocial behavior since childhood, when, for example, in order to escape from inner and external restrictions, they run away from home or school.

The above-described prepsychotic manic-depressive personality types are seldom seen in pure culture.

Precipitating Factors

The three types of personality that we have described lead not to a stable equilibrium but to an almost constant state of dissatisfaction and mild depression (or hypomanic denial of depression). In this unstable background, we generally find precipitative factors which bring about the full-fledged psychosis.

These precipating situations may be classified into three categories: (1) the death of a person important to the patient, (2) the realization on the part of the patient of the failure of an important interpersonal relationship (generally with the spouse), and (3) a severe

* As we shall see later (p. 446), he does make an attempt to contact others but not to integrate with them.

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disappointment in a relationship to an institution or work to which the patient had devoted his whole life.

It is obvious that these situations are considered separately for didactic reasons, but actually may be reduced to a single cause: the loss of a valued object. At times, although the loss has not yet occurred, the fact that it is impending is so certain that the patient experiences depression rather than anxiety. Anxiety is the emotion associated with the expectancy of danger; depression is the emotion associated with the experience of loss—the dangerous event has already come and has produced its havoc.*

All the precipitating situations are interpreted by the patient as the proof of abandonment, of having lost the battle and consequently the purpose of life—the love of mother. The present situation reactivates the childhood threat of fear of loss of the mother's love and assumes the emotional form of the old feeling—with much greater intensity, however, because the threatened loss has already and finally occurred. All the efforts of the patients to prevent such loss (either by respect of duties and work, or by excessive, demanding dependency, or by hypomaniclike fervor) have failed.

Let us examine in more detail the situations mentioned above.

The first situation, when a person dear to the patient dies, is a symbolic reproduction of parental abandonment. The patient feels depressed not only because he feels he has been finally abandoned—that is, deprived of the sources of love—but also because he feels responsible and guilty. The guilt feelings arise from two different levels: on one level, the patient feels that he has "killed" the dead person; his bad behavior has made the person unhappy and sick and more likely to die, or has made this person want to leave the patient. On another level the patient feels guilty because he recognizes that, in those moments of reemerging resentment, he wished the death of the lost person. The wish has now become reality; to the wish is attributed the primitive power of producing the reality; consequently, the patient feels guilty for having entertained the murderous desire.

The second occurrence takes place when the patient realizes fully the failure of an important interpersonal relationship. The symbolic parent, generally the marital partner, is recognized, or half-consciously recognized, as a tyrant who took advantage of the compliant, submissive attitude of the patient, rather than as a person to be loved and cherished. The patient has tolerated everything, wanted peace at any cost, but it is impossible for him to continue to do so. He feels that he has wasted his life in devoting himself intensely to the spouse, in loving her or forcing himself to love her at any cost. The realization that the spouse deserves not devotion but hate (actually, in many cases what she got was only devotion, not love) is something the patient cannot accept because it would undermine the foundation of his whole life, would prove the futility of all his efforts. Thus he tries to repress this hate; he will deny to his friends that he hates the spouse; on the contrary, he will blame himself, for if he does not love the spouse he will be found to be unworthy and will be finally abandoned.

In the third instance the loss is less personal. A sudden event such as a dismissal or a failure to obtain a promotion makes the patient realize that his whole life has been a failure. The institution to which he has devoted so much of himself (for example the Army, the church, his profession, his work) has badly disappointed him, and again the patient blames himself.

Loss of employment is a relatively common precipitating factor. Malzberg[47] found that, during the economic depression of 1929 to 1937 the effect of loss of employment or of financial loss was statistically evident in manic-depressive patients. For instance, in the year 1933, 26.2 per cent of New York state hospital first-admission patients diagnosed as manic-depressive psychotics presented as the precipitating factor loss of employment or financial loss, whereas in the same year only 9.6 per cent of first-admission patients with the diagnosis of de-

* It is not implied here that the feeling of depression removes the feeling of anxiety. Some anxiety, at times even to a pronounced degree, is retained by every melancholic patient, in connection with additional possible losses, but depression is the typical feeling.

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mentia praecox, presented the financial loss as a precipitating factor.

In some patients, an attack is apparently precipitated not by a loss but by what even seems a pleasant event. For instance, women in their forties or fifties, who may have undergone previous subliminal attacks of depression, can develop a severe attack shortly after the marriage of an only son or daughter. Here the event is experienced by the patient not as a pleasant happening but as a loss. The child whom the mother needed so much, and who was her only purpose and satisfaction in life, is now abandoning her. These cases belong to the second category.

In other cases an attack occurs after a promotion, which is interpreted by the patient as a new imposition. The patient is tired of new duties; furthermore, the new position with added responsibility removes the security the patient had established with painstaking effort. In other cases, the individual, faced with promotion, dreads the expected envy and rage of previous associates to whom he is closely bound. The expectation of such emotions in others separates him from them and thus leads to the depressive reaction.

Often, depressions are precipitated in a young parent by the birth of a child which ostensibly he had wanted. Here again, several mechanisms are put into operation by the birth. One is the desperation at the expectation of the increase in duty that the child will require, and a brooding again about the futility of life. In some young fathers the birth of a son reactivates the trauma of replacement by a new sibling (see p. 432). In these cases one finds unconscious fantasies about the lost breast (for now the baby will have the breast of the mother-wife). It is interesting that, whereas the birth of the child precipitates a schizophrenic psychosis only in the mother, it precipitates an attack of depression as frequently in fathers as in mothers. As a whole, however, postpartum depressions are much less frequent than they used to be, and much less frequent than schizophrenic reactions. Zilboorg,[93] who has made a detailed study of them, explained them as the result of a psychosexual conflict.

Postpartum manic states are less common. The patient mentioned at the end of this page underwent a brief manic state a few days after the birth of her first child. This manic state was mixed, presenting a great deal of conscious anxiety and hostility.

In many other cases psychotic attacks do not seem to be precipitated by any definite happening or loss. Here the precipitating factor is not a specific happening but a total reappraisal of life. The patient becomes more and more discontented; he claims that everything is all right, but an inner dissatisfaction, an inability to experience *la joie de vivre*, possesses him, and he finally becomes openly depressed. *It is the denial of the dissatisfaction that has led many psychiatrists to believe that these manic-depressive attacks often occur without any psychogenic cause.* At other times, the precipitating event seems to be so small as to make the psychiatrist disregard the significance of it. Kraepelin,[54] to show the relative unimportance of psychogenic factors, reported a woman who had three attacks of depression, the first after the death of her husband, the second after the death of her dog, and the third after the death of her dove. Now, from what we have so far discussed, it is apparent that each of these deaths was not necessarily traumatic per se. One may guess that the death of the dove reactivated the sorrow the patient had experienced at the previous deaths, and was also symbolic of a much greater loss, perhaps that of the meaning or purpose of life.

Manic attacks are often precipitated by seeming successes. The patient wants to keep up the fervor that the success has produced, lest he find himself later in a state of depression. A girl, who later in life had several attacks, both manic and depressive, had her first manic attack, of a few days' duration, at the age of nineteen, after winning a local radio debating contest. She was supposed to participate again in a subsequent national contest, but she became so excited, hyperactive, and euphoric that this was impossible. The opponent whom she had defeated on the local contest won. Here again, it is difficult to ascertain whether it was the success or the fear of not retaining it that precipitated the attack.

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Often, however, manic attacks occur as a sudden reaction to creeping depression.

The Psychotic Attack

When the precipitating event or the precipitating situation reveals to the patient that he has "lost," the attack ensues either in the form of depression or in the form of mania.

What is the meaning of the psychotic attack? Does the patient really mourn his loss? Does he punish himself? Does he want to punish others? He probably does all these things in an intense degree. Undoubtedly, he mourns his loss, but he also wants to make a desperate effort to redeem himself by punishing himself. The mechanism described earlier is again in effect, but in a more pronounced form. As Rado[76] says, "Melancholia is a despairing cry for love." Probably the patient feels: "Punish yourself as parents would do to you and you will be accepted again. You are acceptable but not accepted. Forgiveness is eventually available. The intermittent love will be given again."

At this point we must try to understand the meaning of the suicide attempt. Three possibilities must be considered: The patient (1) wants relief from suffering, (2) wants to punish himself, and (3) attempts to kill the introjected person (parent or spouse).

The first two possibilities are self-contradictory or self-exclusive until seen from the standpoint of the emotional state of the patient. The feeling that it is better to die than to suffer so much is certainly experienced. The patient would not carry out the suicidal ideas, however, if these ideas were not reinforced or sustained by the other idea that he deserves to die and that he must inflict on himself the supreme punishment. Thus these two motivations, logically self-contradictory, coexist and reinforce each other.

The more orthodox Freudian interpretation holds that suicide represents the attempt to kill the detested incorporated person.

According to our original interpretation of the psychological growth of the child in accordance with Buber's concepts of I and Thou, it appears that the manic-depressive patient, much more than the normal person, has accepted the Thou since his early infancy. At times he let the Thou suffocate or smother the I. In this light, the suicidal attempt is the culmination of this process: It is the Thou who finally kills the I, not the I who kills the Thou. If the I would kill the Thou, there would be a complete and sudden reversal of the previous and constant trend of denial of the self. Rado[77] has ingeniously tried to solve the problem by assuming that the super-ego (the Thou) is divided into two parts, one which the patient wants to love, and one which the patient wants to kill. I am convinced, however, that, at least in my personal clinical experience, the patient really wanted to kill himself. By killing himself he achieved a complete acceptance or a complete introjection of a distorted image of the Thou.*

There are several other factors that support this point of view. First of all, many cases of suicide seem to occur not when the state of melancholia is at its peak but at an early stage of remission, when the worst is over. This characteristic may, of course, be interpreted in various ways. The first explanation is a simple and mechanical one: When the patient is very depressed, in, or almost in, stupor, he cannot act, is extremely slow or immobile, cannot move or think coordinately, and therefore cannot carry out his intentions. When he becomes less retarded, more capable of coordinating his thoughts, he goes ahead with his destructive intention. There is the alternative possibility that the patient, who has gone through terrible experiences at the acme of the depression, is afraid that these experiences may recur and, rather than face them again, he prefers to die (this of course corresponds to the first possibility mentioned).

Yet neither of these interpretations seems adequate, in my opinion. It seems more likely that the patient feels that even the depth of depression has not been enough, has not succeeded in relieving him entirely of his guilt feeling, and that only by killing himself will he entirely redeem himself.

This interpretation is supported by other factors. Significantly, there is almost complete re-

* Strange as it may seem, this author thinks that it is the suicide of the schizophrenic, more frequently than that of the manic-depressive, that has the purpose of murdering the introjected other, or those parts of the self which are obtained from others. In the schizophrenic too, however, this is by no means the only mechanism of suicide.

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lief after the suicide attempt, whereas the Freudian interpretation would lead one to expect an increase in guilt feeling (for having attempted to, but not actually succeeded in, killing the super-ego) and a consequent increase in depression. As Weiss[92] and others have emphasized, in the attempt itself, that is, in the gambling with death, the patient feels that he has been punished adequately. He has done what the Thou wanted and now he can live peacefully. Often, of course, there is no need for the suicide attempt; after having gone through the acme of the depression, the patient feels suddenly relieved, and a marked improvement occurs.

According to Kolb[52] "The suicidal manoeuver is often determined by family indicated permission for acting out." In his clinical experience the psychodynamic explanation for acting out which has been given for other antisocial acts is valid also for suicide:

> In families where suicide has occurred the likelihood of suicide for the manic-depressive patient is much higher than otherwise. Where suicide has not occurred one usually finds threats of suicide or intimidating actions suggesting suicide on the part of parents.[52]

The relief experienced by the patient after the acute depression is remarkable. The patient feels guilt-free and accepted and wants to settle down in his own life. Even reality seems pleasant now; he does not want to be alone; he feels that he wants to be close to his mate. This attempt, however, will not work out unless psychotherapy intervenes.

The attack of psychotic depression, like every other psychotic defense, offers not a solution but a pseudo solution. When the patient cannot find relief with the end of the depression, he may, in order to avert the danger of recurrence, develop hypomanic traits which may eventually explode into a complete manic attack. We then have the typical circular psychosis. The manic attack thus must also be considered a defense against the depression. But in the manic attack the Thou is not eliminated or projected to the external world; it is only disregarded. The patient must continue to force himself into a distracted and frenzied mood, which shuts out introspection. In the manic state there is no elimination of the Freudian super-ego, as perhaps there is in some psychopathics: The super-ego remains, and the manic frenzy is a method of dealing with it.

But neither the depression nor the manic state actually brings about a solution to the deeply rooted conflicts. Even after having paid the penalty of the psychotic attack, the patient, after a more or less free interval, will tend to be affected again with the same difficulties, which will be channeled in the same patterns, and the cycle will repeat itself.

Today, however, we see in an increasing number of cases that a patient, after having experienced one or more attacks of manic-depressive psychosis, develops a typical schizophrenic symptomatology. In these cases, findings indicate that there were always some projective tendencies present along with strong introjective tendencies (see Chap. 23). Once the manic-depressive mechanism has failed, the individual resorts to the projective mechanisms, which until then had occupied only a secondary role. In some cases these schizophrenic symptoms consist only of delusional, persecutory trends, and they are not in themselves of grave prognostic meaning, but if a typical hebephrenic picture ensues, the prognosis is serious. As we have already mentioned, in an increasing number of cases we see, from the onset of the disorder, combinations of schizophrenic and manic-depressive patterns, both in the manifest symptomatology and in the underlying dynamic mechanisms, with schizophrenic features predominating. These are the so-called schizo-affective psychoses.

¶ The Study of Manic-Depressive Psychosis from the Point of View of Social Psychiatry

*The Decline of Manic-Depressive Psychosis**

Manic-depressive psychosis offers a field of inquiry for social psychiatry, for there has been,

* The content of this section and the following one, as well as parts of the previous section on the dynamics of this psychosis, are drawn from the paper, "The Decline of Manic-Depressive Psychosis. Its Significance in the Light of Dynamic and Social Psychiatry," read by the author on May 17, 1957, in Chicago, at the 113th

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in recent times, a marked decrease in the incidence of the disease which seems susceptible of sociological explanations.

The decline in frequency is reflected also by a decline of interest among psychiatrists about the condition. Whereas, at the time of Kraepelin, this psychosis received an amount of consideration equal, or almost equal, to that of dementia praecox, a relative but progressive disinterest has gradually been evident in the last few decades. Books and articles continue to be written,[12, 19, 22, 27, 39, 42, 55, 61, 77] but schizophrenia appears much more often in the literature, particularly in the United States.*

Practicing psychiatrists justify their decrease of interest with the statement that they encounter this disorder much less frequently. The statistics seem to support this observation, made at a clinical level. In 1928, in New York, there were 10 new first hospital admissions of manic-depressive patients per 100,000 inhabitants; in 1947 this incidence had decreased to 3.7 per 100,000. The percentage of first admissions of manic-depressive psychosis in 1928 was 13.5 per cent of all admissions; in 1947 the percentage was reduced to 3.8. Thus, in a period of twenty years, the incidence of manic-depressive psychosis in New York has been reduced to approximately one third. Similar statistical trends are obtained in most of the other states. The statistics point out a definite decrease of this psychosis, but their interpretation is difficult, because, as in all cases of psychiatric vital statistics, there are many variables involved. Bellak[12] offers three possible explanations: (1) an actual lessening of the relative frequency of this disease; (2) greater toleration by the healthy population of milder cases of manic-depressive psychosis; and (3) changing diagnostic trends.

To these three hypotheses a fourth can be added: new therapeutic methods administered at the beginning of the illness produce such improvement or recovery that the patients do not need to be hospitalized. One thinks here of electric shock treatment, which is capable of rapidly ending a manic-depressive attack. But this hypothesis will not withstand close examination. As we know, the first reports on electric shock by Cerletti and Bini appeared in 1938. Electric shock was introduced into the United States in 1939 by Kalinowski and Almansi but did not receive wide application, especially in private offices with nonhospitalized patients, until the year 1942–43. The statistics indicate, on the other hand, that the decline in first admissions of manic-depressive psychoses started in 1928.

There are some factors which tend to weaken Bellak's third hypothesis, that changing diagnostic trends are completely responsible for this decrease. It is correct that many patients with a mixed symptomatology today are classified not as cases of manic-depressive but as cases of reactive depression, senile depression, schizophrenia, obsessive-compulsive psychoneuroses, etc. The pertinent question here is, Why are we reluctant to make the diagnosis of manic-depressive psychosis?

It can be argued justifiably that this reluctance is not merely caprice but is determined by the fact that, in many cases today, the manic-depressive features play only a secondary role, whereas in the past they played the predominant one.

Relevant information has been gathered in other parts of the world. Gold[38] has found a relatively larger incidence of manic-depressive than schizophrenic psychoses in the lands of the Mediterranean basin, as well as in Ireland. He reports that in Oriental countries, especially where Hinduism and Buddhism prevail, manic-depressive psychosis again becomes much less common, but in the Fiji Islands manic-depressive patients are numerous. He writes further that, whereas in India the incidence of manic-depressive psychosis is low and that of schizophrenia higher, the reverse is true for the Indians who have emigrated to Fiji.

I had received the impression when visiting mental hospitals in Italy that manic-depressive patients, not only with mixed but also with

meeting of the American Psychiatric Association. The editor of the *American Journal of Psychiatry* is thanked for having relinquished the publication of the paper and thus permitted its inclusion in this chapter.

* If we examine, as an example, the annual index of the *American Journal of Psychiatry*, official organ of the American Psychiatric Association, for instance Vol. 113, from July, 1956, to June, 1957, we shall find that, whereas under the heading "Schizophrenia" fifteen original articles and five reviews of books are listed, the heading "Manic-Depressive Psychosis" is not even mentioned.

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classical or pure manic-depressive symptomatology, are more numerous there than in the United States. The official statistics in Italy corroborate this clinical impression. In 1949, in the United States, the rate of first admissions was respectively 4.7 for manic-depressive psychosis and 16.1 for schizophrenia; in Italy it was 10.0 for manic-depressive psychosis and 8.2 for schizophrenia.* Italian psychiatrists,[70, 83] however, state that in Italy, too, manic-depressive psychosis is decreasing in number, especially the manic type, but by no means as rapidly as in the United States.

Another important point to consider concerning diagnostic trends is whether the recent differentiation of the category "involutional psychoses" is responsible for the statistical differences. In other words, patients previously diagnosed as manic-depressive may now be diagnosed as suffering from involutional psychosis. Here again, it is difficult to evaluate all the factors. Previously, involutional patients might have been diagnosed as paranoid conditions, paraphrenia, etc. It is only in the case of pure involutional melancholia that competition with the diagnosis of manic-depressive psychosis exists. It is doubtful whether the cases of pure involutional melancholia, if added to the official figures of manic-depressive psychosis, would reverse the apparent decline or explain the great difference existing today, between the rate of first admissions of schizophrenia and that of manic-depressive psychosis. Again, the trend is demonstrated sharply by the statistics. Bellak reports that, of first admissions to New York civil state hospitals for the year ending March, 1947, 27.7 per cent were diagnosed as dementia praecox, 7.0 per cent as involutional psychosis, and 3.8 per cent as manic-depressive psychosis. (Involutional and manic-depressive combined were 10.8 per cent.)

The second hypothesis of Bellak, that the healthy population has more tolerance for milder cases, is difficult to accept. Bellak states that the "full-of-pep-and-energy" salesman type of person is now an accepted type. He is correct, but, in spite of some similarities, this person corresponds not to the cyclothymic hypomanic, who is liable to become manic-depressive, but rather to the "marketing personality" of Fromm[34] and to the "other-directed" person of Riesman.[81]

These observations and considerations seem to lead to the conclusion offered by Bellak's first hypothesis that the decline in the number of manic-depressive patients is real rather than apparent. Statistics further indicate that, if, in the United States, the same trends continue, manic-depressive psychosis may disappear entirely or reappear later in a near or distant future. Although this decline is not universal, it seems to affect many countries, especially Western countries, but not with the same speed.

It seems apparent that a clear understanding of the reasons for this decline can lead to conclusions relevant to the fields of mental hygiene in particular and of psychiatry in general. In order to understand this, we must resort to social psychiatry, that discipline which, as Rennie[79] has defined it, "is concerned not only with facts of prevalence and incidence . . . [but] searches more deeply into the possible significance of social and cultural factors in the etiology and dynamics of mental disorder."

Cultural Factors

There may be a relation between what David Riesman calls the inner-directed personality and culture, and manic-depressive psychosis. When this type of personality and culture tend to disappear, this psychosis tends also to disappear.

Riesman explains the establishment of the inner-directed society as the result of demographic and political changes. At certain times in history, a rapid growth of population determines a diminution of material goods and a psychology of scarcity. Although this type of society has occurred several times in history, we are particularly concerned with the recurrence which had its beginning at the time of

* Italian statistics were kindly provided by Prof. Francesco Bonfiglio of Rome. To be exact, first admissions of schizophrenics in Italy were 3,541 in the year 1947, 3,780 in the year 1948, and 3,854 in 1949. First admissions of manic-depressives were 4,298 in 1947, 4,562 in 1948, and 4,791 in 1949. The rate of admission for 100,000 represents the annual average of the triennial period 1947–1949.

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the Renaissance and of the Reformation. As Fromm[33] has clearly illustrated, at this time the security that the individual enjoyed in the Middle Ages by virtue of membership in his closed class system was lost, and he was left alone on his own effort. The religious doctrines of Luther and, indirectly, those of Calvin gave the individual the feeling that everything depended on his own efforts. Deeply felt concepts of responsibility, duty, guilt, and punishment, which, up to that time had been confined to a few religious men, acquired general acceptance and tremendous significance and came to color every manifestation of life. This type of culture, which originated during the Renaissance and developed during the Reformation, sooner or later permeated all Western countries; only recently has it faced replacement by another type of culture, the other-directed.* In some countries, such as the United States, this replacement is taking place at a rapid rate; in others, such as Italy, it is taking place more slowly.

In the inner-directed society the parent is duty-bound and much concerned with the care of the newborn child. It is this duty-bound care and the ensuing burdening of the child with responsibilities and the sense of duty and guilt which may permit the child to develop the strong introjective tendencies that play such a prominent role in the development of manic-depressive psychoses.

The similarities between the pattern of life of the manic-depressive patient and the typical inner-directed person are apparent.

1. Very early in the life of the child, the parent is duty-bound and gives such tremendous care to the child as to determine in the latter strong introjective tendencies.
2. A drastic change will occur later when the child is burdened with responsibility. This change will produce the trauma of the paradise lost.
3. The individual feels responsible for any possible loss. He reacts by becoming compliant, working hard, and harboring strong feelings of guilt. Life becomes a purgatory.*
4. This tremendously burdened life leads to depression, or to inactivity which leads to guilt feelings, or as a reaction, to activity which appears futile. These negative states and feelings are misinterpreted as proof of one's unworthiness and reactivate the expectancy of losing the paradise again, this time forever. A vicious circle is thus formed which repeats itself.

Other social studies point out a relation which is more than coincidental between manic-depressive psychosis and inner-directed society. The recent research by Eaton and Weil on the Hutterites[25,26] may throw additional weight on this hypothesis, although these authors do not speak of inner-directed society. The Hutterites are a group of people of German ancestry who have settled in Dakota, Montana, and the prairie provinces of Canada. Their life is very much concerned with religion, and their birth rate is very high, the average family having ten children. This type of society seems to be a typically inner-directed one. In a population of 8,542 people, Eaton and Weil found only 9 persons who sometime in their life had been suffering from schizophrenia and 39 who had been suffering from manic-depressive psychosis. In other words, among the Hutterites, manic-depressive psychosis was 4.33 times more frequent than schizophrenia, whereas in the general population of the United States the incidence of schizophrenia by far exceeded that of manic-depressive psychosis.†

* The reader is reminded not to confuse the other-directed culture and personality, described by Riesman, with what the present author has described as outer-directed personality (see p. 435). The outer-directed personality is a hypomanic-like defense against, or a reaction-formation to, the inner-directed personality. Reisman's other-directed personality is basically a different type of personality, occurring predominantly in an other-directed society.

* At this point many manic-depressive patients deviate from the inner-directed personality, as they develop instead an excessively dependent or a hypomanic-like outer-directed personality (see p. 435).

† According to statistics from the U.S. Department of Commerce, Bureau of the Census, and reported by Bellak, in 1946 the number of first admissions of manic-depressive psychoses exceeded those of schizophrenics in the states of Tennessee and Alabama. Here the cultural factors seem to play an important role. In other predominantly nonindustrial states, such as

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There are also historical facts which point to a relation between inner-directed society and manic-depressive psychosis, but these facts, although suggestive, are by no means reliable or scientifically proved. For instance, consider the fact that, among the physicians of the pre-Christian eras, Hippocrates in particular seemed concerned with cases of mania and of melancholia. It is possible to assume from this that his experience with such cases was extensive, making it probable that their incidence was high. Significantly, Riesman's theories postulate that Athenian culture in Hippocrates' time was inner-directed.

Becker, Parker, and Spielberger[11] have recently subjected my hypotheses to studies of their own. According to them, "the character structure of the manic-depressive appears to reflect the unsuccessful resolution of conflicts associated with the stresses of a culture undergoing a transition from inner to other directed." It is the coexistence within a culture of both inner- and other-directed which predisposes to manic-depressive psychosis.

The inner-directed society actually offers a high degree of security to the individual, for it leaves his fate in his own hands rather than in the control of mysterious, omnipotent, and unpredictable forces. Thus, obviously, I do not mean to suggest that the inner-directed culture is "the cause of" manic-depressive psychosis; rather, I speculate that this type of culture tends, in certain cases, to elicit family configurations and interpersonal conflicts that are generally those which lead to manic-depressive psychosis. What is supported here is a psychosocial or biosocial position similar to that expounded by Opler[71] and by Lemkau and his collaborators.[60]

Other Social Factors

Additional cultural factors either add to or detract from the importance of the structure of the society in the formation of various disease entities. Immigration to a foreign country, with consequent problems of maladjustment, seems to elicit a propensity toward this as well as other psychiatric disorders. Some additional explanation for the various incidence of manic-depressive psychosis may be found in ecologic studies.

In 1939 Faris and Dunham[31] published a study, *Mental Disorders in Urban Areas*, in which they found that, whereas schizophrenia is prevalent in the central areas of the cities of Chicago and Providence, that is, in areas of social disorganization (where delinquency, crime, prostitution, and drug addiction are also frequent) and gradually declines in number toward the outskirts of the city, no definite pattern of distribution was found for the cases of manic-depressive psychosis.

The contrast between the ecologic distribution of manic-depressive psychosis and schizophrenia was so marked that Faris and Dunham saw in it another proof of the distinct nature of the two disorders. Faris and Dunham believe that probably precipitating factors have a more important causal relation to manic-depressive psychosis than to other disorders.

Some of Faris and Dunham's conclusions may be integrated with the explanation given by the present author in other sections of this chapter; others are, perhaps, susceptible of different interpretations. We have seen that precipitating factors are undoubtedly important in manic-depressive psychosis (see pp. 435–437). On the other hand, it is my impression that manic-depressive psychosis is not necessarily connected with a milieu which offers "extremely intimate and intense social contacts," but rather with a structural, well-organized inner-directed milieu, removed from the disorganization or relative looseness of organization that we find either in some other-directed societies or, for entirely different reasons, in low economic or socially unstable elements of the population.

A difference in the occurrence of the two major psychoses is also illustrated by the size of the communities involved. The highest proportion of manic-depressives comes from cities of 100,000 to 200,000 population and from rural areas, whereas the largest proportion of schizophrenic cases comes from metropolitan or urban areas.[58]

Maine, Delaware, and Florida, there was very little difference in the incidence of the two conditions, but the total number is too small for conclusions to be drawn.

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Other studies seem to point out that the economic level of the manic-depressive tends to be higher than that of the schizophrenic. It is debatable, however, whether the low economic condition of the latter is related to the effect of, rather than to the etiology of, the disorder. Manic-depressives are affected by their condition later in life and less seriously.

Summarizing, there is much presumptive evidence that ecological, cultural, and social factors are important in either engendering or at least predisposing to manic-depressive psychosis. It also seems that in the United States, these sociocultural factors, whatever they are, began to decrease sharply in intensity and number in the mid-twentieth century.

¶ Study of the Formal Mechanisms of Manic-Depressive Psychosis

As I have stated elsewhere[3,4,8,9] one must study not only the content of psychological conflict but also the form that the conflict assumes—for the form, more than anything else, distinguishes one disorder from the other.

Formulations of the formal mechanisms of manic-depressive psychosis are still at an early stage of development. We can, however, make some preliminary observations.

We have seen how in the premanic-depressive patient there is a tendency to accept, to internalize the interpersonal environment to a more pronounced degree than in the average person. Fairbairn[20] refers to this phenomenon as internalization of objects, but internalization of objects means only acquisition of symbols, symbols which may replace the objects they stand for.

The person who is likely to become manic-depressive has an overdeveloped ability to accept the symbols of the surrounding adults.* Such facility exists even when these symbols are accompanied by an affective tonality which is unpleasant.

We have seen how, in the environment to which the young premanic-depressive is exposed, the symbols acquired from the adults have a tonality consisting predominantly of feelings of guilt, sin, responsibility, and impending loss. The organizations of symbols representing such concepts as family, duty, religion, fatherland, work, etc., are also connected with this unpleasant or burdensome tonality. The affective tonality which accompanies the symbols may become so intense as to overpower the cognitive aspect of the symbols, or to obscure it. The affective component finally may become so powerful, that the cognitive one remains insignificant, or becomes confused or lost, or attached in an unstable way to a vague cognitive ideation of pain and loss.

What are the possible defenses (normal or pathological in degree) against painful or depressive thoughts? They are three: (1) rejection of the symbols of society, (2) acceptance of the depression, and (3) discharge or escape into action. The first possibility (rejection of the symbols of society) ranges from daydreaming activities and fantasy life to schizoid withdrawal; from the new individualistic symbols which the artistic person is able to create to the use of the paleosymbolic or autistic cognition of the schizophrenic.[4,5,7]

The premanic-depressive is deprived of this mechanism. He cannot lose the social symbols (or the objects, if we prefer orthodox psychoanalytic terminology) which he has introjected so well. In other words, regression is not available to him, and creativity is not his forte. He must retain the symbols, he must accept them even if they are painful, and by doing so he follows the second possibility. Not only does he accept the unpleasant symbols—he accepts them to an exaggerated degree.

In other words, in the depressed person the cognitive component of the symbol does not change, is not displaced, is not substituted by an autistic or paleosymbolic symbol as in the schizophrenic and in some psychoneurotics: the only thing that changes is the intensity of the emotional tone. Of course, this is not totally true. In depressions too, the symbols may be displaced, but much less than in the other psychiatric disorders, and generally only by some symbols which have similar affective components. We have thus a poverty of neosymbols and a change in the affective component of the

* The reader may remember that the manic-depressive has greater ability than the average person for verbal functions (for instance, learning of foreign languages).

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old symbols. The affective component is apt to change only quantitatively (unless the manic defense is resorted to, as we shall see later), because emotions, unless accompanied by cognitive components, do not permit as many varieties as do symbols. This limited possibility of responses explains the relative simplicity of the formal mechanisms of manic-depressive psychosis in comparison to those of schizophrenia.

The depression has a purpose, too, not only at a dynamic level but also from a biological and formal points of view. For instance, let us examine the normal depression which we may undergo after the death of a person dear to us.

Why does the loss of such a person produce sorrow? What is sorrow? Why is it unpleasant? Such questions seem to imply intuitional answers or to be self-understood, but they are not. Sorrow, of course, is a form of mental pain.

It is not implied here that depression is the only form of mental pain, but that it is the most typical, and that it is the evolutionary outcome at a human symbolic-interpersonal level of the biologic nociceptive pain. We may even say that the depression is a concrete representation of the loss of a loved object.

As the recuperative properties of the organism attempt to remove physical pain by the histologic healing process, the organism attempts also to heal from mental pain: here lies the teleologic quality of mental pain. Following the example of the death of the person dear to us, for a few days after the death, all thoughts connected with the departed person will bring about a painful, almost unbearable feeling. Any group of thoughts even remotely connected with the dead person will elicit depression. We cannot adjust to the idea that he does not live any more. But if that person was so important to us, almost all our thoughts or actions are directly or indirectly connected with him and therefore will elicit an unpleasant reaction.

Nevertheless, after a certain period of time, we get adjusted to the idea that that person is dead. By the very fact of being unpleasant the sadness has a purpose—it wants to be removed. It will be removed only by forcing the individual to reorganize his thinking, to change his thoughts into different constellations, to search for new ideas so that he can rearrange his life—especially those ideas which were connected with the departed, so that the departed will not be considered indispensable any longer. This process occurs in the normal person, but the manic-depressed person has great difficulties with it.*

When this process fails, another, slightly less normal mechanism occurs. The depression, rather than forcing a reorganization of ideas, slows the thought processes. In this case the teleologic mechanism acts almost with the goal of decreasing the quantity of thoughts in order to decrease the quantity of suffering. At times, the attempt to slow thought processes succeeds so well (as in the state of stupor) that only a few thoughts of a general and vague nature are left; these are accompanied by an overpowering feeling of melancholy. This acceptance of the depressed mood and slowing of thought processes which have an unpleasant emotional tone are self-defeating mechanisms. In a vicious circle they aggravate the situation instead of alleviating it.

The third defense for the individual in the presence of depressive thoughts is the escape into action and fugitive thoughts. This defense is available to the manic-depressive patient, although it is not as frequent as the second. This defense is the formal counterpart of the outer-directed or hypomaniclike personality.

This defense may be so effective as to prevent the occurrence of the psychosis throughout the life of the patient. Thoughts must be very fugitive, must be changed very rapidly, because any constellation of organized thoughts about practically any topic sooner or later bring about the depression. Pleasant thoughts are searched for; actions that may replace ideas are sought.

The patient resorts to this defense either in order to prevent the depression or in order to escape from the depression (as when he slips from the melancholic into the manic state).

At times, he succeeds in using this defense in an acceptable, or at least tolerable way, retaining, or even increasing, normal abilities.

* At other times he will use it too much, as in the manic attack.

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The ability to recall masses of detail, shown by some hypomanic patients when reporting their experiences, may be useful if channeled into activities that require accurate descriptions. Often however, the wealth of details is useless and irritating. The escape into words, into social symbolism, and into observation of reality almost to a photographic level is obvious.

The following are some excerpts from a woman's conversation during a hypomanic interval. (She had had three previous psychotic depressions.)

The telephone rang; it was the doctor who treated my husband, Dr. B. He told me that I should go to see him right away. I put on my spring coat. It must have been spring, as I remember, because I wore the spring coat. The doctor lived a few blocks away in an apartment in the Hotel Plaza. I went there, took the elevator. They lived at the fourth floor, fourth or fifth, I don't think it makes much difference. I rang the bell. The wife came to open the door. She is such a short woman and her husband, the doctor, was so tall. . . .

These details were, of course, useless and irrelevant to the goal of the conversation. Logicalness, however, was retained. Similar behavior may be tolerated. Often, however, when the looming depression is very intense, the patient must resort to more pronounced manic mechanisms.

The foregoing exposition may create the impression that the manic pleasure consists only in the escape from depression, in the removal of the negative. Not every pleasure, however, is the removal of the negative, or a decrease in the tension which produced pain; it is my impression that the manic does not try only to escape from the pain of depression but tries to gain by extending or enlarging his contacts with the world. Such contacts must remain superficial, however, if depressing connections are to be avoided. A further consideration is the fact that pain elicits in the organism a reaction of *moving away* from the source. At the level of human depression, no movement or moving away is visible, because the moving away is only from depressive thoughts (unless, as we have seen before, the depression is very intense). In pleasure, there is not only a moving away from the source of pain but *also a moving toward* the object which will confer pleasure.[75] And the increased motility of the manic must be considered as an attempt to *move toward* the source of pleasure.

The manic mechanisms, however, fail on account of their pathologic proportions: in order to avoid unpleasant constellations, thoughts must be so rapid that they cannot be organized or, therefore, capable of achieving rewarding actions. The pleasant ideas cannot be sustained and eventually leave the patient with the realization that they are futile. When the manic fervor is exhausted or cannot be sustained any longer, depression ensues or returns.

It is still not clear why some patients are able to avail themselves of the manic defenses and others are not. Perhaps constitutional, cultural, and dynamic factors play roles which cannot yet be ascertained. Studying the literature, however, one gets the impression that in so-called primitive cultures the manic attacks are much more numerous than the depressions.

The incidence of manic attacks is much lower than that of depressions, and many writers today feel that one cannot classify as manic-depressive the many patients who undergo depressions but never have a manic attack.

More conservative psychiatrists, however, tend to retain the syndrome manic-depressive as a unit, a position that can be justified on the grounds that our understanding of its partial manifestations is increased by our acceptance of its unitary concept.

Perhaps, at this point, it is possible to formulate a more complete definition of manic-depressive psychosis:

Manic-depressive psychosis is a periodical abnormal way of living, dominated by excessive affective tones of exaltation and melancholia. The propensity for this intense affectivity is brought about by childhood experiences which lead to excessive introjections of unpleasant symbolic constellations and to more or less specific defenses against these introjections. These defenses, however, not only are not useful but determine vicious circles which may reproduce the disorder in its totality or its various parts.

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¶ Biological Factors and Psychosomatic Mechanisms

Genetic, Constitutional, and Neurological Factors.

Many authors are not convinced that the psychodynamic and social factors are the only etiologic agents in manic-depressive psychosis, since people with apparently similar psychological and cultural environments have not developed this disorder. It is difficult either to accept or to reject this type of criticism because of the complexity and the multiplicity of the variables involved. For instance, the defenders of an exclusively cultural psychodynamic point of view reply that obviously these psychodynamic mechanisms must be particularly pronounced and must be accompanied by inadequate compensatory mechanisms in order to lead to the disorder. Inasmuch as it is difficult to differentiate or to evaluate quantatively these compensatory mechanisms, no definite answer can be given at this time.

On the other hand, since constitutional or predisposing factors or a state of receptivity or nonimmunity are to be found in most pathological conditions, by analogic thinking we may assume the possibility of a biological factor in the etiology of manic-depressive psychosis also.

Pollock, Malzberg, and Fuller[74] state that the incidence of the disorder is greater among the siblings of patients than in a sample of the random population. The psychosis, however, does not appear in accord with the laws of simple Mendelian inheritance.

Slater,[85,86,87] on the contrary, is a strong advocate of the hereditary nature of manic-depressive psychosis. He thinks that the inheritance follows a dominant type which depends on a single autosomal gene. To explain why the incidence of the psychosis is lower than would be expected from his hypothesis, he states that the dominant gene is a weak one.

Matz and Willhite,[68] who have studied manic-depressive psychosis among ex-service men and reviewed the literature extensively, conclude that inheritance is an outstanding etiological factor in manic-depressive psychosis. In the group of patients that they studied they found a familial history of nervous or mental disease or some other taint in approximately 45 per cent. The most frequent "taints" were alcoholism, manic-depressive psychosis, and "other psychoses." Among "other taints" were psychoneuroses and drug addiction. Since so many conditions are included in the category of taints, one wonders how reliable these statistics are.

Kallmann[46] states that the potentiality for developing manic-depressive psychosis depends "on the mutative effect of a single dominant gene with incomplete penetrance." In a broad-minded conclusion Kallmann states that "the dynamics identified with this specific ability [the ability to develop manic-depressive psychosis] cannot be considered part of a person's normal biological equipment, nor are they out of line with current concepts of psychodynamic phenomena observed in potentially vulnerable persons." In other words, certain psychodynamic phenomena have the ability to elicit the disorder in persons who are potentially vulnerable on account of a hereditary background. Kallmann feels also that the hereditary factor is more important in manic-depressive psychosis than in schizophrenia.

Constitutional factors have also been studied by many authors, following Kretschmer's lead. Kretschmer[56,59] described a cycloid type of temperament which is accompanied by a pyknic constitution and a schizoid temperament which is accompanied by an asthenic (leptosomatic) or athletic constitution. He stated that approximately two thirds of manic-depressive patients belong to the cycloid temperament and pyknic constitution, pointing thus to a correlation between the body build and the mental disorder. Sheldon[84] continued this study and concluded that manic-depressive patients are generally mesomorphs, or a mixture of endomorphy and mesomorphy, with mesomorphy predominating.

These constitutional factors, if valid, must be interpreted not as necessary prerequisites, but as contributing or aggravating factors. It is a common observation that the pyknic build, assumed to be related to manic-depressive psychosis, is becoming more and more numerous in schizophrenics too.

Another generally neglected consideration is the reverse of this theory. Are these pyknic

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patients really constitutionally pyknic from birth or have they become so? Strong receptivity predisposes some premanic-depressive children to overeating and consequently to obesity. We must consider the possibility that personality characteristics may affect the body build.

Studies of general pathology in manic-depressive patients are scarce and do not lead to any conclusions. Lewis,[62] who examined 8 cases of manic-depressive psychosis, post-mortem, found that the circulatory and endocrine systems had reacted "in a compensatory way in excess of what is usually found in those dying at the same age level and that deaths from over-compensation in the circulatory organs are relatively numerous."

Kraines[55] feels that the mechanism of manic-depressive psychosis is to be found in a dysfunction (either increased or decreased function) of the diencephalon. According to him, the psychiatric picture is a "psychic response" to this diencephalic dysfunction. This response depends on the personality of the patient and is a secondary manifestation of the illness, not an etiologic factor. Kraines poses the question about the nature of the pathologic process affecting the diencephalon. Since no toxic, infective, degenerative, neoplastic, or traumatic lesions are found, he postulates that the disturbance must be physiologic and must occur on a hereditary and metabolic basis. According to him, the diencephalon is only part of a larger diencephalic-rhinencephalic-reticular system which mediates the illness. The illness is mediated through this neurological system but may be determined by many factors, such as circulatory alterations, metabolic changes, and especially endocrine dysfunctions, particularly of the gonads.

Psychosomatic Mechanisms

A study of psychosomatic mechanisms in manic-depressive psychosis is premature. In a study of schizophrenia[4,6] the common trends in the study of that disorder were reversed: the study started with psychology and ended with neurology, demonstrating how psychological conflicts may lead to a rearrangement of cerebral mechanisms even at a physiologic level. A similar study in manic-depressive psychosis is more difficult because the neurology of highly symbolic emotions is even more obscure than that of cognitive processes. If we accept the priority of an interpersonal-psychodynamic etiology and pathogenesis in manic-depressive psychosis, we must also accept the fact that the conflicts that lead to this disorder could not occur without the participation of the neocortical areas which are indispensable in mediating interpersonal relations and symbols. But these relations and symbols have an emotional counterpart which is probably mediated by the archipallium. As Papez[73] and others[37,65] have indicated, human emotions are probably mediated at a cortical level in the archipallic areas. Such deep emotions as sorrow, sadness, grief, etc., cannot easily be conceived as exclusively hypothalamic or diencephalic functions, although obviously they are also connected with some activities of these structures. They are very different from sham rage and those other emotional expressions which are reported as diencephalic functions. Thus it seems logical to assume that the conflicts of the manic-depressive, which are mediated in the neopallic areas, have functional psychosomatic repercussions in the archipallium. The functional changes in the archipallium, in their turn, may lead to other abnormalities.

To date, a hyperfunctionality of the autonomic nervous system in manic-depressive psychosis has not been sufficiently demonstrated. At a clinical level I have noted rather the opposite —a poverty of autonomic manifestations in manic-depressive patients. In a few patients, who presented intense perspiration, erythema of the skin, and tachycardia when undergoing states of anxiety, all these symptoms disappeared during subsequent attacks of psychotic depression. It seems almost as if the archipallium becomes hyperactive and inhibits lower diencephalic functions.

¶ Therapy

Choice of Therapy

The treatment of manic-depressive psychosis should be considered under three headings: (1) hospital treatment, (2) physical treatment, and (3) psychotherapy.

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A discussion of the first two will be confined, in this chapter, to a few general remarks, since they are discussed extensively in other chapters (Chaps. 68, 69, 70, 71 and 85). Here we will consider primarily the psychotherapeutic approach.

Hospitalization must be considered, especially when there is danger of suicide. Whenever there is a tendency toward suicide, the therapist must make sure that the patient can be under proper surveillance at home; if this is not possible, hospitalization becomes necessary. Often it is more difficult to convince the relatives than the patient that hospitalization is necessary. The depressed patient, perhaps in a masochistic spirit, is ready to enter the hospital, whereas the relatives would prefer to send him on vacation. It is more difficult to hospitalize a manic, as he himself prefers to take trips and to escape into actions.

Recently, however, hospitalization could be avoided in many cases because of the efficiency of convulsive therapy in rapidly terminating acute attacks. At times, merely a few electric shock treatments are sufficient to produce a temporary recovery from a depression. A manic attack may require a longer course (see Chap. 69). Electric shock treatment is, at the moment, the best physical therapy for the affective psychoses, and even today is used for these conditions more often than drug therapy, prolonged narcosis, and psychosurgery.

Although convulsive treatment is only a symptomatic treatment, capable of removing the attack but not of preventing recurrences, many psychiatrists (including the writer) feel that it should be instituted in all cases in which the depression or the manic state has gone beyond a mild stage. Not only will a great deal of suffering be prevented by interrupting the attack, but the patient becomes accessible to psychotherapy much sooner. Psychotherapy of manic-depressive patients is always difficult, but during acute attacks it is even more difficult. Either the flight of ideas or the intense preoccupation with depressed thoughts interferes with the attempts to establish contacts. One must be aware, however, of one serious shortcoming in the use of shock therapy for manic or depressed patients. Once freed from symptoms, they are apt to want to forget the illness, with a consequent reluctance to undergo psychotherapy. Careful preparation and cooperation from relatives, however, may help to induce them to accept it. Of course, if the current attack had been preceded by others, the patient knows from experience that the electric treatment alone is not capable of preventing relapses.

It is advisable that electroshock therapy and psychotherapy be administered by different therapists. One of the fantasies of the patient (probably to a certain extent connected with the manifest recovery from the attack after shock treatment) consists in the feeling of having received enough punishment that he can now consider himself redeemed. The psychotherapist should not be seen as the punishing agent.

Psychotherapy should be instituted in the following instances: (1) at the termination of the convulsive treatment, as soon as the organic signs such as forgetfulness, mild confusion, etc. have decreased in intensity; (2) with patients who, because of physical illness, could not receive convulsive treatment; (3) with those patients in whom the depression or hypomanic state is so mild that therapeutic contact may be easily established; and (4) with patients whose acute attacks have ended spontaneously.

In some cases of the third category, the therapist is confronted with a dilemma: a slight possibility of suicide exists; on the other hand, the patient is still able to work and resents hospitalization, for this would mean being cut off from work and from treatment, both of which he considers necessary. The decision, of course, rests not only on the patient but on the therapist. It will depend on the evaluation of the individual case. If the risk of suicide is deemed minimal, it may be worth taking, in view of the fact that long psychotherapy is not possible in the hospital (with a few exceptions), and in view of the fact that the possibility of suicide is not completely eliminated even in a hospital environment. The situation should, however, be discussed with the members of the family.

Psychotherapy

In many cases of mild depression, as Ostow[72] writes, psychotherapy will offer relief to the

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patient who sees in the therapist a new and reliable love-object. Although the establishment of this transference may be helpful to the subsequent therapy, it cannot be considered a real cure; as a matter of fact, it may be followed by another attack of depression when the patient realizes the limitation of the therapeutic situation. Moreover, this pseudo improvement must be considered as an attempt on the part of the patient to defend himself by assuming the clinging, dependent type of personality.

Kolb,[52] English,[27] and Cohen[22] emphasize this excessive clinging as one of the main problems encountered in intensive psychotherapy with manic-depressives. Some patients do not want to leave at the end of the hour; they claim to remember, suddenly, many things they must say, plead for help, and attempt to make the therapist feel guilty if they are not improving. As Kolb[52] aptly describes, these patients have learned proper or apparently suitable social manners, and, with pleading and tenacity, they are often capable of eliciting in the therapist the reaction they want.

The patient will soon find in the therapist either a person to cling to or to depend on, a love-object, an authority who gives moral assent or disapproval, or a punishing agent. If the patient feels that his needs are satisfied, he will experience a feeling of love for the therapist.

Thus the same situation is repeated in the transference situation that has occurred throughout the life of the patient. He resorts to the same technique: either by clinging and demanding or by complying and seeking approval, he wants acceptance and love. A third method, of course, consists in a flight from the situation which gives the false impression of immersion in reality.

If the life history of the patient has been discussed, it will be possible to point out and explain these mechanisms to him. Sooner or later he will learn to avoid them, as he learns to recognize in them a pseudo solution of his problems and a perpetuation of a vicious circle. The patient will at first have only an intellectual understanding; consequently, the mechanisms will tend to recur even after they have been completely understood. As a matter of fact, even discussion of them will evoke strong emotional reactions which are not congruous with the gained insight but which are the usual affective components of the original symptoms. For, even after the patient has understood the meanings of his symptoms and behavior patterns, he has no other mechanisms at his disposal, no different patterns of behavior.

It must, for example, be pointed out constantly to the patient that he should learn to ask himself what he wants, what he really wishes. Quite often his attempted answer will be only a pseudo answer. He may say, "I wish first of all peace; I wish the happiness of my children." He must learn—and relearn—that peace at any cost implies satisfying others before oneself, and that even the happiness of children, although a natural wish of every parent, is not a wish predominantly related to the individual himself.

In other words, the patient must learn to listen to himself and to reduce the overpowering role of the "Thou." At the same time he must make a voluntary effort to develop inner resources. In the attempt to imitate others, or even to surpass others in proficiency and technique, the patient has never relied on himself. He cannot be alone (unless he is depressed) and alone he cannot do anything that gives him satisfaction; he must work for the benefit of others or take flight into common actions. He must learn that he too has an artistic, individual soul, and if he has the capacity to search for it, he will find it. Creative upsurges in apparently uncreative conventional manic-depressive personalities are a good prognostic sign (with the exception of mixed cases with partial schizophrenic symptomatology).

Summarizing, the patient must first learn to understand all the experiences and mechanisms described in the third part of this chapter; that is, the experienced or expected loss of love, the compliant industrious attempt to recapture it with denial of oneself, the resentment for making strong efforts and consequent aggression, the guilt for failing to recapture love and for having aggression. The early life experiences, remembered, will provide the evidence which the patient needs in order to

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understand the patterns which he has developed. Moreover, the therapist must be alert to spot early signs of depressions, at times precipitated even by trivial disappointments or even by chance associations of ideas. As Jacobson[43] and Kolb[53] emphasize, the recurring depression must immediately be related by the therapist to its precipitating cause. In this way full-fledged attacks are aborted.

Jacobson also feels that the patient should be guided to focus on the recent loss or precipitating cause rather than on the early experiences which led eventually to the present symptomatology. On the other hand, one can find in clinical experience that when the triviality of the disappointment or loss that led to the depression is shown to a patient, he may become "depressed" over the fact that such a "minor cause" could evoke such depression. In other words, we have another instance of the vicious circles that tend to occur in all mental disorders and tend to increase the intensity of the symptomatology. If, on the other hand, the patient is made to understand that the present disappointment or loss is symbolic of a much greater disappointment or loss, he is able to understand the unrealistic nature of the incoming depression and is better equipped to fight it.

At the same time, he must learn new patterns of living, patterns which lead to his own independence, individual growth, and self-realization. The learning of new patterns will reduce the tendency of the old ones to recur.

What is advocated here is in a certain way a psychotherapeutic approach which will attempt to reproduce the healthy formal mechanisms described on p. 445 as a normal reaction to depression and to loss—reconstructions of thought constellations rather than the self-perpetuating depression or the manic flight.

The outlined technique may seem, to the reader, a too intellectual approach. But orthodox psychoanalytic procedure, with the use of the couch and free associations, is not indicated in manic-depressive psychosis even during the interval periods. Many failures in treatment of these patients were due to the adoption of the classical psychoanalytic technique. Many therapists feel today that the retarded or hyperactive patients generally should be treated with less frequent sessions—from one to three a week. Many patients, especially elderly ones, seem to do well with one session a week. The therapist must play a relatively active role, not one that conveys to the patient the feeling that he is being pushed or under pressure, but not one in which the passivity of the therapist is too much in contrast with the natural extroversion of the patient. Whenever the therapist feels that he has succeeded in reaching some conclusions or in understanding the feelings of the patient, he should verbalize them freely. Often the patient prefers to keep quiet, not because he is unable to put things together, as in the case of the neurotic or the schizophrenic, but because he feels guilty or ashamed to express his feelings of rage, hostility, and, paradoxically, even of guilt and depression.

Dream interpretations are very useful, especially in depressed patients.

The treatment of hypomanic patients is far more difficult, as the flight of ideas prevents any significant contact. Here an opposite procedure is to be followed. The patient is asked to cut out details, so that irritation and rage are purposely engendered, or he is reminded that he must talk about certain subjects (the subjects that are liable to induce depression). A conversion to a mild depression is therapeutically desirable. In many cases, however, it will not be possible to induce mild depression exclusively with active intervention of the therapist, and chlorpromazine (Thorazine) must be resorted to (see Chap. 77). This drug, either by decreasing the intensity of the manic or hypomanic state or by eliciting a depression, can be a valuable adjunct to psychotherapy.

Needless to say, not every therapist is suitable to treat manic-depressive patients. Some therapists who have been quite competent in treating psychoneurotic or schizophrenic patients have been utterly unsuccessful with manic-depressive patients, especially of the manic-hypomanic type. The verbose, circumstantial talk, or the photographic reproductions with no signs of originality, the lack of any fantasy or of symbolic material, may tire the therapist. The immediate recognition of these characteristics as defense measures, and of their variation in accordance with the

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transference situation, can help the therapist in his trying efforts.

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CHAPTER 23

SCHIZOPHRENIA:

The Manifest Symptomatology, the Psychodynamic and Formal Mechanisms

Silvano Arieti

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IN THE LAST TWO DECADES the field of psychiatry has grown in many directions, but schizophrenia retains the first place among psychiatric conditions in claiming the therapeutic dedication and in renewing the searching endeavor of psychiatrists the world over.

The Second International Congress for Psychiatry, held in Zurich in September 1957, which was entirely devoted to this disorder, revealed both the magnitude of the effort and the lack of a satisfactory integrating approach. Despite the mass of data reported by the many participants—results of varieties of research and differing therapeutic approaches—there was not a single concept on schizophrenia that was not rejected or challenged by some other authors. Even the name schizophrenia was disapproved of by several people.

As a preliminary definition of schizophrenia, we shall adopt that offered by Blakiston's *New Gould Medical Dictionary*.[24] This definition is more descriptive than explanatory, but has a great deal of pragmatic value.

> Schizophrenic reaction [is] one of a group of psychotic reactions, often beginning after adolescence or in young adulthood, characterized by fundamental disturbances in reality relationships and concept formations, with associated affective, behavioral and intellectual disturbances in varying degrees and mixtures. These reactions are marked by a tendency to withdraw from reality, inappropriate moods, unpredictable disturbances in stream of thought, regressive tendencies to the point of deterioration, and often hallucinations and delusions.

¶ Historical Survey

The concept of dementia praecox as a nosologic entity appeared very late in medical history. Kraepelin is the first writer to structure

this concept. Two precursors of Kraepelin must, however, be mentioned: Morel, was the first author to use the term dementia praecox (*de mence precox*). On page 566 of his treatise published in 1860, he for the first time associates the two words *dementia* and *praecox* to describe a case of "stupidity" in a young man which "degenerated into a state of dementia." Kahlbaum,[97] in 1863, described a special psychiatric condition occurring in puberty and termed it "paraphrenia hebetica"; in 1874 he described catatonia under the name *Spannungsirrsein*. Only in 1898, however, did Kraepelin[105] conclude the synthesis and propose the concept of dementia praecox.

The Classical Period

Kraepelin's insight consisted in including three conditions under one syndrome; (1) catatonia, already described by Kahlbaum, (2) hebephrenia, already partially described by Kahlbaum's pupil Hecker,[81] and (3) "vesania typica," a condition also described by Kahlbaum and characterized by auditory hallucinations and delusions of persecutions. In these different clinical pictures, Kraepelin saw one fundamental nosologic picture characterized by progressive decay and finally by dementia. Thus the outcome, or rather what was supposed to be the outcome—dementia—was the fundamental criterion. By separating the patients who eventually develop dementia from those who do not, Kraepelin was able to differentiate a set of symptoms which he thought were characteristics of dementia praecox, in contrast to another set of symptoms which constitute the syndrome of manic-depressive psychosis. Kraepelin thus could differentiate and define as dementia praecox a symptomatology consisting of hallucinations, delusions, incongruous emotivity, impairment of attention, negativism, stereotyped behavior, and progressive dilapidation in the presence of relatively intact sensorium. He distinguished three types—the hebephrenic, the paranoid, and the catatonic, according to the predominance of certain symptoms over others. Later, following Bleuler's suggestion, he added the simple type.

Kraepelin's descriptive approach, although revolutionary and epoch-making at the time of its development, is outdated today, as it studies and does not lead to psychotherapeutic lacks psychodynamic, sociocultural, and formal possibilities. Kraepelin's aim was to define disease entities based on definite organic pathology, and he always felt that dementia praecox was ultimately based on a faulty metabolism, although he could never prove this belief.

Bleuler is chronologically the second major author who contributed greatly to our understanding of schizophrenia. He probably was the first to understand both the values and limitations of the Kraepelinian conceptions. In 1911 he published a monograph[26] on this subject which has remained a classic in the psychiatric literature.

He accepted the fundamental nosologic concept of Kraepelin but enlarged it to a great extent, because he considered as related to dementia praecox many other conditions such as psychoses with psychopathic personalities, alcoholic hallucinoses, etc. Furthermore, he thought that the largest number of patients are never hospitalized because their symptoms are not severe enough; that is, they are latent cases. He also saw the syndrome described by Kraepelin not as a condition necessarily progressing toward dementia, but as a disorder characterized mainly by an alteration of the faculty of association and by a splitting of the basic functions of the personality. Thus, he felt that the name dementia praecox should be replaced by the name schizophrenia (derived from the Greek words *schizin* [to divide, to split] and *phren* [mind])—a term that has almost completely replaced the older dementia praecox.

Bleuler tried in two ways to overcome the limitations of Kraepelin's system: by accepting the dynamic concepts of Freud, which had already appeared in the literature, and by attempting explanations of the formal processes.

According to him the formal mechanism underlying all the schizophrenic symptoms was the so-called loosening of associations. This loosening is recognizable in various degrees in elisions, blocking, logical errors, etc.

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Another of Bleuler's major contributions is his concept of autism.[25,26] Autism is a way of turning away from reality; it is a special way of behaving, but predominantly a special way of thinking which is opposed to logical thinking. Autistic thinking reproduces or interprets not external reality, but a world of fantasy, dominated by wishes and fears and mediated by Freudian symbolism. Bleuler felt that, although autistic thinking might occur in many situations, such as when emotions are very strong, or in artistic productions or in the play of children, its most pronounced form appears in schizophrenia.

Adolf Meyer[122-126] accepted the basic nosologic concept of Kraepelin and Bleuler, but gave it a creative twist. He was no longer satisfied with studying the symptomatology of schizophrenia as it presents itself to the psychiatrist after the outbreak of the manifest symptoms, and stressed the fact that this condition should not be studied in "cross-section," but "longitudinally." He felt that the patient should be studied from the beginning of his life, and all the factors that might have contributed to the development of the psychosis should be evaluated. Schizophrenia thus becomes a "schizophrenic reaction," a reaction to the events which gradually prepare the ground for the psychosis. If we study the patient longitudinally, Meyer taught, we see a gradual deterioration of his way of living. Many "faulty habits" such as brooding, excessive fantasy life, decrease of interests seem at first "trivial and harmless subterfuges," but are gradually substituted by more pathologic habits and eventually are transformed into full-fledged schizophrenic symptoms. Meyer is thus one of the first psychiatrists to emphasize the "longitudinal" importance of psychological factors. Although his approach constitutes a definite advancement over the previous ones, it is not entirely dynamic and remains vague for the following reasons: (1) although Meyer takes into consideration the psychological factors, the role that anxiety plays is not suspected and therefore not studied; (2) the "faulty habits" are well described but are accepted on a realistic level—that is, their symbolic meaning is not fully appreciated; (3) by making it appear that the shift from faulty habits to schizophrenic symptoms is only a matter of quantitative transitions, the specific quality of schizophrenia is minimized and the ground is open for attacks on the concept of schizophrenia.

The Psychoanalytic Schools

Although Freud devoted practically his whole life to the study of the psychoneuroses and had only a secondary interest in the psychoses, his contributions to the whole field of psychiatry are so important that the field of the psychoses too has been tremendously enriched by them. Here it is possible to enumerate only the major Freudian contributions pertinent to our understanding of schizophrenia.

The longitudinal study of the patient, advocated by Meyer, acquires full significance only when the role of anxiety is determined. Freud, by disclosing the role that anxiety plays in human life, especially in psychopathologic conditions, indirectly opened up the field of schizophrenia to the psychodynamic approach. In *The Interpretation of Dreams*[58] he describes many processes which also apply to schizophrenia. The symbolic content and the archaic forms of dreams find a counterpart in the schizophrenic symptomatology.

Freud's concept of the unconscious also applies to schizophrenia, not only because of that lack of awareness that accompanies much of the psychodynamic processes which lead to schizophrenia but also, paradoxically, because the "inability to make things unconscious" is one of the important characteristics of this psychosis. In a paper published in 1896,[67] Freud gives the dynamic interpretation of a case which was later recognized as one of the paranoid type of dementia praecox. In this paper, for the first time in the history of psychiatry, the term "projection" is used and this mental mechanism is explained. In another paper on narcissism, published in 1914, Freud gives more details about his interpretation of schizophrenia as a narcissistic neurosis.[66, vol. 1] In this paper he applies the libido theory to schizophrenia. The libido is withdrawn from

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external objects and is directed into the ego, giving rise to a state which is called "narcissism."

In his book, *Psychology of Dementia Praecox*,[94] written in 1903 (nine years before his break with Freud), Jung became the first to apply psychoanalytic concepts fully to schizophrenia. His studies, especially his word association tests, convinced him that delusions, hallucinations, and other schizophrenic symptoms were due to the activity of the autochthonous complex—that is, to a group of ideas which, on account of their disturbing emotional charge, had become removed from consciousness and were maintaining a more or less independent existence. Jung applied to schizophrenia the mechanisms that Freud had described in dreams. He wrote, "Let the dreamer walk about and act as though he were awake and we have at once the clinical picture of dementia praecox."

In 1913 Jung differentiated two psychological types: the extrovert, with an exaggerated emotivity and the psychic energy directed centrifugally toward the environment, and the introvert, with inhibited psychic energy, that is, energy directed away from the environment and toward the self. He thought that the person who is to become schizophrenic has an introvert personality.

Later Jung[93,95] advanced the theory of the collective unconscious. According to him, many symptoms of schizophrenia are the reproductions of the "archetypes" deposited in our "collective unconscious."*

Sullivan[161] introduced a new point of view in psychiatry by shifting the attention of the therapist from the intrapsychic or intrapersonal to the interpersonal.† According to him, schizophrenia is an indirect outcome of unhealthy interpersonal relations between the child and his parents (called by Sullivan the significant adults).[159,160,161] These faulty interpersonal relations do not permit the establishment of enduring patterns of response which eliminate anxiety (that is, they do not permit a normal development of what Sullivan calls self-system). The patient resorts throughout his life to distorted interpretations of interpersonal situations (called parataxic distortions) and finally may lose "consensual validation," that is, recognition from others of the validity of his statements. When the anxiety increases and a state of psychotic panic develops, the early experiences, which had been disassociated from consciousness and were part of what Sullivan calls the "not-me," regain awareness in a symbolic but nevertheless frightening manner.

The Phenomenological-Existential School

The phenomenological-existential school of psychiatry has received much attention from students of schizophrenia in the German-speaking countries, where it originated, as well as in France, Italy, and Japan; but relatively little attention in the United States.

Space limitation will compel us to consider only two authors: Binswanger[20-23] and Minkowski.[128,129]

Binswanger is perhaps the best-known psychiatrist of this school. He has devoted four large works to the study of schizophrenia, which consist of the detailed existentialistic analysis of four patients to whom he has given the names Lola Voss, Ilse, Ellen West, and Suzanne Urban. These works have become classics for students of existential psychiatry.

In the reports of these cases Binswanger is interested not in constitutional or psychodynamic or symbolic or characterologic studies of the patient, but in the underlying *structure* that existed prior to the illness and that explains the way of being-in-the-world of the patient, his pathologic potentialities, and the uniqueness of his experiences.

Binswanger tries to explain the delusional world of the patient as the evolving of a theme (terror, for instance, in the case of Suzanne Urban, who is the prisoner of her own theme of terror and becomes the prisoner of a world of terror). Fear of filling the body and becoming fat in order to compensate for an empty existence is the theme in the case of Ellen

* For the concepts of collective unconscious and of archetypes, see Chap. 72.

† For a larger discussion of Sullivan's concepts, see Chap. 70.

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West. Undoubtedly these studies enrich our understanding of the schizophrenic patient and will be useful, provided they are complemented by the psychodynamic, formal, and psychosomatic studies. We must mention, moreover, that it was relatively easy for Binswanger to demonstrate this general theme of the delusional world of the patients because the cases he selected, although prognostically serious, did not yet present a segmentation of the personality or regression. Other psychiatrists might consider them cases of paranoia or paranoid conditions rather than rapidly advancing schizophrenic syndromes.

Minkowski, a pupil of Bleuler, added to Bleuler's conceptions the flavor of Husserl's and Bergson's philosophies. In his major work *La Schizophrenie,* he states that the crucial point of the schizophrenic syndrome is "the loss of vital contact with reality."[129] He also adds that such contact can be re-established as a result of therapy, but does not give instructions on how to re-establish such contact. In other studies[128] he focuses his attention on the alteration of the sense of time and space in schizophrenics. Whereas space expands to include the whole category of the objects that are involved in the patient's delusions, time is blocked and limited to the present.

Other important existentialistic studies of schizophrenia were made by Frankl[64] and Wyrsch.[176]

The Manifest Symptomatology

The clinical symptomatology of schizophrenia, with its various types and stages, presents multiform aspects, but the description of the symptomatology, as reported in this section, will be relatively brief.

General Description of the Disorder

The patient, generally as a young human being (from the time of puberty to his early thirties, but less commonly at any other age of life), starts to show some striking anomalies in his behavior. Although some unconventional traits may have been manifested even earlier, they were apt to be almost unnoticed. Now they become apparent, at times in a slow, insidious, gradual way, at other times more or less acutely.*

The patient seems less interested in life in general and is obsessed instead with some specific problems. Finally he expresses ideas that seem bizarre and are not acceptable to his family or his community. He starts to think that certain things are related to him or have a special meaning (*ideas of reference*). For instance, if he met a person on the street, it was because that person had to spy on him. Finally, the patient gives some interpretation to things that are not supported by the observations made by other persons. (The house is wired, dictaphones are hidden to register the patient's thoughts; poison has been put in the food.) These are false beliefs, or *delusions;* they are generally of negative character, inasmuch as they seem to convince the patient that some people or outside forces want to persecute him, injure him, or at least watch him or plan some future disturbance. At a later stage, however, these delusions may become pleasant in content and even grandiose (the patient is a queen, a millionaire, etc.; a great actor is going to marry her, etc.). Whereas persecutory delusions refer mostly to others, grandiose delusions more frequently refer to the patient himself.

The perceptual functions of the patient seem altered, too, as he sees or hears things in a distorted way. At times things are misidentified (*illusions*). Much more frequent than the illusions, however, are the *hallucinations,* or perceptions occurring without any object or stimulus in the external environment being responsible for them. The patient hears voices which accuse him of being a spy, a homosexual, a murderer, and yet nobody is there to say these things. Hallucinations involve every sense, the auditory being as a rule the most common throughout the course of the disorder. In the beginning, however, especially in very acute cases, visual hallucinations are sometimes as numerous as the auditory. Hallucinations involving smell, taste, and touch are much less

* For a description of the prepsychotic personality see pp. 472–473.

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frequent. Olfactory hallucinations, generally related to one's body, are relatively frequent in mild cases which do not require hospitalization.

In addition to this content of thought which is definitely psychotic in character, the patient may manifest other symptoms which seem neurotic, especially at the beginning of the illness: asthenia and other hypochondriacal complaints.

At times the general behavior of the patient seems normal and the only apparent symptoms are the abnormal ideas. In the majority of cases, however, the general behavior strikes the examiner as much as the content of thought. The general behavior appears odd in many ways: mannerisms, grimaces, purposeless acts, stereotyped motions, impulsive gestures are observed. In addition in the catatonic type there are particular symptoms to be described later.

The mood and the affective sphere in general are altered. The patient may appear angry, highly emotional, suspicious, cynical, etc., especially when he refers to his delusional complexes; as a whole he is somewhat inadequate emotionally. Often the emotional tone does not seem appropriate to the present situations and almost always a blunting of affect, ranging from a relative coldness to complete apathy, can be detected. The patient seems to have completely lost interest in his surroundings and to be withdrawn into himself. He is often described as being "in a shell," in his own world, as if he had lost not only his understanding of but also his interest in reality. When he presents this picture of withdrawal he is generally underactive. His activities are reduced to a minimum and are often performed in a routine, stereotyped manner. Often he has to be pushed to do things. He may be so unwilling to act that he may become neglectful of his personal appearance. A deterioration in his habits of living is apparent in all advanced cases.

The speech and language show peculiar characteristics, some of which will be examined again in this chapter. If certain questions are asked, the patient seems *evasive*, because he does not answer them directly. At times he seems to beat around the bush—he says something related to what was asked but not exactly what was requested. For instance, to the question, "Who is the President of the United States?" he may reply "White House." At times he seems to use impressive abstract words, but in an empty or inappropriate way. In advanced cases it may be difficult to understand what the patient tries to convey. His sentences consist of a sequence of words which seem unrelated to one another (*word-salad*). At times certain words are used repeatedly in a stereotyped manner (*perseveration*); other words are used which do not appear in the dictionary, and which the patient has coined by condensing or putting together usual words (*neologisms*). In many cases the patient is unable to talk (*mutism*), or able to do so only after overcoming a great resistance (*blocking*).

The sensorium and the intellectual functions are not seriously impaired. Orientation, memory, retention, grasp of general information, calculation, etc., may seem disturbed in many cases. The disturbance is actually the result of the other symptoms described, and may disappear once these symptoms disappear. What seems impaired from the beginning is only an ability for very abstract thought, as we shall see later in more detail. Even this symptom, however, is reversible.

Insight, that is, realization of being in an abnormal condition, is absent except in mild or initial states.

PARANOID TYPE

The cases generally classified as paranoid type present, fundamentally, the picture described above; they also, however, present some characteristics of their own. First of all, the onset of the psychosis may occur a little later in life than in the other types. Although many cases of this type occur even as early as the time of puberty, they are common even in the fourth and even fifth decade of life. The older the patient, the more difficult it will be to decide whether his symptomatology is a schizophrenic one or one which is better classified as paranoid state or paranoia (see Chapter 25).

Paranoid patients are as a rule more intelligent than the other schizophrenic patients, although all types of I.Q. are found. From the

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beginning they are suspicious and bitter. They may assume the angry, antagonistic, defiant attitude of the person who is unfairly victimized, or the attitude of the submissive person who wants to be helped but does not know what to do because "strange things are happening."

The content of thought of these patients is characterized by ideas of reference and delusions, even more than other types of schizophrenia. Although the delusions are unsystematized in the majority of cases, they are more systematized than in the hebephrenic type and may be quite well systematized at the beginning of the illness.* In American patients they are almost always persecutory in content, especially at the beginning of the illness. Occasionally one finds grandiose delusions from the beginning of the illness. For some undetermined reasons delusions of grandeur are somewhat more frequent in European patients.

Hallucinations, especially auditory, are common. They may, however, be totally absent in cases in which the personality is fairly well preserved and the delusions well systematized. The progression of the illness may be rapid and lead to advanced regression in a short period of time; as a rule, however, the majority of paranoid patients regress less rapidly than the other types, and many of them remain indefinitely at a stage of illness which is not much advanced and may be called the first or primary stage (see later in this chapter). Paranoid patients remain in better contact with the environment and may adjust better to hospital routine. Often their activities can be channeled into useful work. On the other hand, their suspiciousness, ideas of reference, and delusions may make them antagonistic, rebellious, and even violent. Escapes from hospital and homicidal impulses, at times successful, are more common in this group.

Case 1

George is a 22-year-old man, the second of two siblings in a middle-class family. Although described as high-strung throughout his life, he never showed gross abnormalities of behavior. During college, however, he found the scholastic work increasingly hard. He finally decided to quit school and accepted a job as a salesman, but found that this occupation too was not satisfactory. He became increasingly preoccupied with certain thoughts. On hearing the word "homo," he understood "homo"; if he heard the word "fair," he felt "fairy" was the word really meant. He became more and more convinced that people thought he was homosexual. When he saw groups of people in his neighborhood he was sure that they were talking about him. He often "heard" them talking about him and making accusations. He became more and more preoccupied, upset, unable to attend to his work. He became somewhat neglectful of his appearance, oblivious of the many usual aspects of life, and more and more involved in thoughts of being accused, spied on, spoken of, ridiculed. In a few weeks it became impossible for him to hold his job and he quit voluntarily. A few days later he became increasingly restless. The psychiatrist who was consulted recommended hospitalization.

Hebephrenic Type

The hebephrenic type of schizophrenia is probably the most difficult to define and to diagnose. At times the only difference between this and the paranoid type seems to consist in a more rapid disintegration.

The content of thought is characterized by many delusions which are poorly systematized and poorly rationalized. Grandiose delusions are more common than in the paranoid type. Also much more common are hypochondriacal ideas, preoccupations with the body image, and kinesthetic delusions. It is not rare to find a patient who thinks that he has lost his bowels or that his heart has changed place, his brain has melted, etc. Hallucinations are common and, more frequently than in the paranoid type, are pleasing in content.

The mood may be slightly depressed; oftener it is one of apathy and detachment, interrupted now and then by an apparently humorous or jocular attitude. The patient often smiles in situations which seem completely inappropriate. For instance, a question may evoke an incongruous smile instead of a verbal answer.

* Delusions are called systematized when an attempt is made by the patient not to accept them as unrelated beliefs, but to rationalize them, or to explain them more or less logically with the rest of his life, or with other complexes.

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Language disorders are prominent, especially in cases of rapid regression. Word-salad, clang associations, neologisms are very common.

The dilapidation of personality is soon evident. The neglect of personal habits becomes more pronounced and the patient has to be taken care of.

The prognosis for these cases used to be very unfavorable, as the patient used to sink into an advanced stage of personality disintegration. Today, however, a form of combined treatment succeeds in arresting and recovering many cases.

Case II

Gladys is a 17½-year-old white girl, attending high school. Both her parents had psychotic depressions, from which they recovered with the help of shock treatment. Gladys's familial surrounding is characterized by parental conflicts, usually bickering over money matters. Gladys is the third of three children. The other two never received any psychiatric treatment and are described as well adjusted.

Gladys had always done well in school; but, before consultation, she became apprehensive, her marks fell down, and she became afraid to do her home work. On March 7, 1956, she was seen in consultation. She was in a state of great excitement. She said that soon she would have to take the examinations and she was not prepared. She did not know anything. She constantly repeated the same question: "Should I go to school? Shall I pass the examinations?" but no reassurance would help her. She continued to ask the same question incessantly. Apparently she seemed in good contact as she seemed alert and emotionally alive; actually, nothing that the examiner said registered. No delusions or hallucinations were elicited.

During the night, however, Gladys became more excited, expressed suicidal ideas, and was hospitalized. At the time of her admission she was extremely confused, hyperactive, and resistive. At times, when she was asked a question, she seemed unable to speak spontaneously, but would occasionally utter small whimpering sounds, moving her lips as if to pronounce words but being unable to do so.

The second day after her admission she began to masturbate in the presence of the other patients and also to pick at the skin of her face. She was restless, agitated, and screamed a great deal. At other times she sat on one chair in her room and stared vacantly out of the window. She refused to eat and had to be tube-fed. At other times she laughed in an incongruous way, was flighty, talked in an apparently joyful mood, although what she was saying often appeared completely incoherent.

A few weeks later she occasionally expressed the idea that she was in a concentration camp where the Russians had allegedly put her. Later, when she was given electric shock, she misidentified one of the nurses who was leaving the room, believing that this nurse was her mother.

It is out of place to describe here accurately all the sequences of her behavior. It is enough to say that the members of the staff thought she was not suitable for psychotherapy. She was given a course of electric shock and then one of insulin, but there was no improvement in her condition. On the contrary, she seemed to regress rapidly. In August she was treated with large doses of Thorazine. She became more accessible and responsive to psychotherapy. In September she left the hospital, apparently free of the serious symptoms. She remained, however, somewhat flighty and tending to joke in a rather inappropriate way. Since then she has been undergoing psychotherapy. There has been a gradual, slow improvement.

CATATONIC TYPE

Catatonic schizophrenia, more than any other type, presents characteristics of its own.

After a certain period of excitement, which may even be absent in many cases and which is characterized by agitated, apparently aimless behavior, the patient slows down, reaching sooner or later a state at times of almost complete immobility. The patient may become so inactive as to be unable to move around and take care of his physical needs and must be confined in bed (*catatonic stupor*). The patient in this condition cannot dress or undress himself, does not have the initiative to feed himself in the presence of food or to talk in the presence of other people, even if questions are asked of him. He seems completely paralyzed. At other times, the patient is not so intensely affected, but his activities are still reduced to a minimum. He is not

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really paralyzed. What is disturbed is his faculty to will. He cannot will and therefore cannot will to move. At times he is very obedient and suggestible, because he follows the will of someone else. For instance, if a patient is told, "Show me your tongue, I want to prick it with a pin," the patient may obligingly comply. The examiner may put the body of the patient in the most awkward positions, and the patient will remain in those positions for hours. This is the phenomenon of *flexibilitas cerea* (waxy flexibility). At other times the patient puts himself in an awkward or statuesque position and remains in that position until he is put to bed, to resume the same position the following day. A phenomenon that seems opposite to this suggestibility but is instead related to it is *negativism*. Instead of doing what he is requested to do, the patient does the opposite. For instance, if he is told to show the tongue, he closes the mouth tightly or turns the face away. If he is told to stand, he assumes a reclining position, etc. In many cases a few activities remain, but they are carried out in a routine, stereotyped manner. Any spontaneous or new activity is abolished.

Delusions and hallucinations are present in many cases. They cannot be elicited, however, because the patient cannot communicate to the examiner until he improves. Often they are of a general and cosmic quality. "The world is being destroyed." Attempts to talk to the patient often elicit other symptoms. Echolalia is prominent—that is, instead of answering the questions, the patient repeats the questions. At other times the answers are monosyllabic; at still other times neologisms are numerous. The handwriting manifests a peculiarity of style which is even more pronounced than in other types of schizophrenia. The general behavior is characterized by mannerisms, grimaces, and bizarre acts.

Case III

Anthony is a 24-year-old male who, in the past few weeks, had been brooding excessively about his life. He did not feel well but did not know how to explain his malaise. No hallucinations or delusions were elicited. There was an urge to make contact with people, while on the ward, but there was also a sense of disappointment. One morning a few days after his arrival, he was found in a statuesque position, with his legs contorted in an awkward position. Attempts to talk to him were of no avail. He acted as if he could not hear or see anything. His face was completely deprived of any mimic play and did not reveal any emotion. A few days later he could talk a little bit, but in an echolalic way. For instance, to the question, "What is your name?" he would reply, "What is your name?" He had to be taken care of, and spoon-feeding was necessary. Total remission from this episode was obtained with electric shock treatment.

Simple Type

Simple schizophrenia almost never occurs in an acute manner. The beginning is slow, insidious, and generally goes back to a time preceding puberty. The major changes, however, occur after puberty, when the family realizes that the patient is not up to par in spite of the expectations that at an earlier age he had evoked in people. The patient becomes quite inactive and limits his life as much as he can. He refuses to go out, to go to school or to work, and gradually his life becomes very restricted. When he talks there is no looseness of ideas or illogical sequence of thought, as in other forms of schizophrenia, but rather *poverty of thought*. The patient is able to talk only about a few concrete things, abstract notions being eliminated. Careful examination of thought processes reveals an impairment of abstract thinking.

Hallucinations, delusions, ideas of reference, and other obvious symptoms are absent. In spite of the absence of these obvious symptoms, the behavior of the patient remains odd, inappropriate, insufficient to the demands of life, and his affect is inadequate. Unless hospitalized or successfully treated, the patients remain a burden to their families. When no family is available, they end up by becoming hoboes, prostitutes, men at the services of gangsters, etc.

Case IV

Mary is the older of two sisters. The father was an alcoholic who died when the patient was a child; the mother died when the two daughters were in their teens. Although Mary had never

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appeared very bright, her inadequacies became more evident after the death of her mother. At that time she became even more dependent on her sister. Mary had several jobs, but could not fulfill them adequately. She was repeatedly fired, or she herself left the job because she felt the work was "too much for her." She refused the few invitations to go out with young men and restricted her life to a minimum. Finally it was agreed that her sister would go to work and she would attend to the care of the household. But even that became "too much for her." She would remain idle for hours and hours and showed no interest in anything. She had to be told what to do, even in relation to her personal needs. Finally the sister decided to hospitalize her. At admission she appeared neat and tidy and able to take care of herself, and accepted hospitalization without protest. On the contrary, it was a relief for her to be away from the world, where she had to make so many efforts. No hallucinations, delusions, or ideas of reference were elicited. Her life became reduced to a few stereotyped acts. The nurses and attendants could not persuade her to do more than a minimum amount of work on the ward. When her sister visited her in the hospital she seemed to sink into a mild state of depression.

CHANGING ASPECTS OF SCHIZOPHRENIA

In the last few years many clinicians have noticed some changes in the symptomatology of schizophrenia, changes in the incidence of the various types and in the intensity of the symptoms. As far as the intensity of the symptoms is concerned, many psychiatrists, especially those who are in private practice and do not work in psychiatric hospitals, report that they see many patients with symptomatology so mild as not to require hospitalization. These are not latent cases in the sense described by Bleuler, but patients who are actively psychotic, although their symptoms are few and not pronounced. It is difficult to determine statistically whether this increase in mild cases is more apparent than real. The explanation that comes to mind is that today, with the greater understanding of psychiatry and with increased psychiatric facilities, many patients who, because of the relative nonseverity of their symptoms would not have been recognized, are easily diagnosed now. Whether the increase in these mild or oligosymptomatic cases is real or apparent, the fact remains that the psychiatrist in private practice today is bound to see a large number of them and therefore must be able to recognize them.

In addition to the change in the intensity of symptoms, there is also a quantitative change in the percentage of the various types of schizophrenia, a change which is apparent especially to psychiatrists who are associated with hospitals. Until about two decades ago, there was not too marked difference in the incidence of the hebephrenic, paranoid, and catatonic forms (with the simple type trailing); now many admitting psychiatrists feel that the paranoid type is by far the most common.

It is relatively easy to understand the decline in the number of hebephrenics, as possibly many cases previously diagnosed as hebephrenic were paranoid with rapid disintegration. Timely intervention would have arrested them at a paranoid level. More difficult to explain is the decline of full-fledged catatonic patients, who, until fifteen years ago, were much more common. From colleagues working in small hospitals we hear that the admission of a catatonic patient with typical symptoms, such as stupor and waxy flexibility, has become almost a rarity.

Oligosymptomatic Forms of Schizophrenia

It must be understood that when we refer to mild or oligosymptomatic cases, we are not speaking about the borderline cases described in Chapter 21. A borderline case, as we generally use this term today, is that of a patient who, although presenting a symptomatology so serious as to be classified between the neuroses and the psychoses, generally is not psychotic, does not act as a psychotic, and most probably will never become fully psychotic. The mild cases which are going to be described are considered psychotic.

Paranoid Type

No definite delusions or hallucinations are found in the oligosymptomatic form of the para-

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noid type. The patient, however, is suspicious and antagonistic and a *paranoid flavor* characterizes his conversation. Often his parents, siblings, or in-laws are the object of his distortions in thinking. The aim of these relatives or other people is allegedly that of hurting the patient, of spoiling his reputation, etc. Even what the therapist says to the patient is misinterpreted, as the patient often clearly gives it a special twist. This tendency to misinterpret, at first limited to dealings with relatives, later spreads to employers and co-workers, so that finally it becomes impossible for the patient to maintain his occupation. If the patient is not treated, full-fledged psychotic episodes, with definite delusions and hallucinations, may occur.

Hebephrenic Type

In the oligosymptomatic form of the hebephrenic type, the patient complains a lot about physical ailments. Often he attributes the responsibility for his troubles to previous physicians who allegedly have treated him badly. At times there is an incongruous euphoria. Odd ideas, either of reference or semi-grandiose, creep in. There is an apparent lack of anxiety.

Catatonic Type

There are no motor disorders in the oligosymptomatic form of the catatonic type, but the activities of the patient are reduced to a minimum. It takes the patient an enormous amount of time to do simple things. To get dressed or undressed may require two or three hours, and it becomes a real ordeal. The patient refuses to get out of the house. When he goes out he arrives extremely late. Occasionally, almost catatonic episodes occur. There is no catatonic immobility but the patient is confined to bed for several days, refusing to get up in spite of absence of physical illness. The patient may improve completely, only to develop a full catatonic attack a few years later.

Simple Type

It is often difficult to distinguish the oligosymptomatic form of the simple type from that of the mild catatonic type. The patient seems to have more anxiety than the classical form of the simple type. Like the catatonic, he does not want to go out of the house or seek employment, and tells you that he "cannot do it." Activities are reduced to a minimum and are extremely slow. The sleep rhythm is altered. Often he sleeps during the day and stays up until very late at night or the early part of the morning. In quite a few cases he becomes overconcerned with his appearance, or his weight. He may go into periodic eating sprees which alternate with periods of almost total starvation.

It is often difficult to determine to which one of the classical types of schizophrenia these mild cases belong. Often one gets the impression that they are mixed or undifferentiated and that the effort made to recognize in them a particular type is mostly due to our desire to adhere to the kraepelinian terminology.

A type of schizophrenia which is increasingly recognized by many practictioners is that described by Hoch and Polatin in 1949[86] as *pseudoneurotic schizophrenia*. Under this name the authors described a syndrome whose symptoms are not usually considered characteristic of schizophrenia. The diagnosis is made on the subjective evaluation of the constellation of symptoms. The patients present "pan-anxiety" and "pan-neurosis." That is, "an all-pervading anxiety structure . . . does not leave any life-approach of the person free from tension." By "pan-neurosis," the authors mean that the patients do not have only one or two neurotic manifestations, but that "all symptoms known in neurotic illness are often present at the same time." Gross hysterical mechanisms, vegetative dysfunctions such as poor sleep, anorexia, vomiting and palpitations, phobias, obsessions, and compulsions may all be present. The neurotic manifestations shift constantly but are never completely absent. "A considerable number of these patients have short psychotic episodes or later become frankly schizophrenic."

Atypical Forms of Schizophrenia

In addition to the types of schizophrenia described in classical psychiatry, several other forms which are atypical or rare, have been individualized.

The most important of this atypical form is perhaps *childhood schizophrenia*, first described by DeSanctis under the name Dementia Praecocissima,[51] which has recently received much consideration in the American literature.

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Since the topic of childhood schizophrenia is presented in Chapter 41, no report of it will be made here.

Schizoaffective psychoses are conditions characterized by recurring episodes which present a mixture of schizophrenic and manic-depressive symptomatology. For instance, the patient may present ideational content with delusions, ideas of reference, and hallucinations which seem typically schizophrenic, and yet at the same time show other symptoms such as a mood of depression accompanied by ideas of guilt and self-accusation or a mood of elation with a grandiose overtone. Although at the beginning of the illness the manic-depressive traits appear the predominant ones, in the long run the symptomatology assumes a typical schizophrenic aspect, indistinguishable from the classic types of schizophrenia. If the illness is characterized by several psychotic episodes, generally every successive attack is more and more typically schizophrenic and less and less manic-depressive.

Schizophrenia in old age is a condition which is accepted by a few, denied by many. At times we see a paranoid condition in old people which resembles a schizophrenic reaction. The more maladjusted the personality of the patient before the onset of the psychosis, the more schizophrenic or schizophreniclike is the condition. The majority of psychiatrists classify these cases under the heading of *paranoid type of senile psychosis.* In other cases, which present many bizarre delusions of grandeur and hallucinations which are "voices of comfort" to the patient, we must probably deal with latent cases of schizophrenia, of long duration, which become manifest when old age occurs.

Schizophrenia accompanying other diseases presents diagnostic problems. Not infrequently we see schizophrenic symptomatologies with patients presenting the serology of general paresis, or epilepsy, Huntington's chorea, postencephalitic conditions, multiple sclerosis, pernicious anemia with nervous complications, cerebellar atrophies, etc. Although in some of these cases the crippling effects of the organic disease may have increased the anxiety of the patient and released a potential schizophrenia, most psychiatrists feel that in the majority of these cases an organic diagnosis should be preferred.

Propfschizophrenia is a form occurring in a small minority of mental defectives, generally at the moron or borderline level. It is characterized by paranoid episodes with delusions and hallucinations, which may be followed by slow regression.

Folie à deux and *à trois* will be discussed in Chap. 25.

Course

Schizophrenia distinguishes itself from any other known pathological condition by the great variability of its course. Some patients recover from an acute attack even in a few hours or days, others in several months, others remain sick for the rest of their lives. Those who remain sick may show an arrest of the disorder at a certain stage, whereas others undergo a slow but progressive regression.

This author feels that, in addition to distinguishing schizophrenia from the point of view of types, it is important to differentiate the stages, which he distinguishes thus: the first or initial stage; the second or advanced stage; the third or preterminal stage, and the fourth or terminal stage.[4, 5, 7, 8]

Most of the patients seen by psychiatrists in private practice belong to the first or initial stage. Even if the patients are undergoing a second or third attack, they generally belong in the first stage, as modern types of treatment prevent them from progressing further. After the third attack the patient tends to advance rapidly to subsequent stages. Statistics vary considerably as to the frequency of recurrences.

The first stage of schizophrenia extends from the period when the patient starts to lose contact with reality to the formation of the characteristic symptoms of schizophrenia. The onset may be acute or slow. In acute cases the patient retains great anxiety and restlessness. He seems either to fight his illness and want to return to reality or to fight the external world in an attempt to vindicate his symptoms. There is great variation of symptoms in this period, except in case of the catatonic patient, who may exhibit all the catatonic

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characteristics from the very beginning. Some catatonic patients, however, may change into a paranoid picture and vice versa.

This first stage is characterized by the presence of anxiety, and lack of a certain equilibrium, in spite of the presence of typical psychotic symptoms. We may distinguish in it three substages:

1. A substage of *panic*—when the patient starts to perceive things in a different way, is frightened on account of it, appears confused, and does not know how to explain "the strange things which are happening."

2. A substage of *psychotic insight*—when he succeeds in "putting things together." By devising a pathological way of seeing reality, he is able to explain his abnormal experiences. The phenomenon is called "insight" because the patient finally sees meaning and relations in his experiences, but the insight is psychotic because founded on mental processes which occur only in a state of psychosis.

3. A substage of *multiplication of symptoms*—when symptoms become more and more numerous as the patient vainly attempts to solve his conflicts and remove his anxiety with them.

The second, or advanced, stage is characterized by an apparent acceptance of the illness. All the classic symptoms are present and they do not seem to bother the patient as much as before. Life has become more and more restricted and lacking spontaneity. Routine and stereotyped behavior are outstanding.

In the third or preterminal stage many symptoms seem to have burned out and the four types of schizophrenia resemble each other so much that it is often difficult to distinguish a paranoid from a catatonic. At this stage primitive habits such as that of hoarding useless objects and of decorating oneself in a bizarre manner are conspicuous.[4,5,7,8] This stage generally occurs from five to fifteen years after the beginning of the illness, but may occur sooner or later.

In the fourth or *terminal* stage the behavior of the patient is even more impulsive and reflexlike. Primitive habits are replaced by others even more primitive. Hoarding of objects is substituted by food grabbing, and later by ingestion of small objects, edible or not (placing-into-mouth reaction).[5,7]

Later, during the fourth stage (although in some cases even at a much earlier one), many patients present what appear to be perceptual alterations. They seem insensitive to pain, temperature, and taste, although they still react to olfactory stimuli. This anesthesia is the cause of many accidents (for instance, burning by sitting too close to a radiator). Although it is pronounced, it may be the result of the fact that the rough sensations are not associated and elaborated to the perceptual level rather than of a definite impairment at the level of sensation.[7]

Diagnosis

Psychodynamic and formal studies, as well as prolonged contacts with patients for psychotherapy, make the diagnosis easier, in the great majority of cases, than the diagnostic studies used in the past.

It is true that there is a group of cases, called latent, borderline, character disorders, etc., where the diagnosis is questionable, but here the diagnosis is apt to be the result of the nosologic concepts held by the psychiatrists rather than of the symptomatology of the patient. Furthermore, in these borderline areas the diagnosis is really less important than the dynamic understanding of the case.

The first rule to be adopted in attempting to diagnose schizophrenia is that an individual symptom or a few symptoms should not be considered absolute proof of the condition, but that the constellation of symptoms should be evaluated in its entirety.

Schizophrenia is at times confused with functional as well as with organic conditions. Of the former, it used to be confused with hysteria, when this neurosis was much more common than it is now. Hysterical attacks occur more suddenly in young adults who generally present an extrovert personality, and are characterized by conversion syndromes. The symptomatology is easily influenced by certain persons in the immediate environment and responds easily to hypnosis.

Not infrequently manic-depressive psychosis

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is diagnosed because the symptoms of that psychosis may also appear in schizophrenia. They are, however, eventually replaced by schizophrenic symptoms, and in a second attack the diagnosis is easy. (For differential diagnosis between catatonic stupor and excitement and depressed stupor and manic excitement, see Chapter 22.) The same consideration holds true for psychopathic conditions. At times, early schizophrenics are diagnosed as psychopaths. In patients who eventually reveal themselves as schizophrenic, the apparent psychopathic acts are more bizarre and the general detachment from reality more pronounced.

Organic conditions which may be confused with schizophrenia are the following:

General paresis, but history of syphilis and serological and spinal fluid examinations leads to the diagnosis.

Epilepsy, especially psychomotor. Some schizophrenic attacks seem epileptic, but are generally not accompanied by loss of consciousness. Electroencephalogram generally leads to the diagnosis.

Brain tumors, especially of the prefrontal lobes, and early arteriosclerotic and presenile psychoses may be confused, particularly when at first they manifest themselves with paranoid symptoms. In these cases, however, X-ray, electroencephalogram, pneomoencephalogram, as well as the marked change of the sensorium, lead to the diagnosis. Huntington's chorea is occasionally mistaken for schizophrenia (see Chapter 61).

Mental deficiency may be mistaken for the simple type of schizophrenia, and vice versa. Generally, in mental deficiency the defect was apparent in childhood whereas in the simple type it manifested itself at or after puberty.

Alcoholic hallucinations must be considered every time there is a history of alcoholic addiction.

The catatonic type of schizophrenia may at times be confused with a rare syndrome called akinetic mutism, first described by Cairns[39] and associates in patients having lesions near the third ventricle. These patients cannot move or talk, but generally have other neurological symptoms and are affected by hypersomnia.

¶ The Psychodynamics of Schizophrenia

What was described in the previous section is only the last and most apparent phase of a much-troubled life history. Psychodynamic studies reveal that the road leading to schizophrenia has its beginning in the remote past of the patient, perhaps shortly after his birth. Some authors push the beginning further back, to the intrauterine life.[63] Others feel that the parental attitudes which are so important in determining the conflicts of the patients have their roots in sociological, historical, and geographical conditions.

It is generally agreed that the psychodynamic studies should include only the psychological life experiences of the patient. Other experiences such as physical illnesses, unless studied in reference to the psychological impact that they have had, cannot be included among the psychodynamic factors.

Although these psychodynamic studies have revealed nothing that can be considered absolutely specific for the life of schizophrenics, we find that certain constellations of circumstances, events, or factors cluster more frequently in the life of schizophrenics than in that of the average individual. We find, thus, that the troubles of the patient start early in childhood.

The Family of the Schizophrenic

One of the first vivid impressions that we get in dealing with patients and their relatives is that the family of the patient is not a happy one, or at least was not so in the formative years of the patient. The unhappiness, although aggravated at times by realistic situations such as poverty and physical illness, was as a rule determined by psychological factors, predominantly by the unhappy marriage of the parents. The marriage was unhappy not only because of the character incompatibility and

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personality difficulties of the parents but also because such difficulties, instead of being compensated for or countered by less destructive defenses, were enormously aggravated by the process of living together. This atmosphere of unhappiness and tension, although all-pervading and pronounced, in many cases is not apparent to the casual observer, as an attempt is made by all concerned to conceal it not only from the external world but also from themselves. At times it is almost totally repressed and replaced by psychological insensitivity.

Theodore Lidz has made intensive studies of the family of the schizophrenic and, in collaboration with his associates, has written a number of papers which study such families from every angle.[111-115]

Lidz and his associates found that the role of each spouse in the family cannot be well established and that no attempt is made by them to complement or to help each other. There is no possibility of getting together, of reciprocal understanding and cooperation, no mutual trust, no confidence, but rivalry, undercutting of worth, threat of separation, and enrollment of the children's support against the other. Each partner is disillusioned in the other: the husband sees the wife as a defiant and disregarding person who also fails as a mother. The wife is disappointed because she does not find in her husband the father figure she expected. In this background the family is often split into two factions by the overt *marital schism* of the parents. Generally the children belong to one side of the schism or to the other.

In addition to marital schism Lidz and his associates find "marital skew" a frequent occurrence in the family of schizophrenics. In these skewed marriages, the serious psychopathology of the dominant parent is accepted or shared by the other. This author, too, without using this term, has described several skewed marriages in the families of schizophrenics.[4] He has found that a frequent combination is that of a domineering, nagging, and hostile mother, who gives the child no chance to assert himself, married to a dependent, weak man, too weak to help the child. He found another combination less frequently, but frequently enough: a tyrannical father is married to a weak mother who has solved her problems by unconditionally accepting her husband's rules. These rules do not permit her to give enough love or feeling of acceptance to the child.

Mothers and fathers of schizophrenics have also been studied individually. Many authorities consider the mother the main dynamic factor in the genesis of the child's future psychiatric condition, and have devised the classification "schizophrenogenic mother." She has been described in many ways: overprotective, hostile, overtly or subtly rejecting, overanxious, cold, and distant, etc. In many cases she is found definitely unfit for motherhood. She is unable to give herself to the baby. Sometimes she tries, but does not know how. The author has found that in the majority of cases the mother was either extremely rejecting in the tender years of the patient, or extremely anxious.[6, 11]

The father of the schizophrenic patient was also studied by Lidz and his associates.[114] Whereas previous authors had emphasized the weakness, aloofness, and ineffectiveness of the father in the paternal role, Lidz and associates describe him as insecure in his masculinity, in need of great admiration in order to bolster his shaky self-esteem, not infrequently paranoid or given to paranoidlike irrational behavior, and equating his wife in imperviousness to the feelings and needs of others.

Summarizing these studies, and in particular Lidz's, one may conclude that although nothing has been found which is specific for the families of schizophrenics, presumptive evidence indicates that a tremendous amount of conflict, tension, and anxiety exists and has always existed in these families. It does not matter whether the parents are overtly rejecting or overanxious or irrational and paranoid: the result is the same. They offer to the patient an environment saturated with anxiety, an environment where his attempts to grow psychologically will be thwarted.

Before leaving this topic, however, we must consider two facts to which Lidz and his asso-

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ciates have given particular importance: the first is that the family operates as a destructive agent not only in the first two or three years of life, but also afterward. The second is that the irrationality of the parents is often transmitted directly to the patient. In other words, some delusional or quasi-delusional conceptions of the parents are accepted by the patients, without further elaboration, just as happens in *folie à deux*. As a matter of fact Lidz speaks of a *folie à famille* in the family of the schizophrenic.

To this writer it seems that to a large extent Lidz and his collaborators are right. Many therapists (Rosen,[148] Benedetti[17]) reached similar conclusions. For instance, a patient kept hearing a voice telling her that she was a prostitute. But she had really been accused by her mother of being a prostitute, because she was wearing lipstick and had been kissed by a boy. We must remember, however, that in the majority of cases the irrationality is not transmitted with such simple mechanisms. The irrationality of the patient, although stemming from that of the parent, undergoes extensive autistic metamorphoses.

Childhood

It is necessary to discuss some phases of normal psychic development in order to understand better what happens in the person who is likely to become schizophrenic. The writings of Sullivan,[161] Buber,[33] George Mead,[121] and a few others have helped the author to formulate these concepts.

The newborn human being needs other members of his own species in order to survive and to grow physically and psychologically. This growth will proceed in accordance with its potentialities if the child, with the help of others, obtains a state of *satisfaction* and a state of *security*.[160] A state of satisfaction of the physical needs, such as food, sleep, rest, warmth, and contact with the body of the mother, is enough for the growth of lower species, and for the growth of the human being in the first months of life. But, in order to continue to grow normally after the first twelve months, the human being needs, in addition to a state of satisfaction, a state of security.

Before the others acquire a "significant" or symbolic importance, the life of the child is almost entirely governed by reflexes, conditioned and unconditioned, and by autonomous mechanisms.

Things are taken for granted by the child; they are expected to occur as they have occurred before. After a certain stimulus, hunger for instance, a subsequent act—the appearance of the mother's breast—is expected. Later the child comes to feel that all things in life are due to others or depend on others. It is up to mother to give him the breast, to keep him on her lap, to fondle him. The child learns to see everything in a teleologic way—everything depends on the will or actions of others. But together with the feeling that everything depends on others there is also the feeling that people will do these wonderful things. In other words, the child expects these wonderful things to happen; he trusts adults. At first, of course, these feelings of the child are vague, indefinite. Since the child is deprived of the use of abstract words to describe these phenomena, his expression of these feelings remains at a primitive level. We may describe them as diffuse feelings, postural attitudes, physiological preparation for what is expected, nonverbal symbolism, and so forth.

Later, the child also expects approval from others. That is, the child expects the significant adults to expect something of him; the child *trusts* that the adults will *trust* him. In other words, there is a reciprocal trust that things are going to be well, that the child will be capable of growing up to be a healthy and mature man. The child perceives this faith of the mother and accepts it, just as he used to accept the primitive responses to the usual stimuli. He finally assimilates the trust of the significant adults, and he *trusts* himself.[11] Thus, things will no longer depend exclusively on others, but also on himself.

This feeling of trust in oneself originates to a large extent from the approval that the others had for the child, or, as Sullivan says, from reflected approvals.[160] This favorable expectancy, which at first is limited to the immediate future, becomes extended to the immediate

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contingencies of life and then expands into a feeling of favorable anticipation as far as a more or less distant future is concerned. A basic optimism, founded on basic trust, is thus originated. Security consists of these feelings.

This atmosphere, first of satisfaction, and then of security, facilitates the introjection in the child of the symbolic world of the others. It is this introjection that actually permits the emergence and the growth of the self, especially the introjection of the attitudes, feelings, verbal symbolisms, etc., emanating from the mother.

Using Buber's useful terminology and conceptions, we may say that an I-Thou relationship exists. Psychologically, this means that without others and trust in them there would be no I, no development of the self. Buber's "I-Thou" expression corresponds approximately to Sullivan's "me-you" expression.

The development of the self, emerging by the incorporation of the Thou while a state of satisfaction and security exists, permits the child to attain a stable self-image. The self-image consists of (1) the body-image, (2) self-identity, and (3) self-esteem. As to the body-image, the child will have a realistic appraisal of himself and will be able to identify with his own sex. As to self-identity, the child will become aware of his role in the family and in society. As to self-esteem, he will trust himself and will have a sense of confidence and optimism.

It is obvious that in the families of schizophrenics this normal development cannot take place. We find, instead of a state of satisfaction and security, an atmosphere of anxiety. Anxiety occurs in absence of a state of satisfaction or security or both. The anxiety due to lack of satisfaction would not alone lead to schizophrenia, because it is based on mechanisms more primitive than those involved in the pathogenesis of this disorder. Some schizophrenics were not deprived of satisfaction during the first year of life, but of security later, for many parents are capable of functioning as such when the child is a baby, who has not yet developed a will of his own and is completely dependent. In many other cases, however, the patient was deprived of both his early need for satisfaction and his later need for security.

In the families of schizophrenics there is at first no emotional detachment: all are involved with each other without helping each other, but the little child cannot entirely accept the others, or the Thou, because the Thou is too threatening, is a carrier of too much anxiety. This is the beginning of the schizophrenic cleavage, this never-complete acceptance of the Thou, or the social self, of that part of the self that originates from others. This Thou tends to remain unintegrated or to become dissociated, like a foreign body which is easily externalized in forms of projection and hallucination.

These difficulties in accepting the Thou are manifested by the reluctance of these children to acquire the language and ways of the surrounding adults and by the emergence of such autistic ways and expressions as neologisms. Autistic tendencies exist even in normal children to a minimum degree, but they are more pronounced in pathological conditions—that is, when the child is afraid of the first interpersonal relations. In some cases autistic manifestations become so pronounced as to offer the picture of childhood schizophrenia or of "early infantile autism," as described by Kanner.[100,101] In most cases, however, even of preschizophrenics, these autistic tendencies are repressed and the individual acquires the symbols of the others, but a propensity to lose them and to return to one's private autistic ways will persist.

A second characteristic in the childhood of preschizophrenics, found from the second to the fifth year of life, is a certain inconsistency in what is repressed from consciousness. To use Sullivan's terminology, the "not-me" threatens to come back to awareness, as the normal mechanism of removing unpleasant things from consciousness seems to be less efficient in these children. At times the child succeeds in repressing the bad images that he forms of the parents, especially of the mother. But these repressed images tend to become conscious again or to be transformed into symbolic forms later on in life. In a minority of cases, the bad image of the mother is totally repressed and replaced by the image of the good, omni-

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potent mother, corresponding to the image the child had built during babyhood, when his needs *for satisfaction* were well taken care of. This image of the mother, however, predisposes to regression and total dependency. If the child should become a baby again, mother will love and protect him.

The self-image, too, is based on unstable foundations. Because the patient is rejected or feels rejected by both parents and cannot identify with either one, he may have difficulty in identifying with either sex. Later he may not be able to find a complete heterosexual or homosexual integration, and may maintain some unconscious uncertainty about his sexual identification. Being unable to take or to visualize roles, he will have an unstable sense of self-identity, and being unable to introject trust, will have low self-esteem.

Often, the parents perceive that things are not right with the child. This realization increases their anxiety, leading not to constructive remedies, but to increased unhealthiness in the atmosphere. It is a two-way stream, a reverberation of anxiety from the parent to the child and from the child to the parent.

Children who are raised in disturbed homes nevertheless succeed in finding "compromises" or remote defenses which permit them to deal with others. With much more difficulty than normal children, they develop what Sullivan calls enduring patterns of response, or a workable "self-system." There is another important handicap in the formation of the self-system—the inconsistency of the parents. The children cannot learn effective defensive measures, because the unpredictability of the parents may render these defenses inadequate. Nevertheless, some kind of integration occurs even in the most unfavorable situations. We have thus the formation of a personality, although a prepsychotic one. It is in this prepsychotic personality or character structure, rather than in typical psychoneurotic symptoms, that the psychotic-to-be finds his defenses.

Another difficulty in the formation of a workable self-system lies in the presence of the double-bind type of communication, which Bateson[13,14] has found prevalent in preschizophrenics. The future patient receives, predominantly from his mother, a message with two or more logical meanings so related to each other as to induce painful conflict. In the words of Donald Jackson,[91] "It's a sort of game, or gambit, set up by mother so that the child is damned if he does and damned if he doesn't"; he does not know to which of the messages to respond. Bateson gives the following example as an illustration: the child cries and the mother goes to him. Her impulse is to get rid of the child, perhaps to kill him, but her feelings about this impulse compel her to feign acceptance or love. The child perceives the original impulse and the simulated love (the double-bind) and becomes confused and anxious.

Such situations undoubtedly occur oftener in the childhoods of schizophrenics than in the childhoods of other people and may be considered one of the factors responsible for the general state of anxiety that eventually leads to the disorder.[11]

The Prepsychotic Personality

The most common preschizophrenic psychotic personalities are the schizoid and what the author calls the stormy personality.

The schizoid personality is found not only in people who are liable to become schizophrenic but also in neurotics, in people with character disorders, and in a mild form even in people who are considered normal. In the potential schizophrenic, however, it is particularly pronounced and has additional characteristics.

The person who has a schizoid personality appears aloof, detached, less emotional than the average person, and less involved. This emotional detachment originated as a defense against those intense interpersonal relations which occurred in early childhood and which proved destructive. Neurotic children may find defenses in other ways against similar family situations—that is, they may become compliant and submit to the parents unconditionally or become aggressive and fight the parents, and/or develop several neurotic symptoms, such as phobias, compulsions, etc. The person who is becoming schizoid selects instead a pattern similar to the one Horney[87] described as

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"moving away from people." Emotional detachment will permit the child to be less concerned or to suffer less on account of the bad images he has formed of his parents, and on account of his self-image and of the general difficulties in life.

In addition to this emotional detachment, or rather as a consequence of it, the schizoid person limits his life experiences—his social contacts, his activities, his usual functions. The "object-relationships" are decreased in number.

It is important to remember that this schizoid personality is only a character armor, a defense the patient has evolved in order to fight the anxiety in living. Actually, the schizoid person is very sensitive; it is because of his oversensitivity that he has to defend himself with this character armor. By decreasing his contacts with society, he shows paradoxically how involved he is with society, and how afraid he is of people.

Although this defense may protect the patient so that he can remain schizoid for the rest of his life, it may also become more destructive than constructive unless treatment or other circumstances change his basic attitudes. When the patient had to contend only, or predominantly, with his family, this character armor may have been an adequate defense, but at about the time of puberty the patient discovers that not only his family but the world at large makes demands on him. He feels "pushed around" when environmental forces compel him to do things in spite of his detachment. On the one hand, reduction of his experiences in living has made him unprepared, hesitant, awkward, fearful; on the other, the early unhealthy experiences, which he may have forgotten, continue to alter or to give a particular flavor to his present experiences. Symbolically, and unconsciously, every interpersonal situation is experienced as a reproduction of the old parent-child relationship. As a matter of fact, a compulsive attitude often compels the patient to make this reproduction more like the original situation than it actually is.

At times the patient himself is not satisfied with his withdrawal and harbors strong desires to make excursions into life, but every time he tries, he is burdened with anxiety, is awkward and ineffective, and meets defeat. Defeat in its turn reinforces his inferiority feelings, and a vicious circle is thus perpetuated.

In addition to the schizoid personality, which is well known in the psychiatric literature, the present author has described another type of personality frequently found in persons who are apt to become schizophrenic. This is the *stormy* personality.[4]

People with a stormy personality did not find a defense in emotional detachment or withdrawal. They tried many possible ways; at times extreme submissiveness, at other times aggressiveness, at other times even schizoid detachment. This variety of responses to people was generally determined by the inconsistency of the parents. These patients have developed an even less workable enduring pattern of response than have the schizoids. Their self-images and self-identifications are even more indistinct than those of the schizoid. They keep trying to reach people, but each attempt leads to hurt. In a certain way they are like schizoid persons who have been deprived of the character armor of indifference and therefore experience a tremendous amount of conscious anxiety. They are very vulnerable; every minor event can unchain a crisis. Life is generally a series of crises, frequently precipitated by little happenings which are magnified by the patients, who unconsciously see in them symbolic reproductions of original anxiety-producing situations. At other times the patients seem actively to precipitate crises. They search actively for a meaningful way of living, but the inappropriateness of their actions (bizarre marriages, love affairs, absurd jobs, etc.) lead them to repeated crises. They actually live a stormy life: often they resort to excessive use of drugs and alcohol in order to abate the storms.

Precipitating Factors and Psychotic Episodes

As we have already mentioned, in many cases the prepsychotic personality actually hastens a state of overt disequilibrium. At times a slow change in inner and overt behavior oc-

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curs, and we have that deterioration of habits described by Adolf Meyer.[124] At other times, we find that new situations strain the already tenuous defenses of the patient. A new situation, such as a marriage hastily made in spite of psychological unpreparedness, a reunion with a person who elicits great anxiety, a change or a loss of a job, etc., may increase the anxiety and precipitate the actual psychotic episode. In these cases one has the impression that a challenge presents itself which the patient has to accept and which is liable to disrupt the weak defenses. Frequently the birth of a child is such a challenge, precipitating a psychosis in the mother. These psychoses, which Zilboorg[176] called postpartum psychoses, are actually either schizophrenic or manic-depressive attacks, much oftener the former. The woman, as a result of a double identification with her own mother and with the child, experiences a state of panic. At times she would like to leave husband and child, but she cannot; she accepts the challenge, but the challenge proves too much for her and she develops a psychosis.

Social Factors

Sociological, historical, and geographical factors have important connections with the incidence of schizophrenia, but space limitations prevent us from giving an adequate account of this subject. The volumes by Faris and Dunham,[56] Malzberg,[129] Weinberg,[169] and Rose[147] deal more specifically with these subjects. See also Chapter 6 of this book for ecological factors and Chapter 7 for statistical data.

Only fundamental issues will be briefly mentioned here.

Schizophrenia is believed to occur in every country and under any type of culture. Studies of comparative incidence rates, however, are even more difficult in schizophrenia than in other conditions because of the different concepts of schizophrenia adopted in the various schools of psychiatry and because of the large number of mild cases which may or may not be hospitalized, according to such varying factors as opportunity for treatment, therapeutic policies, and attitudes of the community.

Although the following statements have not been established with any scientific or statistical rigor, they are probably accurate:

1. The incidence of schizophrenia seems to have increased everywhere.

2. Schizophrenia occurs more frequently: in urban areas than in rural areas; in industrial areas than in nonindustrial; among foreign-born than among native-born; among immigrants than among people born in the place where they reside; among ethnic minorities than among the majorities.

3. Faris and Dunham[56] found that the rates of schizophrenia vary in different areas of the city. In the center of the city there is the highest incidence, with progressive decline going toward the periphery. They are, however, also the areas where delinquency, crime, prostitution, and drug addiction are more frequent. It would seem thus that schizophrenia tends to occur more frequently in areas of extreme social disorganization.

4. The present writer has the impression (not statistically proved) that, although schizophrenia may occur in every type of society, it tends to be more common in that type of society which Riesman[141] calls other-directed. In other words, it would have a distribution different from that of manic-depressive psychosis. It is much more difficult, however, to prove this impression than it is in the case of manic-depressive psychosis, and the point of view must remain a mere hypothesis.

The recognized importance of these social, and cultural factors does not lessen the importance of personal and dynamic factors. Cultural factors generally affect the individual in two ways:

1. By their impact on the internal organization of the family, on the assignment of specific roles and emotional values and, more specifically, on the determination of most of the methods by which children are raised. For instance, in an industrial, urban society, the woman to some degree loses the traditional role of homemaker; some of her roles may then become uncertain, less satisfactory, especially her role of mother, and she may have more chance of becoming a schizophrenogenic

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mother. The same could be repeated for the father, who loses some of his older prerogatives and roles.

2. By certain specific mores which may inflict adverse psychological pressure on the individual, putting him under greater strain and depleting the psychic reserves which might have compensated for the forces leading to schizophrenia.

¶ The Formal Psychological Mechanisms

The Progressive Teleologic Regression

Although the psychogenic conflicts described in the preceding section are necessary in the genesis of schizophrenia and indeed constitute an important part of what has to be studied in its connection, only when they assume a particular form do they constitute the disorder. In other words, what is specific in schizophrenia is not the content or the nature of the conflict, but the *form* the conflict assumes. I call the particular form assumed in schizophrenia, a progressive teleologic regression.

Regression, as the term is used here, is not limited to the Freudian concept of return to earlier levels of adaptation, but includes the Jacksonian concept of return to lower levels of functionality. Whereas the *content* of symptoms may reproduce, in either identical or symbolic fashion, earlier ontogenetic experiences and their derivatives, the *forms* that the symptoms assume may use even mechanisms that appeared in earlier phylogenetic levels. In the schizophrenic's psychological structure, an attempt is made *to fit a higher content into a lower form.*

The second term, teleologic, implies that the regression is purposeful, having the purpose of removing excessive anxiety and re-establishing some kind of psychic equilibrium. This is not a completely vitalistic or animistic concept; it is an additional application of concepts developed in general medicine by Claude Bernard and in psychiatry by Freud. It is not a denial that psychological and psychopathological phenomena are removed from physical determinism (according to which causes have effects, not purposes) but an additional affirmation that the human being, as we are able to understand him today, seems to be subjected to both mechanical and teleologic causalities.[3,4,6] Cybernetics today tries to find a reconciliation between a deterministic and a teleological interpretation of biological phenomena (see Chapter 87).

We visualize the process as an excessive state of anxiety which produces an impairment of the highest mental processes, perhaps a partial functional paralysis. At the same time, the lower levels tend to be disinhibited in accordance with the mechanisms described by Jackson,[1014] and to show manifestations of their own. One possibility now open to the organism is that of maintaining this state of unrest and disequilibrium. The organism will tend, however, to readjust at the re-emerging lower levels, because these lower levels seem to remove part of the conflicts. The lower-level exerts a strong pull, or some "kind of fascination." It is easy for the individual to "succumb to its charm," and to attempt to re-establish an equilibrium at that low level. How much of this is teleologic and how much is deterministic, only further studies will be able to establish.

The regression is *progressive* because, although it is purposeful, with few exceptions it fails of its purpose and tends to repeat itself. An individual who is deprived of the highest level of integration can be compared to an animal experimentally deprived of the cerebral cortex. This animal will not be in a physiological condition comparable to that of an organism of a low species which does not possess the cerebral cortex. Rather, it remains in an abnormal condition, because its whole organism is attuned to the cerebral cortex, or integrated with the functions of the cerebral cortex.

In similar way the schizophrenic patient will *regress to*, but not *integrate at*, a lower level: he will remain disorganized. The organism then defends itself from this disorganization

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with further regression to an even lower level. The process repeats itself in a vicious circle that can lead to complete dilapidation.

A limited regression from the highest levels of functionality may be a preserver of normality in sleep, convalescence, neurotic conditions, and some overwhelming circumstances, but it is pathological in schizophrenia because it resorts to mechanisms usually repressed and discordant with the state of normalcy of the individual.

We must now examine the specific aspects of this schizophrenic regression. We shall take into consideration only the fundamental ones: (1) the concretization of the concept; (2) the paleologic way of thinking and related phenomena; (3) the desymbolization and desocialization, and (4) the motor dysfunctions. Actually all these aspects are related and probably different manifestations of the same basic phenomenon, but we shall take them into consideration separately for didactical purposes.

THE CONCRETIZATION OF THE CONCEPT

The process of concretization may be best illustrated in the paranoid type of schizophrenia.

Immediately prior to the outbreak of the psychosis, the patient experiences feelings of despair and inadequacy and an impression that the whole world is hostile toward him. Some of these feelings are abstract, all-pervading, indefinite, and imperceptible. They represent the culmination of his disastrous life history, particularly in presence of a new challenge with which he knows he cannot cope. After the onset of the psychosis, the indefinite feelings become finite, the imperceptible becomes perceptible, the vague menace becomes a specific threat. It is no longer the whole horrible world which is against him; "they" are against him. It is no longer a feeling of being under scrutiny, under the eyes of the world; no longer a mild sense of suspiciousness toward his unfriendly neighbors. The sense of suspiciousness becomes the conviction that "they" follow him. We have thus a reduction of the conceptual and abstract to the concrete, the perceptual. The "they" is the concretization of feeling; later, "they" are more definitely recognized as F.B.I. agents, neighbors, or other persecutors. A return to a situation similar to that of the childhood, when a few powerful people (members of the family) were responsible for the difficulties of the patient, undergoes a displacement in the attribution of responsibility. In by far the majority, but by no means all of these cases, not the members of the family but other people are considered the wrong-doers.

In different patients we see all the possible transitional stages from abstract feeling to definite perceptions. Some patients say that they have the feeling that people follow and speak about them. Other patients say that they see and hear people following them and talking about them. In the latter the process of concretization of the concept has reached its most advanced stage: that of perceptualization of the concept.

Goldstein[76] was one of the first to see the schizophrenic process as an expression of the concrete attitude (see Chapter 65). According to him, the schizophrenic abandons the realm of the abstract and withdraws into the concrete.

Although Goldstein's conception is extremely useful, I feel that it does not encompass the whole process of concretization of concept. This process involves, in addition to withdrawal from the abstract into the concrete, active concretization. Especially at the beginning of the psychosis, the schizophrenic not only loses the abstract; he transforms the abstract into the concrete.

The patient still experiences the abstract conceptualizations because to some degree they continue to exist for him—the abstract level is impaired but not completely lost. The feelings cannot be sustained or coped with in the impaired abstract level and are immediately channeled into lower levels where they acquire a different representation.

Hallucinations are perhaps the most typical examples of perceptualization of the concept. For example, a patient who, before the onset of the psychosis, had a very low opinion of himself, especially on account of his homosexual desires, now has an olfactory hallucina-

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tion. He smells an awful odor emanating from his body. Here again we have a perceptualization of the feeling he has toward himself: he is a rotten character, he stinks.

In the intermediary stages between the abstract level and the perceptualization of the concept, the patient undergoes peculiar experiences. At times, but especially at the beginning of the first psychotic attack, these subjective experiences are felt as a struggle, "a fight against a tendency to give in." The patient tries to resist the temptation of accepting this limited, perceptual world and is afraid that sooner or later he will succumb. Succumbing would somewhat relieve a state of confusion and panic.

At other times the opposite process occurs: the patient searches actively for this corroborative perceptual evidence.

In patients who have auditory hallucinations and, through psychotherapy, have acquired some understanding of their symptoms, three stages could be recognized in the hallucinatory experience: First, the patient is in a state of anxiety. (A situation that would not arouse too much anxiety in an ordinary person has acquired a particular meaning for the patient and provokes great turmoil—for instance, returning to a lonely home from a party, after having vainly hoped for a date.) Second, the patient puts himself in the *"listening attitude."* He expects to hear something derogatory. (This would be the evidence he searches for.) For instance, he must try to listen to what the neighbors say. Third, the patient actually hears; he *hallucinates*.

Most patients are aware only of the third stage. As a rule, only during intense psychotherapy do they acquire awareness of the first two stages.

Let us now examine hallucinations in their three important characteristics: (1) perceptualization of the concept; (2) projection to the external world of the inner experience; and (3) the extremely difficult corrigibility of the experience.

The perceptualization of the concept is an extreme degree of concretization. It is not the only type of perceptualization of concept, dreaming being another important one. In dreams, thoughts acquire the form of visual perceptions. In hallucinations, they acquire the forms of many types, but predominantly of the auditory. Thoughts, which ordinarily consist of images (verbal, visual, auditory, etc.), use a lower mechanism—the mechanism of perception.

The second important characteristic of hallucination, projection to the external world of the inner subjective experience, also exists in dreams. The dreamer believes that the action of the dream actually takes place in the external world. This characteristic may be easily understood if we remember that this characteristic is also present in every normal perception. If I see an object in front of me, the perception of that object occurs inside me, around my calcarine fissure, but my organism projects this perception again into the external world. Thus, in hallucination, the most important fact is not that the subjective experience is externalized, because this externalization or projection occurs in every perception, but that an abstract thought has been perceptualized and follows the law of perception instead of those of thinking.

In a previous publication I called the third characteristic the incorrigibility of the experience. I think now that the term difficult corrigibility is more appropriate, because patients in psychotherapy learn to recognize and correct the hallucinatory experiences, although with great difficulty. In the majority of patients, however, hallucinations are not corrected. The patient not only has the dynamic wish to believe the content of the hallucination but also the need to interpret experiences in accordance with the levels of mentality to which he regresses.

The concretization and perceptualization of the concept (for instance, in the case of the patient who smells an awful odor emanating from his body) may seem metaphorical and symbolic. Let us remember, however, that these experiences are metaphorical and symbolic only for us, who retain our usual way of thinking or at least the possibility of shifting from one to another of different ways of

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thinking. But these experiences are not metaphorical for the patient. They are intensely lived; they are his reality.

PALEOLOGIC THOUGHT

The patient struggling in his attempts to resist the "fascination" of the lower levels is in a very unpleasant state of mental confusion. Often, in this state, he suddenly experiences what has already been described as "psychotic insight." For instance, given a sequence of events such as noticing, during the course of a few days, that several people glance at him and then hearing his doorbell ring twice in an evening, the patient will suddenly realize that these are not coincidences—there is a relation between the events; agents of the F.B.I. are watching him in order to prove that he is a spy.

If the patient were resorting only to that process called concretization of the concept, he would not begin to use this method of interpretation. But here he regresses to a lower level of rationality; he no longer operates with Aristotelian logic but rather uses a logic *sui generis* which has been called paleologic. Paleologic is, to a great extent, based on a principle enunciated by Von Domarus.[166, 167] This author, as a result of his studies on schizophrenia, formulated a principle which, in slightly modified form, is as follows: "*Whereas the normal person accepts identity only upon the basis of identical subjects, the paleologician accepts identity based upon identical predicates.*"

For instance, if a normal man is told, "All men are mortal; Socrates is a man," this normal person will be able to conclude, "Socrates is mortal." This conclusion is valid because the subject of the major premise (all men) contains the subject of the minor premise (Socrates). If, on the other hand, a schizophrenic happens to think: "The President of the United States is a person who was born in the United States; John Doe is a person who was born in the United States," in certain circumstances he may conclude, "John Doe is the President of the United States." This conclusion, which to a normal person appears delusional, is reached because the identity of the predicate of the two premises "a person who was born in the United States" makes the schizophrenic accept the identity of the subjects, "the President of the United States" and "John Doe." Of course, two additional factors permit him to reach such a conclusion: first, the over-all state of anxiety makes the use of the highest levels of mentation less efficient; second, he has an emotional need to believe that John Doe is the President of the United States, a need which will arouse additional anxiety if it is not satisfied. It is not difficult, then, to see how, in a teleologic way, the patient grasps the re-emerging paleologic level in order to reach the conclusion that he desires.

It must be emphasized that the schizophrenic does not necessarily adopt paleologic for all or even most of his thinking processes. Especially in the early stages of the illness, paleologic thought is found only when it involves the complexes of the patient. Later, however, it tends to extend to other areas. In this early selectivity for the emotionally determined complexes, paleologic thinking differs from organically determined mechanisms which apply indiscriminately to any content. In the light of Von Domarus's principle,[4, 7, 8] even bizarre and complex schizophrenic delusions can be interpreted.

Occasionally, the schizophrenic has insight into his mode of thinking and makes his deductions consciously. Usually, however, this process is as automatic as the normal person's application of Aristotelian logic.

The application of Von Domarus's principle extends far beyond schizophrenia. The whole phenomenon of Freudian symbolism may be interpreted from a formal point of view as an application of this type of logic. The symbol is not only something which stands for something else but also something which has at least a common characteristic (predicate) with the thing it symbolizes. Freud demonstrated that a person or object A, having certain characteristics of B (that is, a common predicate with B), may appear in dreams as B or a composite of A and B. The wife of a dreamer may appear in a dream as having the physical appearance of the dreamer's boss. The two persons are identified in the dream because the

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dreamer is concerned with a characteristic common to them (domineering attitude).

Of course, we do not attribute to the word predicate only the meaning usually given to it in logic or grammar. The term, as used here, refers to an attribute of the subject, in the broadest sense. It may also be a tangible part of the subject. Thus, in this type of thinking there is a tendency to identify a part with the whole—e.g., a room with the house to which the room belongs. Expressed differently, $a = a + b + c$ because the two terms of the equation have a in common. The predicate, furthermore, may refer not only to a quality inherent in the objects but also to spatial and temporal contiguity. The predicate which leads to the identification is called the *identifying link.*

Often, what should be only an *associative link* becomes, for the schizophrenic, an *identifying link.* According to my own studies,[4] this mechanism underlies the disturbances of association in schizophrenia. It is beyond the purpose of this chapter to describe and to interpret all alterations of association which may occur in schizophrenia. Here it will be enough to mention that regressed schizophrenics substitute associative words for those actually appropriate. For instance, if a regressed schizophrenic is asked the name of the President of the United States, he may reply, "White House." The idea of "White House" is a normal association to the idea of President of the United States, but in the regressed schizophrenic, associated ideas are identified and substituted for one another. The understanding of this transformation of associative links into identifying links will lead to the interpretation of word-salad, which otherwise appears an incomprehensible phenomenon.

Cameron[42] has made important studies of *disorganized* language and talk in disorganized schizophrenics. He characterizes the talk of these patients as: (1) *asyndetic*—lacking essential connectives; (2) *metonymic*—lacking precise definitive terms for which approximate but related terms or phrases are substituted (for instance, a patient said that he had three menus instead of three meals); (3) *interpretative*—having parts of one theme appearing as intrusive fragments; (4) *overinclusion*—including material only remotely related; (5) *noncorrespondence*—lacking relationship between what is done and what is said; (6) calling for *transformation in the rules* of procedure to justify failures; and (7) shifting verbal *generalizations* concerning solutions, hypotheses which were inadequate.

Desymbolization and Desocialization

The individual during his childhood introjects symbols and roles from the surrounding adults. During the schizophrenic psychosis, he tends to lose these introjected symbols and roles. Desocialization or withdrawal in the schizophrenic means much more than being at a physical distance from the interpersonal environment and living in an ivory tower (as the schizoid does). For the schizophrenic patient, desocialization implies a change in the process of symbolizing, change which will permit the loss of the introjected symbols which originate from others and the replacement with more primitive ones.

In order to understand this process, a brief discussion of the process of symbolization in the human mind is necessary.*

The symbolic property of the mind permits the human being *to go beyond* what is given by the perceptual apparatus. Sense perceptions give information about what is here and now, that is, present in the spatiotemporal world in which the subject lives and by which he is stimulated, but symbols and the symbolic apparatus will permit him to become aware even of what is not given.

We may recognize a hierarchy of symbols. The simplest is the sign, which we have in common with infrahuman animals. The smell of a mouse, which is not seen, is, for the cat, the sign that the mouse is around. The physician sees a rash on the skin of the child and he realizes that that rash is the sign of measles. Signs are parts or cues of objects or situations which stand for the whole objects or situations which are *present* or *about to be present.* We may even say that the *sign* is that

* For a more adequate discussion of this subject the reader is referred to Cassirer,[45] Langer,[107] R. Spiegel (Chapter 46 of this book), and, in relation to schizophrenia, Arieti.[4]

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predicate of the subject which makes the observer become aware of the presence or imminent presence of the subject. *Symbols* must be considered as belonging to higher levels than signs because they stand for something which is not present.

The image is the most primitive form of symbol. The external object is no longer present, but the individual retains an internal image which tends to reproduce the past perception of the object. Thus, the image of the mother may be with the child even when the mother is not present.

The image, however, tends to be private and cannot be externalized. In phylogeny the next step occurs when an individual succeeds in equating an external event or thing for something which is not present. (A sound or a thing [fetish] or a gesture may be equivalent for the object which is not present.) The thing that is taken as equivalent of the absent object is originally perceived as part or predicate of the missing object and becomes a paleosymbol. But paleosymbols too are individualistic, and private. Paleosymbols (and the higher types of symbols) may be auditory, visual, tactile, etc., but, for the sake of simplification, we shall consider only the auditory.

When an auditory paleosymbol, for instance the sound *ma-ma*, uttered casually or accidentally by a primitive man in connection with his mother, is understood by a second man (for instance, a sibling) as referring to the mother, we have the occurrence of a *verbal symbol* (called also *common* or *social symbol*). The verbal symbol evokes in the person who pronounces it the same reaction that it evokes in others,[121] it elicits "consensual validation."

The verbal symbol is something which not only replaces the missing object but also is shared by many people. Thus, it is no longer a paleosymbol, even for the person who used it for the first time, because the person now knows the reaction that the symbol will elicit from others, and knows that this reaction is approximately similar to his own.

The evolution of the word from the paleosymbol to the most abstract levels cannot be described here in detail but a brief summary will be presented. A word, when it is created by primitive men, has at least two characteristics: first of all denotation (not connotation).* The denotation is the object meant. The denotation of the word *ma-ma*, of our example, is the mother of the primordial siblings. Second, it has *verbalization*. The verbalization is the word applied to the object; it is the word as a word, that is, as a verbal entity, independent of its symbolic value. In primitive societies the emphasis is on these two aspects of terms. The word is so strictly tied to the object it denotes that it is often confused with that object. We have thus "word magic": the word applied to an object assumes the same quality that the object itself has. A great deal of attention is paid to the word, from the point of view of sound, rhythm, rhyme, assonance, homonymy, etc.

Later on, however, the word acquires *connotation* (or enlarges the primitive connotation); that is, it represents the concept of the object it stands for. It refers not only to a particular embodiment of the object but to the whole category of the object. Thus, in the example given, the sound *ma-ma* came to refer not only to the particular mother of the primordial siblings but to any mother, and came to assume the meaning, "female who begets offspring."

At high levels of development new symbols and roles are continuously created. The child is immediately exposed not only to many already made words, which have denotations and connotations, but to groups or configurations of words which reproduce or represent concepts and roles.

At the same time that he learns new words, he learns new relationships and concepts and the roles that he must assume. The image of himself, which consists predominantly of the body image, self-esteem, and self-identification, needs words, concepts, and roles reflected to the self from the human environment.

In schizophrenia, we have an approximate reproduction in reverse order of all the stages of symbolization and socialization. Furthermore, all of these stages may overlap, be

*This is not entirely correct. A primitive connotation may coexist.

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mixed in several proportions, so that what results is a very confusing picture.

The process of desocialization starts first with the progressive loss of those organizations of symbols which are referred to the self. There is thus a tendency to reject, or to divest the self of, those attitudes and tendencies which were reflected from others and became part of the self, and a tendency also to project, or give back the introjected attitudes. For example, the nagging, scolding attitude of the parent is originally introjected by the child, who will acquire a critical, condemnatory attitude toward himself. When the patient becomes psychotic, this attitude is projected, or given back to a parent-substitute—an authority or a person paleologically conceived as a persecutor because he seems to have one of the persecuting traits of the parent.

Thus, projection is not only attributing an idea to others but also giving back, restoring to the people who built it, an unpleasant part of the self. The patient no longer accepts self-condemnation as a part of the self; condemnation now comes from the persecutor. This mechanism is greatly complicated and obscured by the fact that what is given back is returned not to the original givers but to persons who symbolize them. Thus, paleologic mechanisms will transform the condemnatory quality of a parent into the persecutory actions of an F.B.I. agent.

We may distinguish three successive stages: First, the stage of introjection. The action or attitude of the parent is still external, actual, and is being introjected. Second, the stage of assimilation. The child has accepted the attitude of the parent, which has become his own attitude toward himself. He accuses, hates, or controls himself as the parents did. Third, the stage of projection (the psychotic stage). The patient projects back to symbolic parents those attitudes toward himself that he now rejects.

This mechanism of projection may be viewed as the expression of a changing interpersonal relation between the *I* (the patient) and the *Thou*. In the first stage the *Thou* is the parent or parent-substitute; in the second stage the *Thou* has become that component of the patient himself which may be called super-ego, if we adopt Freud's terminology, and includes the self-image of the bad child. In the third stage the *Thou* is the persecutor.

The stage of introjection is represented by the early life of the patient, when the unpleasant experiences took place. These unpleasant experiences are repressed but continue to act on the patient during the second stage by unconsciously motivating him toward awkward actions and distorted interpersonal relations. They participate in making the derogatory self-image much more pronounced and more difficult to tolerate. During the third stage the psychosis tries to eliminate this self-image.

At the same time that delusional formations occur, or later, other processes take place which are more directly related to language. Although the healthy person in a wakened state is concerned mainly with connotation and denotation of a symbol, he can shift his attention from one to another of its three aspects; the regressing schizophrenic, however, is concerned more and more with denotation and verbalization, and experiences a partial or total impairment of his ability to connote. This is what I have called *reduction of the connotation power*. For example, when regressed schizophrenics are asked to interpret proverbs, they do so literally. (A patient, asked to explain the proverb, "When the cat's away, the mice will play," replied that the mice felt free to play when the cat was away. He could not give to the word cat the special connotation, "a cruel person in authority.")

At the same time that the connotation power is decreased, denotation and verbalization become more important.

The verbal characteristics of schizophrenics are well known. The patients pay much attention to the sound, alliteration, and repetition of words. They seem to enjoy writing or pronouncing words which have sound associations —as, for instance, in the following series of words written by patients: "C, see, sea." "I know it, you know it. Chuck, luck, luck, Buck. True-two. These are it. I know it. I know it, you know it." "Are you pure? Sure. Yes! Yes!

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Yes! Frame! Name! Same! Same! Same! Came."

In the course of the illness, the patient gradually relinquishes common symbols and reverts to paleosymbols—that is, to symbols which he himself creates and which have no consensual validation. The paleosymbols represent a return to the level of the autistic expression of the child. As it happens in children, however, these paleosymbolic expressions are not completely original and private, but use remnants of common symbols. Often we recognize, in neologisms, common symbols which have undergone autistic or paleosymbolic distortions.

This process of desocialization and desymbolization is sometimes delayed or arrested by restitutive phenomena (see Reference 4, pp. 303–309). With the progression of the schizophrenic process, however, the process of desocialization increasingly impoverishes the patient's repertory of common symbols. With the advancing impoverishment of common symbols it becomes progressively more difficult for the patient to assume his own role and to visualize the roles of others. This process reveals how much of man is actually made of social life. When what was obtained from others is eliminated, man remains an insignificant residue of what he used to be.

CAUSALITY AND ACTION: MOTOR DYSFUNCTIONS

Man uses two forms of causality to explain the universe and himself. The first is mechanical or deterministic causality; "Each cause has an effect." The necessary antecedent A is the cause of a necessary, consequent B. The second is teleologic causality. Things occur because of their purpose. B (reading a book) takes place because of A, the reader's *purpose* (learning a subject). Psychological causality is a variety of teleologic causality.

In pathological conditions or primitive thinking, mechanical causality plays a very little role. Instead of finding a physical explanation for an event, the paleologic thinker looks for a cause in a personal motivation or an intention. Every act, every event occurs because it is willed or wanted either by the person himself who seeks an explanation or by another person or by something which becomes personified. In other words, causality by logical deduction, often implying concepts involving the physical world, is replaced with causality by psychological explanation: *the necessary antecedent of any event is an act of will.* The study of primitive concepts of causality consists of the study of what is attributed to the will. For studies of anthropomorphization in primitive men or children, see Arieti,[4] Piaget,[139,140] Werner.[170] This method of interpreting the world—called *projected psychological causality*—is always found in paranoiacs and paranoids who interpret almost every occurrence as expressions of psychological intentions related to their delusional complexes.

More difficult to understand, perhaps, is the concept of *introjected psychological causality*, which is pronounced in catatonics. Although this type is psychological causality related to the thinker himself, and therefore not essentially dissimilar from projected psychological causality, it requires the study of other aspects of the problem. Here one's own will becomes the antecedent of events.

The symptomatology of catatonia consists not of motor disorders but of will disorders. The patient cannot move, not because he is paralyzed, but because he cannot will to move. The human action is not a simple motion, it is also an act of will. One of the first things primitive man became aware of was that he was able to will. He became aware of this long before he was able to evolve the concept of physical (deterministic) causality.

Human action is a very complicated phenomenon. Just as symbolism includes an elaborate transformation of what the posterior human brain (temporal, occipital, and parietal lobes) receives from the external world, willing and acting include the elaborate transformation of motor impulses, which take place in the anterior brain (frontal lobes). At the same time, of course, other noncortical mechanisms permit the precise execution of the movement as a neurological function.

What seems to be the first clear-cut manifestation of willed action is the inhibition of the reflex response. The toilet-trained baby is a clear example of this. Because of rectal distention,

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he has the impulse to defecate, but he learns to inhibit the response. He learns, by using cortical mechanisms, to control his sphincters. The will of the child is necessary: the child must want not to defecate. He develops the capacity and the will to resist. But if the child wants not to defecate, although it would be pleasant to do so, it is because he learns to please his mother. Thus, even in the first volitional acts, which imply choices, a new dimension enters: the interpersonal (the Thou). From a philosophical point of view it seems almost a contradiction in terms: the first acts of volition are acts of obedience, or of submission to the will of others. Choice, this new, portentous tool which emerges in phylogenesis with the human race, in the early ontogenetic stages requires support from others before it can be exercised independently.

Individual primitive man, as an independent doer, often feels guilty.[4] To do is to be potentially guilty, because, after all, you cannot know what event will follow what you are doing. It might have an effect on the whole tribe; its repercussions might be enormous, such as an epidemic or a drought. Kelsen[102] has illustrated well the relations between *to do* and *to be guilty* in the primitive. In order to diminish their feelings of guilt, primitive men refrain from acting freely; they perform only those acts which are accepted by the tribe. The tribe teaches the individual what act to perform for any desired effect. Ritualism and magic thus originate. By performing each act according to ritual, primitive man removes the anxiety that arises from the expectation of possible evil effects. The ritual ensures that the effect will be good.

From a certain point of view, the subsequent development of humanity can be seen largely as a gradual freedom from this reliance on the support of the group and as an expansion of the individual will. This act of liberation from the influence or suggestion of others ontogenetically is seen during the negativistic stage of children, who refuse to do what they are told to do. By disobeying, they practice their newly acquired ability to will; but they do so with the most primitive method (volition of resistance).

The phylogenetic history of human action may be summarized diagrammatically:

ACTION
- Resistance to reflex response or volition of resistance
- ↓
- Volition with introjected guilt causality
- ↓
- Volition with compliance to { mother / tribe / ritual }
- ↓
- Volition

This is, of course, a simplified scheme, and many intermediate stages have probably been omitted. Furthermore, many stages overlap and coexist. In normal human beings, all possible stages are found, but in pathological conditions we find a preponderance of earlier stages and partial or total loss of others—for instance, in neurotic persons, neurotic compliance to others; in obsessive-compulsives, volition with compliance to ritual. But the most pathological forms of volition are found in catatonic patients.

Dynamic studies reported elsewhere[4] indicate that people who are apt to become catatonic are those who in their early childhood have been prevented from developing confidence in their own actions and reliance on their capacity to will. The parents or parent substitutes have forced these patients either not to will or to follow parental decisions. When the patients later had to make their own choices, they found themselves unable to act; if they acted, they were criticized and made to feel guilty. In catatonia, the typical schizophrenic childhood struggle with significant adults is connected particularly with the actions and choices of the patient.

The eventual catatonic may try to remove the anxiety which accompanies his actions by compliance or obsessive-compulsiveness. In precatatonic patients, in fact, we find strong ambivalent attitudes, pseudocompliance, and compulsions. But if the symptoms are not sufficient to protect the patient from excessive anxiety, or if they cannot be built up rapidly enough to dam the anxiety, catatonia develops.

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Catatonia is a removal of action in order to remove the panic connected with the willed action. Sometimes this panic is generalized. When it is extended to every action, the patient may lapse into a state of complete immobility (stupor).

In less advanced cases, one clearly recognizes the impairment of the function to will. For instance, as an answer to an order, the patient starts a movement, but then stops, as if a counterorder had prevented him from completing the movement. Having decided to obey, he is then afraid to will the act involved, and he stops. At other times there is a series of alternated opposite movements, rather like a cogwheel movement, superficially similar to that observed in postencephalitic patients affected by muscular rigidity. In the middle of a movement the patient becomes afraid of willing that act, decides not to perform it, and arrests his arm. But to decide not to perform the act is also a volition. The patient becomes afraid of it and starts to make the movement again. To do this is also volition and he is again afraid. This series of attempted escapes from volition may go on for a long time; it is a horrifying experience, which only a few patients are able to relate.[4]

This fear of volition accounts for other characteristics encountered in cases of catatonic schizophrenia. In order to avoid anxiety and guilt, the patient cannot will any act, but he may passively follow orders given by others because the responsibility will not be his—there is a complete substitution of someone else's will for his own. Waxy flexibility or the retention of body positions, no matter how uncomfortable, in which the patient is passively put, can also be explained in this way. When the patient is put in a given position, the will or responsibility of someone else is involved. If he wants to change positions, he has to will the change, and this engenders anxiety or guilt.

Quite often the reverse seems to occur. The patient will resist the order, or will do the opposite. This is the phenomenon of negativism which has baffled many investigators. This action of willed disobedience is sometimes present in the normal person and in the negativistic child, as if unwillingness to obey or to follow an order automatically engenders an action of resistance. Perhaps we may understand this phenomenon of negativism if we interpret it as a return to the most primitive act of volition, or volition of resistance.

There seems to be a correlation, although not yet statistically proved, between the decline in the catatonic type of schizophrenia and the decline of manic-depressive psychosis. Perhaps a cultural environment which emphasizes the concept of guilt predisposes to these two conditions (see Chapter 22). But, whereas generally the premanic-depressive feels guilty for not acting, the catatonic feels guilty for acting. Actually, this is not the only difference between the guilt of the manic-depressive and that of the catatonic. The guilt feeling of the catatonic is much more primitive; it is a syncretic feeling of guilt-fear and is associated with the elementary concept of action, rather than with the higher concepts of sin and atonement.

At times the catatonic loses this inhibiting guilt-fear complex and acts in an opposite way—that is, as if he were not concerned at all with responsibility or as if he were defying previous feelings of fear and responsibility. His behavior manifests a maniclike sequence of aimless acts. He may become violent and homicidal. This is the state of *catatonic excitement.*

Other patients who remain in a catatonic stupor for a long time develop what I have called a feeling of *negative omnipotence,* or an alleged expansion of will power. They feel that, if they move, the whole world will collapse or all mankind will perish.

(References for this chapter will be found in the bibliography at the end of Chapter 24.)

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CHAPTER 24

SCHIZOPHRENIA:
Other Aspects; Psychotherapy

Silvano Arieti

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AN ENORMOUS NUMBER of studies have been made in an attempt to determine the organic changes which cause, accompany, or are the result of schizophrenia. Their findings are not consistent, their interpretation controversial. We shall report here only those which at present seem to be the most important.

Somatic Studies

Genetic Studies of Schizophrenia*

The hereditary nature of schizophrenia has been suspected by many authors, who have tried to give statistical evidence. Rüdin's[149] work, based on a study of 701 cases, had considerable influence in an earlier period. Rüdin felt that his results pointed strongly to the presence of a Mendelian recessive factor. Bleuler[27] criticized Rüdin's work on the grounds that it did not include the latent, undeveloped, or mild cases of the disorder.

Among contemporary researchers, Franz Kallmann[98,99] conducted two of the most important investigations into the genetics of schizophrenia—the first on the relatives of over 1,000 patients of a Berlin psychiatric hospital, the second on 953 twins from psychiatric hospitals of New York State. He, too, concluded that single-factor inheritance of recessive type is the genetic cause of schizophrenia. He found that full sibs of patients have a higher expectancy (11.5–14.3 per cent) for the disorder than half-sibs (7.1 per cent), and half-sibs have a much higher expectancy than step-sibs (1.8 per cent). He found the highest incidence of schizophrenia in the children of two schizophrenic parents and in one-egg twins.

Kallmann's work was criticized by Bellak[15] on the grounds that he excluded from his studies "the schizoform psychoses," which lack hereditary traits, thus obtaining different statistical results; by Pastore[137] on the grounds of his statistical analysis technique; and by

* See Chapter 8 for a detailed review of genetic studies. The topic will be dealt with only briefly here.

Koller[104] on the grounds that, if simple recessivity is the hereditary basis of schizophrenia, the incidence should be higher among the sibs than the children of schizophrenics, whereas Kallmann's figures indicate the opposite.

As a rule, however, researchers in many countries who have investigated the genetic aspects of schizophrenia seem to feel, with Kallmann, that the disorder is based on a recessive mendelian factor. Those who approach schizophrenia from the aspect of its psychodynamics are reluctant to accept this position. The noteworthy exception is of Rado,[111] who accepts the distinction between genotypes and phenotypes in relation to schizophrenia. Genotype is the inherited cause of development; phenotype the actual outcome of development. The genotype, through its interaction with the environment, causes the schizophrenic phenotype (called also schizotype) to develop an abnormal organization.

Constitutional Factors in Schizophrenia

In 1921 Kretschmer[100] published *Physique and Character*, a work that remained popular in psychiatric circles for about two decades. Advancing his theories concerning personality and constitution, he divided body build into three types: (1) the leptosomatic (or asthenic), characterized by angular profile, narrowness of muscles, small shoulders, flat chest, relatively long extremities, and little muscular development; (2) the athletic type, with strong skeletal and muscular development; and (3) the pyknic type, characterized by pronounced deposits of fat on the trunk, short extremities, and gently curved profile.

Kretschmer saw a certain correlation between schizophrenia and body build. According to his studies, two thirds of schizophrenics are leptosomatic or athletic and one tenth dysplastic.

Sheldon[155] and Lindegarde[116] refined Kretschmer's rather crude technique, and many authors have adopted their method generally to confirm that there is a greater incidence of asthenic constitutions among schizophrenics. Rees[112] and the present writer, however, unlike Kretschmer, have not confirmed a lower incidence of pyknic constitutions found among schizophrenics.

The Endocrine Glands and Schizophrenia

Many authorities suspected an endocrine origin for schizophrenia because of the rarity of the disorder before puberty; frequent occurrence at or shortly after puberty, in postpartum conditions, and again at the time of the menopause; relatively high incidence of dysplastic body build; and high frequency of sexual dysfunctions.

In spite of this list of incriminating factors, no convincing evidence has been collected pointing to an etiologic correlation between schizophrenia and endocrine disorders. None of the classical endocrine disorders, such as acromegaly, hyperthyroidism, myxedema, Cushing's disease, etc., is found more frequently in schizophrenic patients than in the general population. Manfred Bleuler,[29] writing on endocrinological psychiatry, reached similar conclusions.

Studies on the thyroid gland by Witte,[173] Hoskins,[80] and many others have not reached any definite conclusion, although the opinion prevails that there is a moderate functional hypothyroidism. The adrenal glands in schizophrenics have been subjected to intense study, since these glands are involved in what Selye[138] calls "general adaptation syndrome" and states of stress. A majority of researchers have found a dysfunction of the adaptation syndrome (Pincus and Hoagland,[140] Parsons, *et al.*[136]), but uncertainties remain as to the specific mechanism of this dysfunction. Sands[150] found higher 17-ketosteroid excretion in paranoid patients, but is inclined to attribute this finding to "the emotional response of the organism to the paranoid thought."

In extensive research on the gonads of schizophrenics, Mott[134] found varying degrees of atrophy of the testicles in all cases of schizophrenia and a complete arrest of spermatogenesis in the majority of them. Morse[133] criticized Mott's work on the ground that the changes found in the testicles of patients may be the result of age, state of nutrition, concomitant disease, and may have nothing to do

with schizophrenia. Hemphill and his associates,[82] however, using biopsy rather than autopsy specimens, confirmed Mott's findings, with the exception that they did not find atrophy in paranoid patients.

At a clinical level, many authors have found hirsutism and other secondary masculine sexual characteristics in regressed female patients. Very common are also dysmenorrhea and amenorrhea. Ripley and Papanicolaou[145] found a correlation between the severity of the illness and the degree of abnormality of the menstrual cycle. An improvement in the psychological symptomatology was usually accompanied by a return to a more normal menstrual function.

Altschule[1] reported studies, not yet confirmed by others, according to which a protein-free pineal extract is beneficial in the treatment of chronic schizophrenia.

The Cardiovascular System and Schizophrenia

The main alterations found in the cardiovascular system of schizophrenics may be grouped under four headings:

1. Decrease in the size of the heart. Lewis[108, 109] found a hypoplastic heart in schizophrenics who came to autopsy. He did not, however, find this hypoplastic condition in paranoids. Hypertrophy of the heart was never found, even in presence of valvular lesions.

2. Decrease in the volume of the blood flow. Finkelman and Haffron[61] found, in schizophrenics, a diminished volume of circulating blood in comparison to that of manic-depressive patients. Researchers have also studied the intracranial blood flow in schizophrenics, but the findings were so discordant that no conclusion was possible.

3. Decrease in blood pressure. The finding that the blood pressure of schizophrenics is generally lower than that of the general population of similar age is almost unanimously accepted. Freeman, Hoskins, and Sleeper[75] found, in a series of 180 patients, that the average systolic pressure was 104.5 mm. Hg. and the diastolic was 54.5. Rheingold,[143] too, found the blood pressure of 129 schizophrenics to be lower than that of the general population. There is general agreement that paranoid or relatively well-socialized patients have a higher blood pressure than the rest of the patients.

4. Exaggerated tendency to vasoconstriction and resulting diminished blood supply. Shattock,[155] in an accurate and informative study, reported lowering of the temperature, vasoconstriction, and cyanosis in the extremities of patients, especially female. Minski,[120] Stern,[158] and others have reported similar findings which have been interpreted in various ways.

Biochemical Changes in Schizophrenia

Volumes could be written on the studies of metabolism that have been carried out on schizophrenic patients. McFarland and Goldstein,[117] who reviewed the work in this field up to 1938, concluded that the results of all these investigations were almost entirely negative, so conflicting were the reports. Bellak and Willson,[14] reviewing the literature on etiology of dementia praecox, in an article published in 1947, concluded the sections on the biochemical factors with the remarks that the only consistent difference of biochemical findings "from normals lies in the greater variability of values for almost any factor investigated."

Space limitations permit the report of only a few of the most important findings. The reader who is particularly interested in this subject should see References 15 and 90.

Hoskins[90] *found that the output of urine* was twice as large in the schizophrenic as in the normal population, but attributed this to the fact that, generally, schizophrenics drink more water than the average person. A low hippuric acid excretion, suggesting dysfunction of the liver, was found by many authors, but the Quick test, on which these works were based, cannot be considered a reliable method. Buscaino,[33] too, incriminates the liver. Buscaino is one of the staunchest European supporters of the theory that schizophrenia is the result of a metabolic disorder. In a number of papers, summarized in his report at the First International Congress of Neuropathology, he tried to prove that there is, in schizophrenia:

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1. Evidence of functional insufficiency of the liver (bilirubinemia, detoxication power impairment, as shown by deamination test, hippuric acid test, santonin test, etc.). Buscaino states that other researchers failed to get the same results because they relied on only one test, whereas, in order to study the liver properly, one must use a battery of tests ("hepatic constellation" or "instantaneous picture of liver").

2. Evidence of insufficient reactivity of the hepatic and extrahepatic reticuloendothelial system.

3. Evidence of gastroenteric function, as shown by findings of gastroenteritis. Buscaino reports that he has found pathologic amines in the blood and urine of schizophrenics and concludes that schizophrenia is an "aminotoxicosis." One of the disorders of metabolism investigated by Buscaino concerns aromaturia. McGeer *et al.*[118] have also reported that schizophrenics excrete a higher than normal concentration of aromatic compounds in the urine.

In studies of carbohydrate metabolism in schizophrenics, it has been found that, although the blood glucose level is generally normal, the glucose tolerance curve is often abnormal. For a review of glucose metabolism in schizophrenics, see Shattock.[156]

Deficient oxidative processes in schizophrenia have been reported widely.

Like Buscaino, Heath and his associates[80] believe that schizophrenia is primarily a metabolic disorder which manifests itself in varying degrees, "from a very minor deficiency in the so-called mild schizotypes up to a marked deficiency in the chronic overt psychotics." The metabolic disorder, according to Heath, hinges on the formation of a substance he and his collaborators isolated, "taraxein." "The present operational concept" of these authors is that taraxein is a manifestation of a defect in the oxidizing enzyme system.

Electroencephalographic Findings

Early authors reported that the EEG was normal in schizophrenia. Davis[47] described what she termed a "choppy activity," which is a disorganized pattern of low voltage ranging from approximately 26 to over 50 cycles per second. This pattern could not be related to age differences or to menstrual deterioration. Davis did not consider this EEG record specific for schizophrenia, but much more common in this disorder than in others. In fact, she found it in 61 per cent of the records of schizophrenics in contrast to 39 per cent of manic-depressives.[46] Denis Hill[83] found the "choppy pattern" in only 20 per cent of schizophrenics.

Walter[168] observed slow wave changes in catatonic stupor. He found that the alpha activity shows instability and slow activity at 2 to 6 cycles per second. Low voltage was also apparent. These findings were not constant and could not be interpreted.

Hill,[83] who has made an excellent review of the literature on this subject, concludes that the EEG is abnormal in a proportion of patients suffering from schizophrenia, particularly of the catatonic type, but that no specific pattern is found in these patients. Subcortical type discharges, similar to those found in some epileptics, are found, particularly in young catatonics, but are not interpreted by the author as evidence of an organic-pathologic process. Hill states that the available EEG data "do not provide adequate evidence for a genetic progressive pathological cerebral process in schizophrenia."

Neuropathology of Schizophrenia

Schizophrenia has been the object of much neuropathologic research, for the organicists have hoped to repeat for this disorder the history of the development of our knowledge of general paresis. From the time of the founding fathers of neuropathology, such as Nissl, Spielmeyer, and Alzheimer, to the present, these hopes have remained unfulfilled.

The brain of the schizophrenic has not revealed anything more definite than have the other organs. Many alterations were found, but not consistently, and their significance is disputed.

Alzheimer[2] found a local disappearance of ganglion cells in the outer layers of the cerebral cortex. Winkelman[172] found instead diffuse nerve-cell loss. Josephy[92] described cell sclerosis

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and fatty degeneration in cortical layers. Buscaino[36] reported so-called grapelike formations in the brains of schizophrenics. Other authors could not confirm these findings, which were considered artifacts. Klippel and Lhermitte[193] described areas of focal demyelination (later denied by Adolf Meyer and by Wolf and Cowen[174]). Bruetsch[31] found rheumatic foci in brains of schizophrenics. He feels that the incidence of these foci was greater than in the general population and that rheumatic fever must have played an important etiologic role. (Lidz[112] denies the importance of this role.)

In an effort to overcome the technical defects that many authors criticize in the neuropathological studies of schizophrenia, C. and O. Vogt have adopted a refined technique, which consists of a serial study of the cerebral hemispheres in slices eight microns thick. Quantitative computations of the alterations are made and control studies in normal people of the same age are carried out. The Vogts[165] have concluded that they have been able to find anatomical alterations in all cases of schizophrenia that they have studied. The localization, intensity, and histologic aspect of the lesions were found to vary considerably. The most important features were:

1. So-called wasting cells (*Schwundzelle* in German, *cellule fondante* in French). In these cells there is a progressive disintegration and disappearance of the tigroid substance, increase in fat content, and decrease in volume. The nucleus becomes pale at first and then disappears (karyolysis).

2. Alveolar degeneration. The cells lose the Nissl substance and undergo vacuolization of the cytoplasm.

3. Liposclerosis. The cells are shrunken and presumably filled with fat.

Other alterations (such as cell shrinkage, balloon cells, and senile alterations) seem to play a less important role. This impressive work has not yet been completed. All the alterations described by the Vogts are found to some degree in many pathological conditions and even in the so-called normal. The only finding that would be significant would be a quantitative difference from normal. But again even then, there would remain the problem of whether the quantitative change is part of the basic schizophrenic process or the outcome of the abnormal schizophrenic way of living, especially in patients who have been sick for a long time.

Several researchers have studied biopsy material, in an attempt to avoid the artifacts liable to be found in post-mortem specimens. Papez[135] and his associates reported inclusion bodies, presumably microorganisms, like zoospores. The significance of these findings was disputed by Wolf and Cowen and by Alfred Meyer.[127]

Roizin[146] made morphological and biochemical studies of biopsy specimens from twenty-four patients who had undergone topectomy, and electric shock (or insulin coma, or both) prior to psychosurgery. He found several alterations in the medium and large sized pyramidal neurons. He also found changes in the activity of indophenol-oxidase, cytochrome (oxidase) peroxidases, and acid phosphatases.* Roizin's work is an excellent piece of research but, as the author himself admits, inconclusive, because the findings might have been the results of the therapies to which the patients were subjected. (See Chap. 82.)

Dunlap,[52] Spiehmeyer,[157] Wolf and Cowen,[174] Alfred Meyer,[127] and Ferraro,[59] among many distinguished researchers, reached negative conclusions about these neuropathological findings, minimizing their importance on various grounds: these changes are not specific, are of mild intensity, and may be found also in control brains of normal persons; they may be the result of age, malnutrition, concomitant disease, or abnormal way of living of the patient.

Other authors feel that the relatively primitive techniques of traditional neuropathology have led to the negative findings and look forward with great anticipation to the results of new techniques, such as electronic microscopy, tissue culture and microchemistry.

Experimental Reproduction of the Psychosis

Many investigators have administered to humans and to animals pharmaceutical agents

* See Chap. 82: Fig. 6, p. 1660; Fig. 7, p. 1661; Fig. 8, p. 1662.

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which seem to engender syndromes identical with, or similar to, schizophrenia.

In Chapter 84, the effects of two drugs—mescaline and lysergic acid—which are frequently used for this purpose, will be illustrated in detail. Here we shall mention briefly the other drug which, until a few years ago, stimulated much research, namely, bulbocapnine.

Bulbocapnine is one of several alkaloids obtained from the plant *Corydalis cava*. Its chemical formula and its structural formula are related to that of apomorphine. Many authors—beginning with Mode in 1892[131]—have reported paralysis, catalepsy, and apparently "catatonic symptoms" in animals which had been intoxicated with this drug.

In 1921 DeJong[49, 50] started a series of investigations, later continued with the collaboration of Baruk. These authors found that moderate doses of bulbocapnine were producing absolute catalepsy in the experimental animal. The animal became immobile, with a complete loss of motor initiative. If the experimenter imposed certain attitudes upon the limbs of the animal, the animal would retain such attitudes, exhibiting something similar to the waxy flexibility of the catatonic.

DeJong and his co-workers were impressed with the similarity with the catatonic picture to such a point that they considered this intoxication an "experimental catatonia" and attributed it to the action of the bulbocapnine on the neocortex.

Ferraro and Barrera,[60] in an interesting monograph in which they described bulbocapnine intoxication in cats and monkeys, failed to see any psychic component in the production of the phenomenon. They found these symptoms—namely, loss of motor initiative, maintenance of passively impressed postures, maintenance of posture against gravity, resistance to passive movements, and variations of muscular tonus in various degrees—irrespective of the surgical removal of various portions of the central or peripheral nervous systems. The symptoms occurred even when the cerebral cortex had been removed.

The authors concluded that bulbocapnine intoxication reproduces only one important component of human catatonia—that is, the motor component, or catalepsy—but catalepsy alone does not constitute catatonia.

General Conclusions about Somatic Research on Schizophrenia

1. Although Kraepelin himself thought that dementia praecox was due to a metabolic disorder, no consistent findings to corroborate this assertion have so far been obtained.

2. Findings such as those by Heath, Altshule, and others are too recent and are still in need of confirmation from other authors.

3. A great deal of cautiousness must be exercised by all researchers in evaluating their findings lest some of the results or outcomes of the schizophrenic process are mistaken for causes or pathogenetic agents. In the opinion of the present writer, no one has clarified this point better than Horwitt.[88] In his article, "Fact and Artifact in the Biology of Schizophrenia," he writes:

> We are now entering a period of renewed interest in biological research on schizophrenia. Nothing can be more harmful to this rejuvenation of the investigation of the biology of mental health than the publication of reports based on techniques of patient selection which do not meet the minimum standards accepted by other disciplines. The manner in which the patient chooses to manifest his difficulties may not be a function of his physiological status.
>
> Symptoms that are usually considered artifacts in other studies are often erroneously accepted as biological aberrations in the evaluation of the schizophrenic patient. Year after year, papers appear which purport to distinguish between the state of schizophrenia and that of normalcy. The sum total of the differences reported would make the schizophrenic patient a sorry physical specimen indeed: his liver, brain, kidney, and circulatory functions are impaired; he is deficient in practically every vitamin; his hormones are out of balance, and his enzymes are askew. Fortunately, many of these claims of metabolic abnormality are forgotten in time with a minimum of polemic, but it seems that each new generation of biologists has to be indoctrinated—or disillusioned—without benefit of the experience of its predecessors.

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Horwitt gives the following examples of procedural mistakes made in organic studies of schizophrenia: Basal metabolism during emotional stress is not basal at all but may be a reflection of metabolism during intense adrenergic stimulation due to the stress itself. Comparing data from blood samples of schizophrenics and normal people is like comparing samples from soldiers on the battlefields and people in a relaxed, basal condition. He also stresses that the vagaries of psychotic behavior are such as to affect food intake. In many cases this abnormal food intake is responsible for nutritional disorders and metabolic changes. He writes, "Having studied such changes in mental patients for more than fifteen years, I am at a loss to understand how some studies of urinary excretion or of blood constituents can be performed without recourse to nutritional controls." In the same article he gives many more illustrations, which cannot be reported here, of mistakes commonly made in biological studies of schizophrenia.

¶ Psychosomatic Studies

The physical changes that may be found in schizophrenics, particularly those who have been sick for a long time, are many, but research reveals that these changes are not constant and that no primary pathogenetic role can be attributed to them.

In an article published in 1945, the writer hinted at the possibility of a psychosomatic involvement in schizophrenia, and subsequent studies reinforced this point of view.[4, 6, 7, 10] These studies involve the central nervous system and the soma.

The psychosomatic approach to schizophrenia is based on the premise that the psychodynamic factors which lead to the psychosis may have a disintegrating effect on the functions of the central nervous system, where they must be mediated. The central nervous system is to a large extent the creator, or at least the interpreter, of psychogenic stimuli, and this theory assumes that the central nervous system may be disturbed by what the central nervous system itself interprets or creates. This seems to the writer the real psychosomatic interplay, much more so than that intervening between the central nervous system and other organs.

Carl Jung[91] was the first to advocate the hypothesis of the psychosomatic involvement of the central nervous system in schizophrenia (1903), when he thought that perhaps the emotional difficulties which lead to the psychosis may produce toxins which damage the brain.

Ferraro[59] too feels that the histologic changes found in some cases of schizophrenia may be the expression of a psychosomatic mechanism. But these changes are very inconsistent, as we have seen.

Although the present writer does not deny that the disorder is ultimately mediated by biochemical and electrical changes, he believes that under emotional stress, which in the schizophrenic is not adequately coped with by other defenses, functional disintegrations of neuronal patterns, or a disharmony of microscopic spatiotemporal patterns of activity in the neuronal network, or, more simply, an alteration of the normal functional relations between nerve cells, take place. In other words, a neurophysiologic dissolution of activity would take place mainly at the level of high cortical organization and not through the mediation of the autonomic nervous system, as is generally the case with other areas of psychosomatic medicine. This point of view does not exclude, of course, a subsequent but important involvement of the autonomic nervous system.

The symbolic nature of schizophrenic symptoms, at least at the beginning of the illness, seems to indicate that the disintegration or dysfunction has to be connected with the cerebral cortex, but not with those parts of the cortex that mediate motor, sensory, language, functions (because we know that such functions are not impaired in schizophrenia).

If we exclude these areas, only three cortical areas are left to be considered:

The first is an ill-defined area, including a large part of the temporal lobe (Brodmann's areas 20, 21, and 37) and small parts of the occipital and parietal lobes (parts of Brod-

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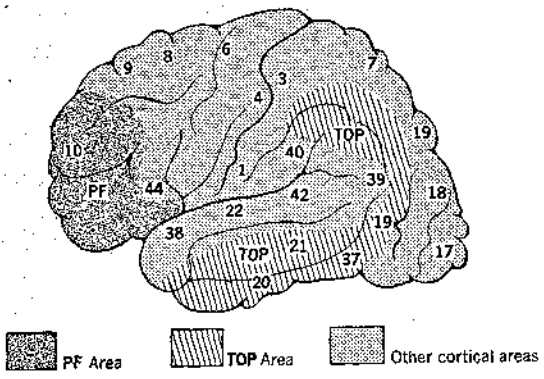

FIG. 1

mann's areas 7, 19, 39, and 40) (see Figure 1). I have designated this the TOP area, from the initials of the words temporal, occipital, and parietal. As I have reported elsewhere[6] this area may be considered the fourth or highest of four levels of the great posterior area of the brain, which consists of the parietal, occipital, and most of the temporal lobes. In this great posterior area, stimuli are received from the external world and progressively transformed in higher mental constructs. Presumably, the fourth level or TOP area, which is the last to appear in phylogeny and to myelinize in ontogeny,[62] is needed, in addition to the other lower levels, for the mediation of abstract thinking and for the high symbolism of interpersonal relations.

It is possible to assume that under the stress of the preschizophrenic anxiety one of two things, or both, may occur:

1. If the phenomenon is interpreted deterministically, the overpowering anxiety may be seen as impairing the intricate and delicate functional neuronal network, which mediates these functions (some kind of mechanical autoimpairment, although functional);

2. Teleologically, the organism in its adaptational strivings avoids the functions which elicit overwhelming anxiety. But these are the functions which require long circuits with participation of the large number of neurons which are in the TOP area.

These two mechanisms may be reconciled, as cybernetics attempts to do. The effect of these mechanisms may be seen as a psychosomatic return to a lower level of integration. Psychodynamically, we may consider this level one which does not permit long-circuited anxiety or difficult interpersonal relations, a level which corresponds to one at which long childhood dependency on others is not needed. Neurophysiologically, the process may be seen as a process of *dysencephalization*. Neurophysiologists give the name encephalization to the process by which functions that in lower species are mediated by lower or more caudal centers shift toward higher centers. Dysencephalization may be seen as the opposite process, which may occur in schizophrenia in a functional way. There is not only a return of the functions of the released lower centers but also a tendency for the functions of the higher centers to be mediated by the lower centers. We have seen, for instance, how anxiety-loaded concepts are reduced to perceptions and to hallucinations. In other words, especially at the beginning of the illness, we have predominantly not a loss of the abstract, but a transformation of the abstract into the perceptual and concrete. This mechanism may be seen as mediated neurophysiologically by a process of functional dysencephalization.

The other great area primarily involved in the symptomatology of schizophrenia is the prefrontal area (PF in Figure 1).

The prefrontal areas permit planned thinking in a sequence of logical processes, make possible anticipation of the distant future, maintain a steadfastness of purpose against distracting impulses from the environment,[119] and enable the focusing of attention, thus permitting elaboration of data obtained from the posterior brain. They also preside over the making of choices and the translating of ideas into actions. These are the functions which are capable of evoking the greatest amount of anxiety. Greenblatt and Solomon[77] also feel that the circuits occurring in the frontal lobes sustain the emotional tension in psychotic individuals. As was said about the TOP area, complex functional prefrontal neuronal patterns may be disturbed by the anxiety they themselves produce; consequently, they may be avoided or impaired, and neuronal patterns of lower orders substituted for them. The archipallium (plus a subcortical structure, the hypothalamus) is a third area, which plays an important role in schizophrenia. A state of

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severe hypofunction of the neocortex (that is, of the PF and TOP areas) may have important repercussions upon the archipallium, in that it may disturb the balance between the neopallium and archipallium.

Some experimental studies on cats[12] have demonstrated that the removal of the neocortex releases the inhibitory functions of the rhinencephalon over the hypothalamus. If the same things apply to human beings, we may conclude that a severe hypofunction of the neocortex (no matter whether organic or functional, provided it is very extensive) releases the archipallium, and consequently the functions of the hypothalamus are inhibited. But a release of the archipallium and inhibition of hypothalamus may engender other abnormal reverberating mechanisms, involving the thalamus and especially the visceral brain. These mechanisms may fail to feed back adequately the neocortex. A pathological vicious circle is thus produced, which started with a psychogenic dysfunction of the neocortex (Figure 2).

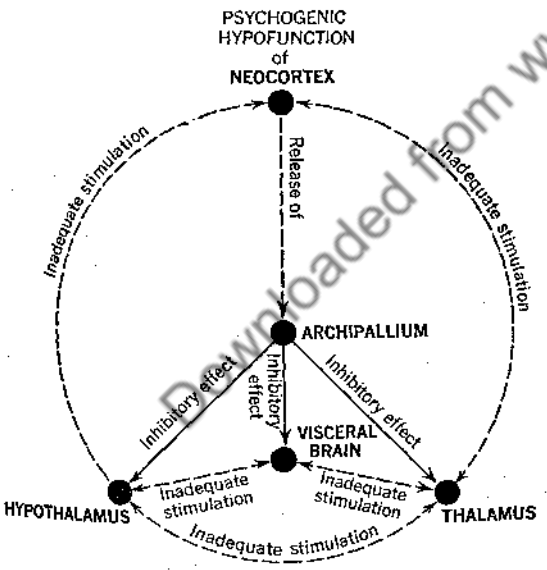

FIG. 2

From this point of view, it is possible to explain many of the somatics and biochemical alterations found in schizophrenia. These alterations would all be consequences of the functional alterations of the hypothalamus and of the encephalic vegetative centers which, in their turn, would be an indirect consequence of a primary dysfunction of the neocortex. But, in its turn, the neocortex is adversely affected by the dysfunction of these other structures.

In addition to these functional neural mechanisms, which are the most important, another simpler mechanism may have some effect on the somatic changes of the schizophrenic. The changed way of living of the schizophrenic, which forces withdrawal from stimulation and marked hypoactivity, may explain some of the alterations observed in the endocrine and vascular apparatuses.[4, 88]

Psychotherapy

Choice of Treatment

The methods of treatment for schizophrenic patients may be divided roughly into two categories: physical therapies and psychotherapies.

The physical therapies will be described in detail in other chapters (insulin shock therapy in Chapter 74, convulsive shock treatment in Chapter 75, psychosurgery in Chapter 76, drug therapy in Chapter 77, and miscellaneous other therapies in Chapter 78). This chapter is limited to a description of the basic principles of psychotherapy.

One finds, first of all, marked disagreements as to treatment of choice. My own marked preference, in the average case, is psychotherapy, although many authors and practitioners do not share this point of view.

My "bias" is based on the belief that physical therapies, as far as we know or can infer, produce only a symptomatic improvement, whereas psychotherapy tends to: (1) remove the basic conflicts which led to the disorder, (2) correct the psychopathologic patterns, and (3) permit the regenerative psychological powers of the organism to regain the lost ground. These assertions, however, should not be interpreted as a condemnation of physical therapies. On the contrary, I have found physical therapies, with the exception of psychosurgery, useful, at times, in a variety of situations:

1. When psychotherapy for psychotic pa-

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tients is not available (and, unfortunately, it is not available to by far the majority of patients), physical therapies should be administered.

2. Psychotherapy is not effective in every case. Although in the last few years we have made great progress in this field, our technique is still not completely satisfactory. We often encounter patients (fortunately, in decreasing number) who do not improve and a few who are actually made worse by any psychotherapeutic attempt. We are forced to the conclusion that, in these cases, every interpersonal relation, even that with the experienced therapist, increases the anxiety of the patient to such a point as to enhance his psychological disintegration. Perhaps, with the refinement of technique, such cases will eventually be extremely rare; but, for the time being, if more than two therapists have been unsuccessful, and the condition is worsening (especially in cases of rapid disintegration or those in which no contact at all is made), an attempt should be made to arrest the process, at least in a symptomatic way.

3. Finally, shock and drug therapies must be used in cases which are urgent because of a concurrent physical illness. Here quick results must be obtained before they could be achieved with the long psychotherapeutic procedure.

Even when shock or drug therapy is used with apparently successful results, psychotherapy is important in order to prevent relapses. Contrary to what some psychotherapists believe, I have found that the majority of patients who have undergone shock or drug therapy are still accessible to psychotherapy.

An increasing number of patients today are being treated with a combination of drug therapy and psychotherapy. The drug therapy decreases the anxiety and makes them more accessible to (or less fearful of) the interpersonal contact. In my experience, this combination does not shorten the treatment but does have the advantage of making hospitalization unnecessary for many patients. In many cases a full-fledged schizophrenic is transformed into an ambulatory schizophrenic. This transformation is not to be disregarded, as many patients are in this way able to work while undergoing effective treatment.

Historical Review of the Development of Psychotherapy of Schizophrenia

Freud's concept that the libido of the schizophrenic is withdrawn from external objects, making it impossible to establish transference, for many years discouraged therapists from attempting to treat patients suffering from this disorder. Actually, psychoanalysis opened the road to the psychotherapy of schizophrenia after some modifications of the classic method were made.

Paul Federn, one of Freud's first pupils, pioneered in this field.[55] He is also known for two major theoretical concepts which underlie his therapeutic applications: (1) the concept of ego-feeling—that is, the ego is normally endowed with a certain quantity of libido, which does not come from other sources, but is autonomous; (2) the concept of ego boundaries. These boundaries are seen as defective in the schizophrenic, so that material from the external world and from the id becomes mixed with the ego. The most important goal of therapy is to establish normal boundaries. Reversing a famous sentence of Freud, Federn said that, as a result of therapy in the schizophrenic, "There where id was, ego must be."

Federn stressed the fact that it is possible to establish transference with the part of the patient which has remained healthy, and strongly suggested that the therapist have a helper to be with the patient in the intervals between sessions. Fundamentally, in Federn's method, the patient is guided to understand that a part of his ego is sick and that that part is not trustworthy.

Gertrude Schwing,[151] a nurse who was analyzed by Federn, applied her analyst's concepts to hospitalized patients. In a straightforward and honest but not fully convincing little book, *A Way to the Soul of the Mentally Ill*, she describes the schizophrenic as a person who has been deprived of the experience of having a real mother, a person who loves her child at any cost. The psychiatric

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nurse must offer that love to the patient. She describes several techniques which establish continuity of contact with the patient and stresses the point that the patient must have the feeling that this new mother is there and does not intend to abandon him. Schwing considers her treatment a preliminary one, to be followed by Federn's method.

Hinsie[58] is one of the American pioneers in the psychotherapy of schizophrenia. As early as 1930 he published a book devoted to this topic. He studied patients in the adolescent period, who voluntarily sought treatment, had insight into the fact that they were sick, and were communicative and willing to follow the directions of the therapist. Thus, Hinsie selected the easiest patients to treat. He relied predominantly on the clinical psychoanalytic method of "free association."

The method instituted by John Rosen was called, at the suggestion of Federn,[57] "direct therapy."[148] (Direct, because the therapist aims at a direct communication with the unconscious of the patient). Others—Ellenberger, for instance—have called it "the psychological shock method," because of its apparent lack of cautiousness and softness.

Rosen too believes that the schizophrenic is the victim of a mother who was suffering from a perversion of maternal love, and tries to offer to the patient what he did not have. The patient must experience in the therapist a powerful, protective, benevolent person, as he wished his mother would have been in his early childhood. The therapist at times assumes the role of the persecutor and tries to convince the patient that he will have a beneficial rather than persecuting effect. The analyst must spend a long time with the patient—up to sixteen hours a day—and, like Federn, must often resort to an assistant. The patient is showered or shocked with interpretations which follow the language of the unconscious and explain the classic Freudian mechanisms. Such overwhelming, all-embracing treatment will often solve the acute episode in a few weeks and must be continued by the second stage of treatment which follows a technique more similar to classic psychoanalysis. During the treatment the analyst enters the psychotic world of the patient, who immediately feels better because he is finally understood. The therapist should not even avoid becoming one of the imaginary persons who appear in the delusions.

Rosen believes that there are not several mental diseases, but only one mental disease, characterized by hebephrenic, catatonic, paranoid, manic-depressive, obsessive, hypochondriac, and psychosomatic stages. Patients who recover go through these different stages.

Rosen's method has been the object of much criticism. Even his admirers point out the fragility of his theoretical framework and attribute his therapeutic successes to his personal qualities: lack of hostility, perseverance, physical endurance, etc. Others feel that the interpretations he gives the patients are arbitrary, not even necessary, and that his success is due simply to the fact that he is able in some way to establish contact with the patient. Others (Horwitz, *et al.*[89]) doubt even his results. They state that his claims of many recoveries were exaggerated; that some of his patients were misdiagnosed; that others who were undoubtedly schizophrenic had relapses and were later treated with physical therapies.

I, too, feel that Rosen's early assertions, like those of any pioneer, seem to suffer from enthusiasm. Also some of the theoretical bases of his technique seem unsubstantiated. Nevertheless, it is beyond question that Rosen obtained at least temporary results and that he was able to inject enthusiasm into many workers at a time when the prevalent opinion was that psychotherapy with schizophrenics was an impossibility.

In contrast to the dramatic, shocking, and perhaps not too consistent aspect of Rosen's method is the calm and steady flavor of Frieda Fromm-Reichmann's technique.[69, 70, 71, 72, 73, 74]

Fromm-Reichmann derived her technique from the theoretical premises of Freud and from the modifications which Sullivan made on those premises. She called her technique "psychoanalytically oriented therapy," not psychoanalytic therapy, to indicate that some modification from the traditional psychoanalytic method had been made.

Fromm-Reichmann thought that only quan-

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titative differences exist between normal, neurotic, and schizophrenic patients.

The schizophrenic is not happy with his withdrawal, as some psychiatrists used to believe, and he is ready to resume interpersonal relations, provided he finds a person he trusts, a person who is capable of removing that suspiciousness and distrust which originated with the first interpersonal relations.

In order to establish the atmosphere of trust, the patient must be treated with kindness, understanding, and consideration, but not with smothering attitudes or as a baby. There is a part of the patient which has retained an adult state and which would resent being treated in a babyish way. Profusion of love or of exaggerated friendship are also out of place. They would be considered bribery and exploitation of dependency attitudes.

Fromm-Reichmann relies much less than Rosen on the therapeutic effect of interpretations. She makes use of them, however, and emphasizes that the symptomatology is susceptible of many interpretations, all correct, and that at times it is useful to give even partial interpretations. As a rule, her interpretations resort much less than those of other authors to symbolism of repressed sexuality. Fromm-Reichmann emphasized the role that fear of closeness plays in the patient's attitude. At times the warmth of the therapist may actually frighten the suspicious patient and precipitate a relapse.

But, according to Fromm-Reichmann, even more important than his fear of closeness is the patient's hostility. Because he overrates his negative destructive qualities, he must be reassured by the therapist and shown how to handle this potential anger.

Fromm-Reichmann stresses the importance of the countertransference which, according to her, is of crucial importance in the treatment of schizophrenics. Often, she states, the difficulty in communication or in the handling of the situation originates from the therapist's problems. The anxiety of the therapist is the greatest handicap and may jeopardize the whole treatment. Mild degrees of anxiety, however, may be an asset in helping the therapist to recognize which problems of the patient arouse his own anxiety.

These brief notes cannot give an adequate account of the details of Fromm-Reichmann's technique. They are completely inadequate also in describing those qualities of Frieda Fromm-Reichmann herself—her courage, her warmth, her humility, her unassuming genuineness—which undoubtedly played an important role in her therapeutic successes—qualities which to a certain extent she was able to infuse in all those who learned from her.

Sechehaye developed the new method of "symbolic realization" in connection with the successful treatment of her patient Renée. Sechehaye has devoted three books to this treatment, which remain perhaps the best-documented study of a single patient.[152,153,154]

Sechehaye accepts many of the traditional psychoanalytic and existentialistic methods of psychotherapy, and to them she adds her own method, which consists of helping to overcome the initial trauma by presenting the patient with a level of interpersonal relations which is corrected and adjusted by the therapist to the weak state of the psychotic ego. Like Rosen, Sechehaye enters the psychotic world of the patient, accepts his symbolism, and attempts "to realize" (that is, to materialize) at a symbolic level the patient's fundamental needs which, through their frustration, led to the psychotic conflict.

Eissler[53] has stressed the importance of early psychotherapy during the acute episode. The way in which the case is handled at the beginning, he claims, often determines the whole course of the illness. He distinguishes the acute phase from "the phase of relative clinical muteness."

Wexler[171] reported the successful treatment of a patient whom he treated by assuming the role of a tyrannical super-ego.

Bychowski has provided, in addition to important studies on schizophrenic thinking, important details on the manifestations, dynamics, and therapeutic handling of hostility.[37,38]

Hill, again, emphasized the crucial role of the mother in the development of schizophrenia and gave details of technique in handling patients.[84]

Bowers[30] applied hypnosis to the treatment of schizophrenia, although the general opinion

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is that such treatment is not suitable for psychotics. She hypothesizes that, in hypnosis, the therapist rapidly establishes contact "with the repressed, healthy core of the patient." She points out that the problems of resolution of the symbolic relationship require the utmost skill, but long remissions have been secured. A successfully hypnotized schizophrenic is moving toward recovery, as he is able to reincorporate the other, the therapist, and thus re-establish interpersonal relations.

Benedetti,[17,18] an Italian psychiatrist who studied with Rosen and now teaches and practices in Switzerland, accepts a great deal of Sullivan and Fromm-Reichmann, as well as some existentialistic concepts. He feels that the two basic tools in the treatment of schizophrenics are sharing of the feeling of the patient and interpretation.

Psychotherapy in Practice

In this section a few more details will be given about psychotherapy of schizophrenics, as practiced by the author of this chapter. This technique is the result of the study of the contributions made by all the authors mentioned in the previous section, as well as of my personal experiences.

General Attitude and Feelings of Patient and Therapist

More important than the technique of a therapeutic session is the establishment of a general attitude, an emotional tone and interchange of feelings between patient and therapist (transference and countertransference). These are intangible and indefinite entities, and therefore difficult to describe and almost impossible to prescribe. It will be sufficient if the reader gets the general flavor of this relationship; more specific technical problems will be discussed later.

When the patient comes for therapy, he feels unaccepted and unacceptable, suspicious, and distrustful of any interpersonal contact to the point of being delusional. His contacts with the therapist must make him feel that he is no longer alone in the world, that he is accepted as a human being, and that this acceptance will not be at the price of his remaining immature or dependent or overcompliant or driven to do things he cannot do, or inhibited sexually or otherwise.

According to Sullivan,[161] therapy must offer the patients a "relationship of security beyond what they have ever had." According to Fromm-Reichmann,[71] therapy must offer a "specific way by which they can trust the world and themselves." Using a terminology applied by Buber[33] and Erickson[55] in a different context, I feel that a relationship of *basic trust* must be established between the therapist and the patient.

It is futile to pretend offering to the patient the love he wants in order to compensate for what he did not have early in life; the therapist cannot love all of his patients, as only mothers can do, but he can offer trust. Basic trust is an attitude or atmosphere of hopeful expectancy. The patient relies on the therapist and feels that the therapist relies on him and that, if anxiety and mistrust disappear, the basic potentialities of the patient as a human being will develop and reach realization.

It is obvious from the foregoing that the countertransference is the most vital tool in the treatment of psychotics, and a necessity for the establishment of basic trust. The therapist likes the patient, and since he cannot like all of them, he must limit the treatment to those for whom he has positive feelings, and in whom perhaps he sees an exaggeration of his own unsolved conflicts.

Although some therapists, such as Wexler,[171] establish this atmosphere of basic trust by assuming a strict, reserved attitude, the majority tend to assume the benevolent, warm attitude of the loving mother. It does not really matter what specific type of attitude the therapist holds—what matters is that it must be consonant with the personality of the therapist and capable of conveying the feeling of basic trust.

Most therapists maintain an attitude of acceptance, warmth, kindness, and consideration. The expression, the gesture, the voice of the therapist should convey these feelings. In some cases the therapist must be somewhat reserved, particularly at the beginning of the treatment, especially with those patients who react with mistrust and fear to manifestations of warmth.

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No matter whether the therapist is overtly warm or reserved, however, he must be convincing, consistent, intensely involved, and, as Betz says,[19] able to communicate to the patient his strength, his fairness, and his kindness.

Of course this general attitude should not degenerate into a smothering oversolicitousness which the patient will perceive as a reproduction of the maternal anxiety which prevented psychological growth and enhanced dependency habits.

The handling of the hostility of the patient is difficult in some cases, as the closeness with the therapist may elicit such hostility. The patient fears that rejection inevitably will follow so much closeness and will consequently be more painful. Thus, he wants to be the one who rejects and hurts first. Whenever possible, the therapist must explain these vague feelings to the patient. At other times he must explain how the hostility is misdirected, not really directed to the therapist but to what he represents. If the hostility persists or cannot be handled in this way, the presence of an attendant or nurse may help psychologically to restrain the patient. If the therapist is afraid of the patient, and unable to solve the fear, he should not treat the patient. If the patient feels that even the therapist is afraid of him, he will become more resentful, distrustful of himself and of the therapist, and consequently more hostile.

Symbiotic tendencies, that is, complete dependency on the therapist for any kind of initiative, are very common during therapy. These tendencies may be useful only at the very beginning of the treatment, when every means must be used to make contact with the patient, but will be harmful later if not checked. The patient must recognize that the therapeutic situation is not a symbiotic bond, similar to the old one with his parents, but a new type of relationship which permits growth, without being accompanied by guilt and stultifying dependency. Related, but not identical, to the symbiotic tendencies is another important tendency which occurs at a later stage of treatment, in a much more pronounced form than in the neurotic: a gradual entrance of the therapist into the self of the patient. The social self craves to be rebuilt, not by the old significant adults, but with the help of the new meaningful other or *Thou*: the therapist.

What some authors call incorporative processes or identification with the therapist occur to a very pronounced degree. Although this is a necessary and useful event at a certain stage of therapy, it nevertheless must be fought gradually and from its very beginning in order to combat excessive imitative habits.

THE TECHNIQUE OF THE SESSION

The couch should not be used, as the patient is very much in need of closeness even in a physical sense. The best method in my experience is that of sitting next to the patient. If the patient refuses to look at the therapist, he should not be forced to do so. If he prefers to look in an opposite direction or to walk around the room, he should be allowed to do so. These attitudes should not be interpreted as rejection of the treatment on the part of the patient but as ways to decrease the intense anxiety caused by the interpersonal relation.

Sessions should be numerous, in some cases one a day at the beginning of the treatment, especially if the episode is acute. Later, they may be reduced to an average of three a week. If the patient is in a hospital he should be visited by the therapist in the interval between sessions. If the patient is ambulatory, the therapist should insist that the patient come punctually. No time should be made up if the patient is late. Although the therapist must be permissive in many ways, he must be strict on the question of punctuality. The young therapist will soon realize how common it is for ambulatory schizophrenics to come just ten minutes before the end of the hour, or at a different time entirely. They test the analyst, in a certain way, to see whether he would allow this lack of discipline to continue. The patient wants limitations to be imposed on him, in an attempt to reorganize his confused life, and the insistence that he come on time is important. Since, however, many of these ambulatory schizophrenics have an inversion of diurnal-nocturnal rhythm of activity—that is, they stay up until late at night and sleep during the morning hours—it is better to help them by

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assigning them afternoon hours. This holds true, also, for hospitalized patients in acute stages.

The length of the session has to be regulated to the individual patient. As a rule, I find that the best length is a little shorter than that of the psychoanalytic session with neurotic or normal people. Generally, 40 to 45 minutes is as much as the patient can stand during the initial stage of treatment. Later, however, the session may be lengthened.

The technique of the session varies of course according to the stage and condition of the patient. If the patient is in an acute condition, frightened, and wanting to tell his troubles, the therapist must listen patiently and reassure him warmly. But if the patient does not desire to talk about himself or anything else, he should not be asked questions. Each question is experienced by the schizophrenic as an imposition, or an intrusion into his private life, and will increase his anxiety, his hostility, and his desire to desocialize. The request for information is not seldom interpreted by the patient as "an attempt to take away something from him." Even the therapist seems to him "to take away," not to give. And yet we must convince him of our desire to give to him because he is so much in need.

This technique of not asking questions is a difficult one, especially for a therapist who has been trained in a hospital where patients must be legally committed. The administration of the hospital requires that information be collected directly from the patient which will show that the patient is psychotic and legally detained. The administration also requires a complete physical examination to exclude infective or other acute conditions. Of course, these procedures are necessary, but I feel that the therapist should not carry them out. Perhaps another physician could take care of these physical and legal requirements before the patient is assigned to a therapist. Although there may be some disadvantages to this procedure and some physicians might resent this division of jobs, this is, as a rule, the best way to avoid the negative feelings that the patient would immediately develop for the therapist. Whenever it is possible, the contemporary treatment of a nonpsychotic member of the family (sibling or parent) can lead to a fuller understanding of the family constellation.

If the therapist is not supposed to ask questions of a reluctant patient, what is he to do? Again, various techniques are indicated according to the various cases:

1. It may be advisable for the therapist to take the initiative and talk about neutral subjects, conveying to the patient the feeling that a sincere effort is made to reach him, without any strings being attached to this effort.

2. If the patient is a mute, or almost mute, catatonic, the therapist must talk to him, expressing sympathy and a desire to break the incommunicability. He must tell the patient that he (the therapist) realizes how frightened the patient is, so frightened that he cannot talk. The therapist knows, however, that he feels and understands. At times, however, it is better not to talk at all to the catatonic if he seems to resent talking and withdraws more. The therapist must then "share" a state of silence without being disturbed by it. Even a simple state of proximity without any talk may disclose to the sensitive therapist almost imperceptible ways of nonverbal communication which are specific for each patient and therefore impossible to report.

3. If the patient is very disturbed, or incoherent, and his speech consists of word-salad, the therapist should not pretend to understand him, when he does not, but listen patiently. Soon it will be realized that the word-salad too makes some sense. Some themes recur frequently, and the atmospheric quality of the patient's preoccupations is transmitted.

4. At a more advanced stage of treatment, the patient will be able to talk more freely about himself and about his life. The gaps which still exist either in the knowledge of his life history or in the understanding of his production are often filled in easily by the therapist's knowledge of the psychodynamics of schizophrenia and of its formal mechanisms. The therapist must, however, always be alert to the possibility of uncommon and unpredictable dynamic and formal mechanisms.

5. If the patient is a verbose, apparently well-systematized paranoid, who fanatically

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speaks about his delusions, an attempt must be made to detour his attention and re-establish his interest in the other aspects of life.

When the patient speaks to the therapist about his own delusions and hallucinations, the latter must not pretend that he accepts them but must explain to the patient that there must be reasons why he sees or hears or interprets things in a different way (Fromm-Reichmann[72]).

Interpretations are not very important, especially at the beginning of the treatment, although they may be beneficial later on.

If the anxiety is decreased to the point that acceptance of the psychotic world is no longer immediate or automatic, it is possible to explain to the patient how he concretizes and symbolizes. A patient of mine could recognize that the olfactory delusions about a bad odor emanating from his body were only concrete representations of what he thought about himself.

Patients who have been made less anxious by the new interpersonal relationship with the therapist are also able to understand and correct their auditory hallucinations. They are able to recognize that the anxiety state makes them anticipate the occurrence of certain things and situations they fear, for instance, that people are talking about them. But, almost simultaneous with that anticipation is the hallucination itself—they hear people talking about them. In the process of treatment they learn to recognize these stages and to catch themselves at the stage of the listening attitude, before it transforms into a definite hallucination.

Goldstein feels that the patient must be exposed to a concrete atmosphere and spoken to in concrete terms, in order to find himself in a comfortable environment where anxiety is decreased (Chapter 65). I have found this to be true to a certain extent, especially at the beginning of treatment, and with patients who show chronic forms of schizophrenia. In my opinion, however, the treatment does not consist only of presenting to the patient a concrete world: he cannot be treated as a defective person who has to learn to live with limited horizons. When his anxiety is decreased, the patient learns that he himself concretizes and he will recognize many of his delusions as actual active processes of concretization.

I found it thus possible and beneficial to explain to some paranoids, in language which they could understand, that the feeling of persecution was a re-externalization and concretization of the hostile feeling they experienced in early childhood. I was also able to explain in many cases how the feeling of having thoughts controlled by an external force was a reactivation or a concrete representation of the childhood feeling that thoughts were being crushed or controlled by those of the surrounding adults.

Quite often, when the patient is still confused, the therapist, who by now has learned much about the patient's life, may be able to summarize and simplify the understanding of his life situation without necessarily resorting to a concrete level of communication. This simplification will permit the patient to remain within a logical and realistic framework without the necessity of deviating toward the paleologic and delusional.

Another recommendation concerns the vacation time of the therapist. The patient must be prepared long in advance for it, especially if the treatment is still at the initial stage.

General Participation in Patient's Life and Assignment of Tasks

Use of a Therapeutic Assistant. The treatment of schizophrenics must consist not only of the sessions but also of a general participation in the patient's life. The patient must feel that the therapist, like a deeply and warmly involved parent, shares many events of his life. This does not mean, of course, taking the initiative, which should be left to the patient whenever possible. The patient wants tasks to be given to him and demands to be made on him, contrary to the way he felt at the beginning of the treatment.

Now that he trusts the therapist and himself, he will consider himself trustworthy of the tasks the therapist assigns to him, and this will increase his self-esteem. Of course, the assignments must not be out of proportion to the capacity of the patient. Many schizophrenics disclose artistic inclinations. At this stage, it may be worth while to encourage them.

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Some of my patients during treatment started to study painting, music, and dancing with considerable success.

Even one patient requires much attention, so much, in fact, that in difficult cases it is impossible for the therapist alone to treat the patient. In several instances it is good practice to resort to a *therapeutic assistant* who will stay with the patient between sessions. The therapeutic assistant should not only create a warm general atmosphere of acceptance but also help the patient to share feelings and do things together with another person. The therapeutic assistant should always be there, near the patient, as a person on whom the patient may depend whenever it is necessary. Federn at times used a relative as a therapeutic assistant. In my opinion, a relative, especially a close relative, such as parent or spouse, is too involved in the emotional problems of the patient to be a good assistant. I have successfully used nurses, social workers, and people in related professions. Before assigning the patient to the therapeutic assistant, the therapist must have had a few contacts with him and be sure that his personality will be acceptable to and accepting of the patient.

¶ The Concept of Schizophrenia

Several authors have expressed doubt about the existence of an entity to be called schizophrenia. Szasz, for instance, calls schizophrenia a *panchreston*, a term coined by Hardin[78] to denote dangerous words which are purported to explain everything, but which on the other hand obscure matters.

Szasz adds,[163] "The problem of schizophrenia which many consider to be the core-problem of psychiatry today, may be truly akin to the 'problem of the ether.' To put it simply: there is no such problem."

Szasz's is probably one of the strongest attacks ever made on the Kraepelinian concept of dementia praecox (schizophrenia). Although I admit that in what we call the schizophrenic syndrome there is still much that is indefinite, variable, inconstant, accessory, I feel nevertheless that there is a more or less homogeneous core which makes us recognize the schizophrenic person as such and leads us to some conclusions, some of which have pragmatic value. The fact that the nature of this core has not yet been fully or uncontroversially determined points to the incompleteness of the concept of schizophrenia but does not prove it is a fallacy.

Psychodynamic studies, although useful in understanding the factors that lead to the psychosis, have helped to make the concept of schizophrenia even less distinct, because of the similarities in the dynamics of these cases and those of other conditions. If we should concentrate on dynamics, almost every seriously disturbed person, child or adult, could be called schizophrenic. In that case, Szasz would be right in calling this word a panchreston. But, if we limit the name schizophrenia to those cases in which the psychodynamic conflict assumes the form of a progressive teleologic regression, then a relatively clear delimitation of the syndrome can still be maintained.

A definition I have found useful (but one which is by no means unanimously accepted) is the following:

Schizophrenia is a specific reaction to an extreme state of anxiety, originated in childhood and reactivated later in life by psychological factors. The specific reaction consists of the preponderant adoption of mental mechanisms which belong to lower levels of integration. Inasmuch as the result is a regression to, but not an integration at, lower levels, a disequilibrium is engendered which causes further regression.

Even this definition is not complete. For instance, it does not mention the hypothetical psychosomatic mechanisms of the central nervous system which mediate the regression.

Any attempt to define and redefine schizophrenia, and any satisfaction we may receive from theories that seem to fit our present knowledge, should not make us unaware that there is still much to learn about this syndrome, the most important in the field of psychiatry and yet, as it has been said, the Cinderella of the medical field.[48] More research is needed not only on the nature of the disorder and its treatment but also on its prevention. Promising signs are rising, however, for example, the founding of RISE (Research in Schizophrenia

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Endowment), an organization which has the purpose of focusing attention and helping research on "one of the most prevalent and neglected of all major diseases of our time."[48]

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CHAPTER 25

PARANOID CONDITIONS AND PARANOIA*

Norman Cameron

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THE CONCEPTS OF PARANOID STATE and paranoia have had a capricious past, and they face a most uncertain future. In the current official classification of psychiatric illnesses they are included as distinct entities, but in actual clinical practice the task of differentiating between them and schizophrenic or manic-depressive psychoses often seems hardly worth the effort. Diagnostic difficulties have, in part, been met by setting up compromise groups, such as depressions with paranoid trends, paranoid reactions with depressive trends, paranoid schizophrenia, paranoid personality, etc. But, although such compromises do make room for many of the nonconformities that living patients always exhibit in relation to arbitrary classifications, they also leave the field in confusion.

Many psychiatrists today cut this Gordian knot by simply abolishing the group of paranoid reactions altogether. They assign most psychotic cases with marked paranoid manifestations to paranoid schizophrenia, and distribute the rest among the manic-depressive psychoses, the involutional reactions, and the sociopathic personality disturbances. This may very well be the future of the diagnostic group. On the other hand, no less a person than Freud has urged that paranoia be kept as a separate clinical type for dynamic reasons, no matter how often it is complicated by schizophrenic factors,[35] and he retained the designation throughout his later publications (for example, Refs. 30, 34, and 36). Most textbooks still include a chapter or a section on paranoid reactions,[39, 47, 66] and articles on paranoid disorders appear every now and then in the current journals. In the present chapter we shall follow Freud's recommendation and the official classification without, however, becoming enmeshed in nosological problems.

Historically, the term "paranoia" must antedate Hippocrates, since it appears as an already familiar word in writings attributed to him. In ancient times it seems to have been used roughly as the equivalent of "insanity" today.

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The term virtually disappeared from medical literature around the second century A.D., but it reappeared in the eighteenth century as the name for delusional and delirious disorders. In the nineteenth century "paranoia" was used in a variety of senses until Kraepelin, in 1893, made his distinction between paranoia, paraphrenia, and paranoid dementia praecox. He defined paranoia in terms of an insidiously developing, unchangeable delusional system, accompanied by clear and orderly thinking outside of the system, and without hallucinations. This is essentially the definition accepted in psychiatry today.

It was Freud who transformed the problem of paranoia and paranoid delusions from one of description and classification into one of genetic development and personal significance. He formulated a case of paranoid psychosis as a defense psychosis, and from this new standpoint compared it with hysteria and obsessions. The psychotic development he pictured as a gradual weakening in the defenses against self-reproaches, which returned to consciousness, but were now ascribed to other people in the form of delusions. For this process he introduced the term and the concept of "projection" (1896).

Fifteen years later Freud expanded and greatly enriched his original formulation in analyzing the paranoid mechanisms involved in the autobiographical account of psychosis written by a gifted psychotic jurist, Schreber.[74] In this analysis Freud[35] linked denial and projection as defenses against homosexual wishes. These wishes, he pointed out, had emerged when Schreber's sublimated homoerotism became resexualized, during a severe regressive episode. He also gave a new interpretation to delusions which he recognized as reality reconstructions, or restitutions, that is, as attempts at self-cure, as signs of recovery rather than as merely symptoms of disease (see also Freud, Refs. 28, 29, 33, and 36). In later years, after he had established the basic importance of aggressive drives and had evolved the ego-id-super-ego topography, Freud[30] gave much greater prominence to aggression in the genesis and structure of paranoid delusions. He stressed the importance of early sibling rivalry, and he reformulated the conversion of love into hate in terms of a reactive shift in cathexis at a primitive ambivalent level.

These newer leads have been pursued in more than one direction. Knight,[57] for example, focused attention upon hate as the basic problem in paranoid delusional development—hate directed against a father figure or a brother figure. The strong homosexual drive, he said, was an attempt to erotize and neutralize the patient's destructive hostility, which failed because the basic hate was too powerful. Following Nunberg,[67] Bak has redefined the paranoid reaction as delusional masochism.[3] Melanie Klein[54,56] pushes the crucial oedipal conflicts back to the first and second postnatal years, and dates from the same period the origin of a cruel, persecuting super-ego which she considers the source of later paranoid delusions.

Glover[39] has given an organized presentation of paranoid reactions in which he emphasizes regression, and both the defense against homosexual wishes and the reactive cathectic shift from homoerotic attraction to extreme hostility. In spite of a descriptive bias at the time, N. Cameron[11,12,14,15] was able to extend the concepts of paranoid denial and projection into fields of social interaction and reciprocal role taking. Finally, Waelder[82] reformulated the structure of paranoid ideas by giving first place to denial rather than to projection. He suggested a schema for delusion formation which closely parallels the generally accepted one for psychoneurotic symptom formation. These developments will be discussed further during and after presentation of the clinical material.*

Official Classification

The official classification of the American Psychiatric Association[20] defines *paranoid re-*

* This brief historical introduction skips over many valuable contributions to our present-day conceptions of paranoid reactions. There are good historical reviews of nineteenth- and early twentieth-century developments.[47,50,63] Outstanding among contributors early in the century are Abraham,[1] Bleuler,[6,7] Brunswick,[9,10] Ferenczi,[25] and Jung.[51] All these, except one untranslated monograph by Bleuler, refer to publications in English.

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actions as psychotic disorders which exhibit persistent delusions, usually persecutory or grandiose, without the presence of hallucinations. Intelligence is well preserved; behavior and emotional response are consistent with the patient's ideas. Paranoid schizophrenia is specifically excluded from this group. Under paranoid reactions, two subgroups are distinguished, paranoia and paranoid state.

Paranoia is an extremely rare psychosis in which an intricate, complex, and logically elaborated delusional system slowly develops, without hallucinations. The paranoid system may be more or less isolated so that, superficially at least, the rest of the personality remains relatively intact, even though the course is chronic and protracted. Paranoiac patients often believe themselves to possess superior or unique abilities.

Paranoid states are psychoses characterized by paranoid delusions which are neither highly systematized and elaborate, as in paranoia, nor fragmented and bizarre, as in schizophrenia. There is no personality deterioration. The disorder may be of relatively brief duration, although sometimes it becomes chronic.

¶ Paranoid Reactions

Since paranoia is only a rare and extreme form of paranoid reaction, there is no point in complicating matters by discussing paranoia and paranoid state separately, as though the two had different origins and meanings. Instead, we shall speak of paranoid reactions throughout the chapter, and give a nod to history by adding a paragraph or so on classical paranoia near the end. It should also be clearly understood from the start that pure paranoid reactions themselves—ones which show no hint of schizophrenic thinking, no taint of depression or elation, and no evidence of psychoneurotic defense—are seldom encountered. Much of what we shall describe in this chapter—the defensive organization, the ego adaptations, and the imaginary pseudo-community restitution—may also be found entering into paranoid trends in other psychoses, in personality disorders, and in psychoneuroses.

Incidence

The incidence of paranoid reactions, within the meaning of the official classification given above, is believed to be high in the general population. There is no way, however, of accurately estimating this. One reason is that they are often well defended and hard to recognize. Another is that mild paranoid characteristics are distributed widely among otherwise normal and psychoneurotic persons, who are in no danger of developing a psychosis. Everyone, for example, is at some time unjustly suspicious of his neighbor, or misidentifies some neutral happening as having special reference to himself. The mechanisms of denial and projection, which underlie all paranoid reactions, are also normal components of everyone's defensive system.

The question is to what degree such trends are dominant, how easily regression follows drive frustrations, and to what extent delusional beliefs can be corrected by experience. And even this last criterion is not infallible. Irrational beliefs, founded strictly upon personal need, fear, guilt, or unmanageable drive, are common among normal persons and social groups, and these beliefs resist correction by experience, with remarkable obstinacy. Nevertheless, to call such widespread phenomena paranoid reactions would be to reduce a useful psychiatric concept to mere nonsense.

Another barrier to an accurate estimate of incidence is the fact that paranoid persons do not usually consider their delusions pathological, and therefore do not seek therapeutic aid. They are often chronically suspicious individuals, who understand neither other people's motives nor their own, and who cannot trust anyone enough to confide freely and accept help. Moreover, when they fall ill, they are characteristically in better contact with their social environment, and better able to make use of it, than are manic-depressives or schizophrenics who are comparably ill. Hence they often weather mild and moderate psychotic episodes without needing hospitalization, and even without being recognized as ill by those close to them. And, finally, among eccentrics,

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cranks, irascible neighbors, inventors, reformers, and persons committing crimes of violence, there are often found paranoid personalities who seem close to psychosis but do not reach it.

Heredity

Since Miller's review of 400 hospitalized patients,[64,65] which included all psychotics with marked paranoid trends, little attention has been paid to the question of heredity as a factor predisposing an adult to paranoid developments. Miller found evidence of paranoid illness in the ancestors of only 8 of these patients, and only 44 were the direct descendants of persons suffering from nervous or mental disease. It is true, of course, that the possibility of hereditary factors—for example, susceptibility to stress,[75] inflexibility of adaptive organization, perceptual hypersensitivity, etc.—cannot be ruled out completely by such negative evidence. Moreover, what we have just said about the difficulties in recognizing paranoid illness and paranoid trends must certainly apply with special force to all studies of hospital records.

Sex and Marital Status

Here again, the available data refer to hospitalized patients and are therefore of little value for our purposes. Tyhurst[81] reports that there is no good evidence concerning sex distribution of paranoid states, but that more recent evidence indicates that paranoia is nearly twice as common among women as among men, a statistic which reverses previously held opinion. Noyes and Kolb[66] state that an abnormally high percentage of paranoid psychotics have never married. They attribute this to a basic homosexual orientation and to chronic anger and hostility which make them undesirable partners.

Age

According to Tyhurst,[81] there is no good evidence to show a characteristic age distribution of paranoid syndromes. He feels that specific paranoid delusional psychoses, without deterioration, appear in later maturity because this is when such disorders become socially intolerable, and not because this is when they begin to develop. As far as nonhospitalized persons are concerned, the point is debatable. Among clinicians who work with psychotics, there is almost complete unanimity that paranoid reactions—and even paranoid schizophrenias—appear a decade or more later in life than do nonparanoid schizophrenias.

Even in a study confined to a university student population, where the age spread to begin with is not large, the mean age of persons developing paranoid reactions was reported as being 11.6 years above that of persons developing any form of schizophrenia.[72] What Tyhurst says about the slow onset and the factor of social intolerance, in most cases, cannot be questioned. But slow onset and social intolerance are also important factors in schizophrenia, so that the reported difference in age of first hospitalization cannot be explained on this basis.

Assuming the widespread conviction to be true—that paranoid reactions develop significantly later than do schizophrenias—the meaning is still unclear. The difference may be an artifact, the product of our classification, which limits paranoid reactions by definition to more or less systematized delusions without personality disorganization. These qualifications tend to rule out the adolescent and postadolescent periods of stress and confusion, that is, periods of maximal drive, when an individual faces the challenges of his peer group alone, and when problems of self-identity,[22] career, marriage, and parenthood become urgent. It is logical, though not necessarily correct, to assume a fundamental difference in the personality structure of those who do not weather this phase (and become schizophrenic) and of those who somehow weather it but succumb a decade or so later to a paranoid reaction.

There are, objectively considered, some sources of frustration, conflict, and anxiety which are certainly more characteristic of the fourth decade, and after, than of the second and third decades. Some time toward middle age, when a person turns thirty, thirty-five, or forty, comes the dawning realization that his

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life span actually is limited. With this recognition may also come fears that his lifelong hopes, overt or latent, will never be realized. Many people become suddenly aware of waning youth, attractiveness, ability, or vigor, and of dangers to what may suddenly seem a precariously held position of security or status. It is a fact that the actual range of choices in one's life does grow smaller with age, that one's commitments become deeper, and the accumulation of disappointment and disillusionment grows larger. To such threats, frustrations, and restrictions the vulnerable individual may react with regression and delusional restitution.

Social Milieu

There is nothing to indicate valid differences in the incidence of paranoid reactions among different socioeconomic groups. Tyhurst[81] reports a higher percentage of hospitalized patients from urban than from rural areas, but the significance of this finding is unclear. He also reports a higher incidence among migration and minority groups, and states that hospitalized paranoids are perhaps better educated than other psychotics. Unfortunately for us, the important contribution of Hollingshead and Redlich to the problem of social class and mental illness[48] does not deal with paranoid reactions as a separate group.

In the end, of course, the question of whether or not there shall be a psychotic illness depends upon a complex interaction of biological, psychological, social, and cultural factors, all of which have a past history as well as vectors pointing to the future. The adult with an unstable or inflexible personality organization, and with relatively poor social integration, faces serious difficulties when he finds his achievements and gratifications falling further and further behind his ambitions and desires. He may react by redoubling his efforts, trying aggressively to meet new challenges, to overcome obstacles and prove himself, and, in his sex life, to spur himself on or look for new and untried sources of gratification.

If the efforts of such a person fail, the temptation increases to seek an explanation outside himself. His increased aggression is likely to arouse counteraggression in others, and this favors the development of delusions. If, as is sometimes the case, a paranoid individual should become disheartened and feel moved to give up, to submit to failure and to fate, he then runs the risk of reviving primitive fears for his own bodily integrity, fears that have been silent within him for decades. Let us turn now to a consideration of the major form of paranoid reactions, the development of persecutory delusions.

¶ Persecutory Paranoid Development

Personality Background

We assume that anyone who develops a psychotic paranoid reaction, under the common stress of adult civilian life, has an adult personality structure that differs from the average in leaving him vulnerable to such a response. This circular statement is self-evident, but its referents are not. To what characteristics of the premorbid personality of paranoid psychotics are we referring, and how do they operate in bringing about situations which may be disastrous to the patient?

A simple answer to this question is not possible. The difficulty arises from the fact that a paranoid person, before his illness, may have been using almost any combination of secondary defenses and ego adaptations. The result is a variety of different premorbid patterns. Nevertheless, certain premorbid paranoid characteristics do appear with considerable regularity, however much they may be overlaid by reactive character structure or psychoneurotic defense, or handled through ego distortion, drive neutralization, and successful sublimation.

To begin with, the individual most vulnerable to paranoid psychosis is a tense, insecure, and usually fearful person, one who operates at high levels of anxiety. He easily becomes suspicious and distrustful.[53] He finds it difficult to confide in others, and if he does confide, as we shall see, he expects to be betrayed. If he has any close emotional relationships, they are

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likely to be limited to a very few individuals, and even these ties may not survive a personal crisis. Usually he is a person with lifelong tendencies toward secretiveness, seclusiveness, and solitary rumination, although these may be concealed behind a brittle façade of superficial social give and take.

The world in which such a person lives is a dangerous world where one must be always on the lookout for attack. People are unpredictable as well as untrustworthy; they must be watched. The paranoid individual, who needs more than the normal degree of understanding of motivation because he is so fearful and suspicious, has next to none. His social reality testing is grossly underdeveloped; therefore, he is easily taken by surprise and exposed to hurts and humiliations which ordinary persons foresee and discount, or avoid by preventive adaptations. The paranoid cannot understand another's motivation, or his own, because he does not have the other's perspective, as a reference point for his orientation, at the same time that he has his own. His failure in establishing adequate early identifications in infancy has left him unable to take the role of others realistically during later social interaction. As a result, he is forever socially incompetent in everyday situations that involve reciprocal role behavior—in ordinary cooperative, competitive, and complementary relationships. He therefore lives with endless tensions over mutual misunderstanding and misinterpretation, and is plagued constantly by ideas of self-reference.

Mild, harmless ideas of reference are familiar to everyone's experience. An occasional mistake in assuming that a critical remark or a compliment is meant for oneself, when actually it is not, lies within everyone's normal range, no matter how revealing it may sometimes be. Persons with well-compensated paranoid trends may even show this characteristic conspicuously without being in danger of psychosis. It is only when self-reference focuses upon some particular theme, or upon certain individuals who seem banded together, that it becomes a sign of beginning failure in paranoid defenses. The apparent self-sufficiency of paranoid persons, we have said, is usually a façade that hides their weakness. They are really over-concerned about what others think and feel about them, and at the same time much less able than the average to satisfy their need to know. When a condition of emotional stress increases this need, without increasing their ability to meet it, they do the best they can by increasing their vigilance and looking for signs that confirm their suspicions.

The persecutory paranoid personality is basically an extremely hostile one.[54, 56, 57] This is both because the individual feels surrounded by hostility, and because his personality organization includes major fixations at sadistic levels, with a preponderance of infantile defenses and an ease of partial ego-regression. The aggressiveness of the paranoid, however, is never aimless, excepting sometimes in an extreme panic reaction. Otherwise, he is always selectively reaction-sensitive, overready to react with defensive hostility to certain kinds of situations, personalities, and implied threats. And the directions of his reaction sensitivity, as we shall see, correspond to his own actual weaknesses, fears, guilt, intolerable frustrations, or ego-alien trends. In short, he is overready to react with what he considers counteraggression, to what he experiences as an assault upon his integrity, threatened from without. And this is true whether he conceives the threats as sexual or not, and whether what he fears is direct bodily attack or a danger to his freedom, his reputation, or his security.

On the defensive side, a major reason for calling the paranoid personality immature is that it must make excessive use of such infantile forms of denial and projection to bolster the characteristically inadequate repression. It is this preponderance of denial and projection that favors delusion formation in times of stress, to make good the lost aspects of reality. The immediate results are (1) to exaggerate normal tendencies to deny responsibility for failure or misdeed and ascribe it to others; (2) to deny unacceptable and unsatisfied sexual desires and attribute them to others; and (3) to deny one's own unmanageable hostility and project it onto others. The absence of realistic role representation in the personality structure[11, 15] leaves the individual with nothing

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to oppose these drive-oriented attitudes. Needless to say, the denial and projection take place automatically at unconscious levels, so that the person is himself quite unaware of what he is doing. The effect of such unconscious maneuvers, however, is to create an atmosphere of tension and uneasiness, which makes others avoid the hostile person's company and increases his actual isolation. He feels unwanted and unloved, inferior or guilty, and pushed continually to overcome his multiple frustrations.

Premorbid Personality Stresses

To offset these basic distortions, other defensive reinforcements, ego modifications, and adaptations are developed into one of a variety of adult patterns. The effect is usually to strengthen the total personality organization, but at the cost of making it more rigid. Indeed, a reactive rigidity, which renders normally flexible adaptation impossible, is a common and striking premorbid characteristic. The paranoid personality often gives an impression of self-sufficiency, superiority, and certainty. This impression in no way represents the basic internal situation but only a fixed inability to allow anything to enter which might upset a precarious equilibrium.

It is easy to understand why a person who must rigidly defend such a structure should be argumentative, insistent, and opinionated, unable to admit weaknesses, mistakes, and failures. The alternative would be to run the serious risk of precipitating a disastrous experience of inadequacy and guilt. Although reactive rigidity appears most clearly under emotional stress and in personal matters, it is also present chronically in some individuals, and in matters which seem impersonal on the surface—for example, a maddening insistence upon the literal application of rules, which expresses the individual's anxiety and not his strength.

Although he is unaware of the fact, such a person does not dare to recognize his weaknesses and failures or his ego-alien trends. Since he cannot successfully repress them, because of his defective defensive structure, he must engage in a continual process of getting rid of them through denial and projection. Now they appear as the real or fancied shortcomings, evil intentions, or misdeeds of others; and he is justified in his own eyes when he attacks these others with disparagement, denunciation, and condemnation. The more he defensively belittles another, the further he gets from seeing his own smallness. The more he points out others' mistakes and sins, the more he distracts attention from his own, and the less danger he runs of having to admit them to himself. By maximizing others' ego-alien or socially taboo aggressions and desires, the paranoid person automatically minimizes his own, to a point where what is left can be repressed. The unconscious guilt, which lurks behind every paranoid mechanism, is likewise denied and projected onto these others. This helps to get rid of still more of the disrupting aggression, which can now be justifiably vented upon the "guilty" ones in the form of contempt, indignation, or attack.

An ambitious paranoid person is likely to push ahead without due regard for others' feelings, which, because of his lack of reciprocal role representation and corresponding social perspective, he honestly does not understand. When he himself feels frustrated, he reacts with personal hostility because of these same defects. Such tactics further alienate people and provoke counteraggression. Now he may complain that people are against him—that he is being blocked, interfered with, discriminated against, or persecuted—all of which has some foundation in objective fact. What the paranoid person cannot see is that this outcome in the field of social operations is originally his own doing. He cannot afford to face this fact. If he cannot otherwise hide failure, temptation, or misdeed from himself, he calls in secondary rationalizations, misinterpretations, and distortions of recall, as a normal person might also do, but with far greater rigidity and determination. It is important to keep in mind that all these maneuvers are carried out under the pressure of urgent necessity, the necessity of defending an unsafe structure against disintegration, and of discharging libidinal and aggressive forces which cannot be otherwise channeled or controlled.

It should be said in passing that by no means

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all paranoid personalities follow the path we are describing. Fortune smiles on some, and others hit upon effective compensatory adaptations. The more fortunate succeed in discharging much of their aggressive and libidinal energy in socially acceptable action, in enterprise and fantasy, and in setting up systems of reaction-formation capable of withstanding considerable stress. The most fortunate succeed also in establishing important sublimations and neutralizations which enable them to discharge otherwise inadmissable impulses wholesale in socially permissible ways—for example, in crusading vigorously against sexuality, depravity, cruelty, and crime, or in lining up actively with normal persons in promoting the constructive uses of brotherly love.

We are here concerned, of course, with the paranoid personalities who fail. Among those, three pathological characteristics are outstanding: an extreme sensitivity to certain unconscious trends in others, with manifest insensitivity to these trends in themselves; a marked tendency to self-reference within the areas of special sensitivity and an inability to correct mistakes through reality testing; and severe defects in reciprocal role representation, the result of defective identification and social interaction at infantile levels. When a paranoid person projects what he denies, we have said, he does not project at random. He ascribes hostile and erotic impulses to people who actually exhibit minimal signs of a corresponding unconscious impulse.[80] Since everyone has hostile impulses, and every heterosexual person has minimal unconscious homoerotic trends, it is not difficult for the selectively hypersensitive paranoid to find persons on whom to project. Thus there is always a core of truth in paranoid accusations. This fact, in part, accounts for the defensive hostility which the paranoid arouses in normal persons, hostility toward one who is stirring up their own anxieties over their own unconscious guilt.

The most obvious flaw in such paranoid accusations is that they assume these minimal unconscious impulses and trends in others to be maximal and conscious. And this gross misinterpretation of a correct, subtle perception can be a crucial step toward precipitating a psychosis. It then leads to the failure of a defensive maneuver and a return of the denied, as a new and imminent danger which seems now to threaten directly from external reality.[82]

Precipitating Factors

The most important internal factor in precipitating paranoid reactions is a readiness to react with traumatic projective discharge when frustration provokes overexcitation.[89] An upsurge of hostile or erotic impulse may come as a result of the loss of major sources of gratification, in fact or fantasy; it may come as a compensatory reaction to the dangers of passive wishes or relative impotence; and it may come as a direct response to external frustration or temptation. The paranoid personality is especially vulnerable to ego disruption from super-ego attack, which may be experienced consciously, preconsciously, or unconsciously, as an increased sense of guilt. Whatever stimulates an increased sense of guilt creates an immediate demand for greater ego-defensive effort, and this means, for the paranoid personality, a sharp increase in denial and projection. Unfortunately, a sudden increase in projection is likely to make the environment seem suddenly more dangerous than ever, more malicious, and often more erotic.

Hostile and erotic impulses are likely to increase whenever new external challenges arise, when there is pressure from new or increased demands, and when one's status or security seems threatened. Rivalry can be dangerous for a paranoid personality, even in the presence of success. Close competitive situations may not only stimulate a vulnerable person to hostile aggression but also expose him simultaneously to homoerotic temptation, such as fantasies of who shall dominate and who submit. The same dangers can arise, even in the absence of serious competition, when a paranoid individual is thrown into close quarters with like-sexed persons for long periods of time. Paradoxically, increased social isolation can have similar effects for different reasons. Isolation leaves a person at the mercy of his fantasies and daydreams, without the safeguard of counteracting stimulation from outside, and

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without such opportunities for reality testing as the talk and action of others may provide. Experimental work in sensory deprivation has brought this clinical factor into new prominence (see the review in Solomon, Leiderman, Mendelson, and Wexler[77]).

The internal stress is still further increased when a paranoid person experiences humiliation in actual failure and defeat. He has always relied for narcissistic support upon extravagant hopes and fantasies to offset his equally unrealistic fears and his deep sense of inadequacy. Now he feels unjustly exposed before the world as incompetent, weak, and degraded. It is easier to understand paranoid overreaction to humiliation if one realizes that, however inflated the patient's self-evaluation may seem, it is always defensive and compensatory. It is not just an expression of ambition and false pride; it is an essential bulwark against superego pressure that endangers ego integrity. Moreover, as we have intimated, failure and defeat may stimulate fantasies of passivity and helplessness, and these fantasies arouse vigorous defensive denial and hostile self-assertion.

The loss of a major source of security or gratification can take concrete external form, of course, as in someone's death or desertion; in actual rebuff, neglect, or deception; in economic loss; or in physical incapacitation. The real and the imaginary can support one another. Failing youth, strength, attractiveness, and health also belong in this group, as do the effects of severe fatigue and physical stress. It must be remembered that hypochondriacal trends are common in paranoid personalities and express, among other things, a conviction that the body is inferior, damaged, or vulnerable. Anything which justifies body overconcern will strengthen such trends. Accident and illness, including intoxication and brain damage, can have the same result, especially when they also place a susceptible person in a helpless, infantile position and decrease his opportunities for reality testing and social interaction.

In this section the discussion has been mainly about external reality situations and influences. This must not be taken to mean that adult paranoid reactions are *produced* by aggressive rivalry and erotic temptation, by failure and defeat, by sudden close contact or social isolation, and by major losses in security or gratification. These are only precipitating factors. They tip a chronically unstable balance, one dependent upon an infantile defensive organization, with defective reality testing, a selective hypersensitivity to unconscious processes in others, and irresistible tendencies to project and form pseudo communities. Nevertheless, these precipitating factors are dynamically and clinically important, since they can start off a process of paranoid development which the patient, because of his defective personality organization, may then become powerless to stop.

Onset

The earliest phases of a psychotic paranoid development may be indistinguishable from the ordinary fluctuations of a paranoid person's life. In retrospect, however, it is often possible to say that in such and such a phase the habitual tendencies toward suspicion, blame, and self-reference became outright delusion. The change can often be related to some such precipitating factor as we have just discussed. We call the initial changes the onset of the psychosis. These changes may appear quickly, or they may incubate slowly and emerge so gradually that no one is sure when they started.

A sudden onset is sometimes analogous to sudden cardiac decompensation. The patient seems to have been functioning as usual up to a certain point, and then, almost without warning, he goes into an unmistakable psychotic episode. The precipitating stress is sometimes proportionately severe and suddenly applied. Sometimes, however, the premorbid equilibrium has been very unstable, and the new stress is only the last straw. In relatively rare instances, sudden onsets lead rapidly into acute panic.

Sudden onsets are not always as abrupt as they appear. Paranoid persons, we have said, often exhibit social behavior which, on the surface, seems maturely organized. They commonly build a rather rigid defensive structure, with extensive reaction-formations, and sometimes with fairly successful sublimations and neutralizations. A psychotic development may

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proceed for some time behind such a façade before the patient finally goes past the point where he can control his impulses and conceal his illness from those around him. When his limits have been passed, the manifestations of psychosis may appear abruptly, even though its internal evolution has been gradual.

Early Phases

In most psychotic paranoid reactions there is a more or less prolonged prodromal period. As a result of frustration, threat, temptation, rebuff, or loss—such as we have just described—the patient first withdraws his interest from his environment and loses interest in it. He becomes preoccupied and, in the process, undergoes regression. It is in this partially withdrawn, regressed, and preoccupied state that he begins the restitutional process, by means of which he will ultimately regain contact with his environment, but on a delusional basis.

At first the patient's experience may be only one of estrangement and puzzlement. Things have changed. They seem inexplicably different, and he tries to understand the situation without being able to do so. His growing anxiety, of course, comes from internal dynamic changes, but, to the patient, it seems related to things outside him. He becomes vigilant and uneasy. He begins to scrutinize his surroundings with more than his usual suspicion and misgivings. He does what he has always done—engages in solitary observation, searches for hidden meanings, asks leading questions, pondering over the answers like a detective, and listens attentively for clues in others' conversations to help him understand.

The patient—now anxious, puzzled, preoccupied, self-centered, and partially regressed—feels sure that something is wrong; something is going on that eludes him. With this fixed orientation he watches the little things people say and do, their glances and gestures, their facial expressions, frowns, smiles and laughter, their postures and movements. In this phase the paranoid patient shows a diffuse reaction sensitivity, that is, a sensitive readiness to react to any source of threatening stimulation within a wide range. We know that self-reference has always been his weakness, both because of his egocentric personality organization and because of his defective reality testing. Now, however, in his preoccupied, regressed, uneasy state, he finds that everything seems somehow related to him, although he still cannot understand what is happening.

It is obvious to us that the estrangement and puzzlement come from the patient's withdrawal of reality cathexes, his egocentric preoccupation, and his regression; but, of course, he does not and cannot know this. We know that the sources of his mounting anxiety lie not in the surroundings but in the patient himself; that they lie in the threat of a breakthrough of unmanageable unconscious impulses which he has already been denying and projecting. As with any suspicious, fearful person, the more vigilant and anxious the patient grows, the more things he will find in his surroundings to increase his uneasiness, feed his anxiety, and augment his defensive projection.

A patient notices, for example, that things have been disarranged on his desk or in his locker. At first he feels annoyed, and then he begins to wonder about it. He cannot find something in a desk drawer or at his bench, and he notices that things seem to have been disturbed. Some furniture has been moved around. Does this have some hidden significance? Clothes, newspapers, books, garden tools, or kitchen utensils seem jumbled up or missing. In the street, on buses, and in stores or elevators, people jostle him or crowd him or obstruct him, and he begins to feel furious. He overhears remarks that sound as if they might refer to him, and if there is laughter he feels this is directed at him. Someone spits on the sidewalk in front of him, or two people approach, smiling, and look at each other. This also seems directed somehow at him. Things are getting more and more mysterious.

Finding a Focus: Preliminary Crystallizations

A situation such as this is too unstructured, too unstable, and too anxiety-laden to persist indefinitely. Even a normal person, feeling as threatened in a situation that he cannot understand, will automatically move on to hypoth-

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eses about it. Paranoid personalities are notoriously intolerant of suspense. They are driven irresistibly to form hypotheses, and this is where their incompetence in social reality testing trips them up. They are unable to represent realistically to themselves the probable points of view of other persons and are unable to confide, communicate freely, and share social perspectives when in desperate need.

The paranoid person is already caught in the web of his own projections. He cannot give up his projected fears and retrace his path, because the projected fears are themselves an integral part of his defensive maneuver against being overwhelmed and disintegrated by his own hostility. The only course open to him at this stage is to go on projecting and to move forward toward a more stably reconstructed "reality," which must include his defensive projections in its organization.

The preliminary crystallizations do not yet constitute a community of persons or a plot. They only express the patient's growing conviction that he actually is being singled out for some special reason which remains obscure. Things seem now to be done deliberately to confuse him, to test his intelligence, to express contempt for him, and make him look ridiculous. He finds signs that his effects are being searched. Objects are left around to try his patience or to communicate something about him, for example, that he is a fool, a pervert, or a criminal. Magazines and newspapers are left open so that he will notice a significant article, a story, or an advertisement. Now and then the food tastes strange; he wonders what is in it.

Things go from bad to worse. When the patient is driving, people saunter in front of his car as if to invite a serious accident; when he walks, drivers seem to drive right at him at street crossings. These are, of course, projections of his own denied murderous impulses and his fear of consequences. People seem to be watching him on the street and in the office; when he looks sharply at them they always look away. He goes to the window, and a man on the corner walks off; he is going to telephone a report about the patient. The patient is likely to believe that his telephone is being tapped and that hearing devices are concealed around his home and place of business. When he tries to divert himself by going to the movies or watching television, he sees and hears things which unmistakably refer to him and to things he never supposed were public knowledge about him. The net now seems widespread and inescapable.

Nearly all paranoid patients try more than once to communicate their misgivings to another person, to get help in understanding what is going on or in defending against it. The trouble is that, for the patient, everything is heavily loaded in the direction of his own projected fears and temptations, which his listener does not and usually cannot share. The layman, unless he falls victim to a rare *folie à deux*, is most likely to oppose the patient's drive-directed reasoning with some realistic evidence, or to expostulate frankly with him over his fantastic interpretations. The patient, unable to see things from any perspective but his own, may simply dismiss the other's reasoning as that of a coward or a fool, a person who will not or cannot face the frightening facts. He may also conclude, sooner or later, that the disbelieving person is really a party to some plot against him and is conspiring in order to throw him off his guard.

Final Crystallization: the Paranoid Pseudo Community

Up to this point the projection, while by no means random, has still lacked a focus—some specific danger coming from some particular direction. The delusional reconstruction has still not built a stable organized picture of external reality that includes his expanding projections. If the patient has spoken of persecution, he has been able to say only that "they" or the "people" are doing things or planning things, without being able to specify who the "people" are and exactly what the plan is. It only remains now for him to conceptualize these dangerous "others" as a unified group, with some definite plot of which he is the intended victim, and he has structured his pseudo community with all his projections operating intelligibly within it.

The paranoid pseudo community is an imaginary organization, composed of real and

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imagined persons, whom the patient represents as united for the purpose of carrying out some action upon him. The supposed "action" corresponds to his own projected libidinal and hostile impulses. The organization may be conceived of by the patient as a gang of underworld criminals or international spies, as a secret police force, or as a racial or religious group. In many cases the pseudo community is well organized and has specific plans, like the gangs in mystery stories. Some of the individuals in it may be identified by name as persons whom the patient knows. In many, the identity of all but the leading persecutor—actually a loved, feared, or hated acquaintance, or a public personage—remains obscure. They are only vague figures in the background.*

The formation of a projected pseudo community ushers in the phase of paranoid crystallization. This marks a final step in the restitutional process, in re-establishing relationships with external reality on a delusional basis. From a dynamic standpoint this step has considerable advantage for the patient. A known danger is easier to tolerate than an unknown one of equal magnitude, and the less diffuse a danger seems, the more effectively one can prepare to meet it. An acutely paranoid patient is forced to make massive projections merely to preserve his dynamic integrity. To have a more or less specific structured focus for this process makes it much easier to effect, with more economy and greater completeness.

This crystallizing out of the pseudo community, with its organization of projective processes in relation to it, is a movement in the direction of greater stability and precision—however false the crystallization itself may actually be. It represents a structuring of drive-directed, cognitive processes into something which can be used as the basis for meaningful, interrelated interpretations. These interpretations, of course, are also delusional. The patient himself often expresses the new stability in some such words as, "Everything became clear to me," an obvious experience of closure, which we have designated as sudden clarification.

* It is obvious that pseudo communities are not confined to paranoid reactions but may appear whenever delusional reconstructions include real as well as imaginary people.

The fatal flaw in this whole defensive maneuver is that what has been denied and projected seems now to return in external reality as an organized plot to ridicule, defame, or attack the patient, to subdue and exploit him, or perhaps to torture and kill him. The urgency of projection, and the patient's inherent inability to take the roles of others in imagination and see things from more than one perspective, leaves his cognitive operations at the mercy of the ongoing psychotic process. This process is itself powered by the unneutralized energy of his regressed, primitivized, dynamic organization.[46]

The result is that the patient's pseudo community organization moves forward irresistibly along the drive-determined vectors, often picking up momentum as it goes. Real happenings are distorted and reinterpreted to feed this ongoing process. Vague and trivial incidents are endowed with definite and important meanings. Contradictory evidence is scorned, ignored, or transformed to fit the over-all motivation of the pseudo community. This is the final picture of restitution, in which a delusional organization of active agents seems to threaten the patient in external reality. Many paranoid patients do not go as far as this; some do, and remain chronically fixed at such a level; others are able to replace some or all of this restitutional structure with more realistic relationships. The rare few go on to elaborate a classical paranoia (see p. 526).

Paranoid Action

It remains for us to consider what course of action the patient follows in relation to what the pseudo community seems to be planning and doing. In many chronic cases this amounts to no more than a morose, suspicious, resentful, or aggressively hostile attitude toward the world, behind which the delusional convictions may be more or less successfully concealed. This group includes individuals who, no matter how they are treated, feel they never get a fair deal, and the many people who feel that no one can ever really be trusted.

In other chronically paranoid persons, with substantially the same attitudes, there are occasional outbursts of hostility or accusation,

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which make others avoid too close contact and serve to isolate the patient. In this group belongs the litigious paranoid who repeatedly hales opponents into court to demonstrate to all the world that he has been wronged. The attempt always fails in the end, because the root of this urge toward litigation lies in the patient's unconscious sense of guilt. No court of law can ever silence accusations that stem from a pathological super-ego. In this group belong also patients who complain to the authorities about their supposed persecutors, or keep reporting the presence of prowlers and suspicious characters to the police, as well as the more fortunate persons who eventually seek psychiatric help to prove that someone else is wrong in claiming that they need it.

Some paranoid persons are driven to take more aggressive action. When their delusions crystallize, they abandon the role of observer and interpreter, and take that of participant in what seems to be going on in the malevolent pseudo community. The trouble is, of course, that what they imagine they are participating in does not actually exist as a construction in external reality, as we shall see in the case about to be described. The action the patient takes may be an attempt to escape by sudden flight, often with elaborate precautions to cover up the trail, in the best tradition of the mystery story.

Instead of fleeing, some patients feel driven to attack, to catch the enemy unawares and take revenge for what they have already suffered, and to forestall what they fear. It is obvious, in such a turn of events, that the patient has found another means of discharging his extreme hostility, without having to recognize it, and with the conviction that his attack is justified. The scapegoats, his victims, thus carry a double burden via his denials and projections—that of seeming to have what are really his own sadistic or erotic intentions, and that of shouldering the guilt for his actually unprovoked attack.

In all of this the paranoid patient is operating within an actual social field, in external reality. But he operates as a solitary individual who has reconstructed the behavioral elements and personal identities of this social field, in terms of his denied and projected delusional needs. His attitudes and interpretations are not and cannot be shared by the other individuals within the social field, since these others do not and cannot share his delusional reconstruction. Thus, if he takes action which, to him, seems just and reasonable, his behavior will almost certainly seem unintelligible and unprovoked to them—as, of course, in terms of the consensus, it is. The others are compelled, under these circumstances, to take protective action, which is almost sure to be aggressive and may be violent.

To the patient this counteraggression seems the final confirmation of his delusional expectation of assault. Thus, in the end he brings about a reality situation that corresponds to his psychotic reconstruction. The hostile world that he has built up in his imagination at last confronts him as external reality. The following case does not carry the patient to quite such an extreme as this, but its development is dramatic enough to illustrate the salient characteristics of a severe paranoid reaction.

Case Illustration

COMPLAINT AND IMMEDIATE BACKGROUND

An unmarried man, forty-nine years of age, was brought to the clinic by relatives after he had admitted his intention of committing suicide in order, he said, to escape being captured by gangsters and tortured to death. He gave the impression of being superficially friendly, polite, and cooperative. It was obvious that he was badly frightened and, behind his friendly politeness, very much on his guard. He told the story of his acute paranoid outbreak willingly and intelligently, although with no recognition of its delusional character. In all other matters, however, he took refuge in a degree of circumstantiality that amounted to a filibuster, and yielded little in the way of communication. What little could be gleaned about his mode of life was clearly of some importance in the background of his illness.

For several years he had been living alone in a cheap hotel, on a modest but steady income from investments. In spite of his comparative youth and good physical health, he lived idly and as though he were an elderly retired businessman

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who had been unusually enterprising and successful. Every now and then he looked into new business prospects, but he never found anything that attracted him. He liked to sit around the hotel lobby and think, he said, from which one could draw the conclusion that he daydreamed and fantasied a lot. He conversed with other men there, played cards with them, read the newspapers, and, following a custom in that region, placed about a dozen small daily bets on race horses, through bookies and by telephone. This is all we knew about his life at the time the paranoid reaction erupted. We learned from him a good deal more of significance in his past, and there was probably much more than we know in his immediate background to make his violent outburst thoroughly intelligible.

Acute Attack

The acute paranoid attack came the day after the patient had picked a violent quarrel with the racing bookies over a bet and had threatened to assault them. The circumstances were as follows. He had placed a number of bets by telephone one day, as usual, and one of the horses he had chosen, with the odds against it, had come in first. He went jubilantly to the bookies for his money, only to be told that he had not bet on the winning horse in that race, but on another one. He was very much taken aback. He went to a nearby bar and had a few drinks. As he thought about it, he "realized" that he was being deliberately cheated. He returned to the bookies, demanded the pay-off, and, when they still refused to give it to him, began shouting insults at them and invited them outside, so he could beat them up. They declined the invitation. For a time he paced up and down the sidewalk, until he cooled off a little, and returned to the hotel, still furious, where he sat and thought about the situation.

As he sat pondering alone in the hotel lobby, nursing his wrath, and probably imagining scenes of violent revenge—as people commonly do when they feel outraged—it flashed upon his mind, he said, that bookies were notorious for having national gangster "protection," which they paid for as a necessary business expense. This thought frightened him badly. He at once jumped to the conclusion that he had done a very dangerous thing in threatening and insulting people under gangster protection. The more he thought, the more he felt in danger of his life. The gangsters would get him. Here we see a man who quickly organized a provisional pseudo community of murderous persecutors out of his projected hostility and infantile fears. As we shall see, his more remote background will help explain why he was so ready with this response.

The very next day things began to happen. He noticed a number of rough-looking strangers hanging around the hotel lobby. They seemed to be watching him closely and waving signals to one another. The patient became himself watchful and apprehensive. At one time during that morning he saw an automobile filled with men stop in front of the hotel entrance. He was immediately convinced that these were gangsters coming to kidnap him, to torture and kill him because he had threatened and insulted the bookies. His vigilance grew, and with it seemed to grow the evidence on every hand that he was in deadly peril. He saw strangers and loiterers everywhere. They all seemed to be watching and shadowing him, wherever he went and whatever he did. There was no escape. He was convinced now that he was a man marked for execution, and, in a near panic, he barricaded himself in his hotel room against surprise attack.

Flight

From his room the patient telephoned a relative and told him the whole story. The relative, who was well aware of the patient's intelligence and business acumen, accepted everything and agreed that the patient must somehow escape the murderers. The two arranged to leave the next morning secretly by car and take a long trip. But during a sleepless night the patient suddenly "realized" that the gangsters must have tapped the telephone wires and heard the whole plan. In a sudden access of fear, he packed a bag, slipped out of the hotel, and drove off alone without daring to notify his relative. He headed west for the home of another relative a thousand miles away. This sequence of first giving a confidence, and then feeling certain it would be betrayed, must have had a basic psychodynamic significance in this man's life, since it appeared again and again. It even led eventually, as we shall see, to his conviction in the clinic that he was about to be delivered into the hands of the pseudo community of gangsters.

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As he fled across country from his persecutors, it became more and more obvious to the patient that escape was impossible. This was true, of course, but not for the reasons he believed. A number of trivial incidents and casual comments by strangers made him "realize" that he was caught in a great net which was closing in around him. Here are two examples from among a great many: He came out of a restaurant in Pittsburgh to find a policeman looking at his auto license. This meant, without question, that the police were in league with the gangsters and were keeping them informed of his movements. The organization of enemies now included all the police. In another town, when he stopped for a shoeshine, the man eyed him narrowly as he worked. "The grapevine was catching up," the patient related later. He now took precautions against having to live through the horrible torture that he knew inevitably awaited him. He hid razor blades in his suit, sealed a lethal dose of sedative in a chewing-gum wrapper, and carried a bottle of Lysol handy in his coat pocket. He slept in his locked automobile, hidden under coats, to avoid being kidnaped from motels.

Eventually, this desperate fugitive from his own projected sadism reached his relative's home alive. He was so terrified, however, and in such unendurable suspense, that he waited only for the moment when he would be alone to kill himself. He wrote a suicide note describing his terror, and speaking also of having suffered all his life from loneliness. The suicide note and the Lysol in his topcoat were discovered, and, with the help of the family physician, he was persuaded to return east by plane and get psychiatric help.

CHILDHOOD

This man's reticence has already been mentioned. His past remained surrounded by an aura of vagueness and secrecy, which seemed to come, at least in part, from a lifelong inability to confide in anyone or trust anyone completely. The relatives, who were interviewed by an experienced senior resident, seemed also to be evasive. Either they knew next to nothing about the patient's past and recent mode of living (which seemed unlikely, as some of them were living in the same city), or else they did not want to convey what they knew. Enough came through these barriers to communication, however, to throw considerable light upon the dynamics of the present illness.

The patient's mother died when he was a small child. His father, whose work compelled him to move about frequently, boarded the children with relatives and friends, shifting them around "from farm to farm and from state to state." Sometimes the patient was with one or another of his siblings; often he was separated from them. There was stability neither in his past nor in his present, nor was there any security in his foreseeable future. He seemed never to have known mother love, and he certainly got nothing psychologically worth having from his father. He was never long enough in any one place to give him the chance to make lasting identifications with parent substitutes, or to build a sense of group loyalty and group identifications with children his own age.

This child lived as a chronically displaced person during nearly the whole of his personality development (cf. Pedersen on refugees, Ref. 70). He changed domiciles so often that it was impossible for him ever to feel at home. He grew up a lonely, insecure, brooding child in a solitary world devoid of genuine, lasting, dependable affection. In casual contacts he seemed to have done quite well. He had many fights with other boys, but he would not talk about these, and said he did not like to think about them. He always felt unwanted and with a great yearning "to confide and confess," neither of which he ever managed to do. It was never clear what burden of guilt lay behind this chronic urge, or whether the patient himself knew what it was.

ADULTHOOD

There is a striking similarity between the pattern of life forced upon this patient in childhood and the solitary, footloose patterns he seemed to choose in adulthood. After a number of miserable failures, he finally drifted into a line of business in which one worked as a salesman for long periods of time completely on one's own. It was a highly competitive field, although one rarely met a competitor in person. But even within this relatively unrestricted framework, the patient was remarkable for his restless, roving existence, his frequent unexplained changes of employer, and his endless shifting of his own headquarters. From what we know of his childhood, it is not surprising

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that he never succeeded in identifying with any of the concerns for whom he worked, in developing any lasting loyalties, or in gaining either security or satisfaction from what he was able to achieve. He knew a great many people, but he had no close friends, and he was never interested in women.

His early retirement, which his success made possible but does not fully explain, was preceded by mutual distrust and suspicion between the patient and his employers. It was common practice in this industry for salesmen of one company to do a favor occasionally for a competing company, for which they were well rewarded on the quiet. It was also common practice for each company to put one of its own detectives on a salesman's trail from time to time, to check up on what he was doing. The patient made the serious mistake, for a person of his personality make-up, of shifting from selling to detective work. He later gave this up, because it made him too anxious and guilty. When, however, he returned to selling, he felt constantly watched and trailed.

The patient inevitably became involved in another profitable illegal deal on the side, and his sense of guilt and insecurity redoubled. He thought he recognized detectives in the street, and sometimes his things seemed to have been disturbed in his office or his room. If he thought he was being followed by someone, he would turn a corner and leap into a doorway or an alley, and then watch to see if this person also turned the corner and seemed in a hurry. He made sudden returns to his office and room, but he never caught anyone. When he felt sure—on the basis of rumination, solitary watching, and circumstantial evidence—that detectives were really on his trail, he would abruptly change office and room, even to another town. Eventually, he had himself transferred to a seaboard territory where he had never worked before. Here, however, his old fears and suspicions followed him, and his work dropped to such a low level that he was finally discharged.

This last was our interpretation, not his. The patient was convinced that enemies within the company—he could name them but he wouldn't—had trapped him into transferring out of his familiar territory where he had been so successful. They had sent instructions to the district manager on the seaboard, he said, to pull him down and get rid of him. It seems likely, from his account, that he had been suffering from a growing paranoid reaction for several years, while the acute episode and headlong flight were actually a sudden decompensation.

Course in Clinic

Therapy was unsuccessful with this patient. Things went along smoothly at first, but he never got beyond what has been sketched above. He said several times that he wanted to get some things in his past cleared up, but he could never bring himself to indicate what they were. He was conspicuously noncommunicative about his sex life. When he made the offhand remark that he had never been interested in women, the query, "Or men?" brought only silence and a look of anger, and anger was rare with him. The first crisis came when a new patient made friendly advances to him. To these he at first appeared to respond with relief and gratitude. But the moment he discovered that this man had worked in the same industry as he had, the picture abruptly changed. He told the resident he knew this man was a detective, planted in the clinic to spy on him, and he now thought his company must have joined the conspiracy of gangsters.

The patient telephoned a local pastor, a stranger to him, and asked him to visit him at the clinic. During the visit he told his story, and made arrangements for another meeting at which, he said, he would go into other matters. After the pastor left, the patient had his characteristic reaction to putting trust in anyone. The pastor, he recalled, was dark-skinned and foreign-looking. Suddenly he "realized" what he had done. He had confided in a member of the underworld, disguised as a minister and sent in by the gangsters, who again must be listening in on his telephone calls. He became terribly frightened and made a suicidal attempt. It was impossible for him to conceive of any interpretation of these events other than his own, and his own, as we have seen, was the result of sudden "realizations" based upon his projected hostile and libidinal impulses. He now demanded, as a veteran, to be transferred to a government hospital, which was done. His ideal, he said, would be to spend the rest of his life in the center of an army encampment. In this statement he summed up his unconscious fears and wishes.

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The case illustrates a severe psychotic paranoid reaction in a man with no memory of having really loved anyone or of having been loved. His childhood seems to have given him no opportunity to build a stable personality system and a realistic picture of his world of objects. He had no chance of developing a normal repertory of realistic social roles; no chance to represent to himself how other people think and feel; no adequate means for matching his own feelings, wishes, impulses, daydreams, values, and expectations with those of other people. The wonder is not that such a person should become psychotic, but rather that he should have done so well for so many decades in a world of only half-intelligible strangers. The same deep personality defects which kept him from forming realistic object-relationships and identifications also helped defeat him in therapy.

Dynamically, the patient gives evidence of a persistent infantile lack of basic trust, a history of inadequate identifications and object-relations, and unquestionable signs of fixation at sadistic levels. His pattern of life and his conspicuous reticence point also to a possibly unconscious homoerotic fixation. His adult ego-adaptive operations, which brought him considerable financial success, were nevertheless carried on largely with the use of sexualized and aggressivized energy rather than with neutralized energy.[45,58] This helped keep him in constant turmoil and confusion, and ultimately tripped him up.

It is obvious that the patient used denial and projection to achieve what normal and neurotic persons achieve through repression and more mature defenses. Hence his continual preoccupation with watchful persons in his environment, to whom he ascribed primitive super-ego functions. Hence, also, his irresistible tendency to organize delusional pseudo communities, with himself as the focus of their supposed aggressions. With age, and the accumulation of frightening paranoid experiences, he tried to escape by retiring. This worked for a few years. Finally, a sadistic outburst stimulated violent projection, a regressive preoccupation, and then a paranoid reconstruction of object-relationships, in a world transformed by fixed delusions.

¶ Other Psychotic Paranoid Reactions

Delusional Jealousy

Even normal jealousy, as Freud pointed out long ago,[36] is by no means rational. It is neither under conscious control nor necessarily proportionate to the external situation out of which it seems to arise. The elements that enter into it are grief over loss or threatened loss of a love-object, hostility toward both the rival and the love-object, and a severe narcissistic injury with a painful lowering of self-esteem.

Jealousy deserves to be called delusional when it exhibits the basic paranoid characteristics which we have already described for delusions of persecution. Delusional jealousy is not merely an exaggeration of normal jealousy but a psychotic restitution product. This is obvious even on the surface, from its fixed character, its exclusion of all contradictory evidence, and its inclusion of the most trivial and minute confirming evidence. The patient with paranoid jealousy watches for indications that he is right with the same intense alertness toward minimal signs of unconscious attitudes in others, and the same blindness to his own trends, that patients with persecutory delusions show. In other words, he gives evidence that primitive defensive operations of denial and projection are in the foreground. A brief case illustration will make this clear.

A thirty-nine-year-old lawyer was convinced that he was the victim of a conspiracy between his wife and her physician. Instead of going to the family doctor, as she previously always had, she insisted, in her second pregnancy, upon going to an obstetrician. This man was not only a friend of her family but also a member of the same minority group to which she belonged and to which the patient did not. His jealousy became marked as his wife continued to praise the doctor. She seemed pleased with the frequency and regularity of her visits to him, whereas the patient

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felt she might have more appropriately objected. After the baby was born, he received a bill far smaller than he had expected. This made him certain that his wife had been unfaithful to him. He thought the baby looked like a little foreigner; it must be the obstetrician's and not his own.

The personal background of this case makes it more intelligible, though no less psychotic. The patient was the chronically insecure son of parents who were passionately devoted to appearances, conformity, and status—apparently as a reaction to their own humble beginnings. Against their wishes, he married the daughter of immigrants, in spite of the fact that he himself disliked and looked down upon his wife's family and friends. It was actually his own attitude that excluded him from this large and close-knit in-group, and, intellectually, he knew it. Nevertheless, he always blamed his feeling of exclusion on them. His wife's choice of obstetrician seemed to him just one more close relationship—too close—that left him out.

The patient had entered marriage with serious misgivings about his own potency and an expectation that a great deal would be demanded of him. It also came out rather late in therapy that he had had an extramarital affair during his wife's second pregnancy, partly as a spite reaction to what he imagined she and the obstetrician were doing, and partly to reassure himself. His affair, which involved a good deal of pregenital activity, made him feel exceedingly guilty, self-depreciatory, and fearful of discovery. It was evidently this which had reinforced the patient's suspicions and projections, and prepared him for his final delusional reconstruction of reality. In therapy he was able to work out some of the origins and meanings of his jealousy and to recover from his paranoid illness. His ease of projection, and his apparent readiness to withdraw from a love-object and regress, left him still vulnerable to similar episodes. He gained enough insight, however, to make a recurrence less probable.

In the case just given, there was evidence of certain feminine attitudes toward marriage on the patient's part, and a tendency to identify with his wife in imagining the obstetrical examination situation. In addition, there was some collateral preoccupation with boys' genitals, which came out in his incidental talk about sculpture, and with the whole topic of pregenital sex play. Freud's original account stresses unconscious homoerotic trends in the background of delusional jealousy, such as we see in this case. Freud[35] used a variant of his formulation of persecutory paranoid delusions to represent the unconscious mechanisms involved. It is as if the jealous paranoid patient defended himself by a denial, "I don't love him," and a projection onto the woman rather than the man—"I don't love him, *she* does." We shall return to these formulations later on.

Erotic Delusions

There are paranoid delusions in which the patient believes that he is loved sexually by another person who, for one reason or another, does not make a direct avowal but does indicate his or her love in a thousand little indirect ways. It is most common among women and passive men. The individual selected as the delusional lover is usually of the opposite sex, and often a public figure—in politics, on the stage, in television, the movies, etc. These delusions are responsible for a good many police actions, since paranoid and paranoid schizophrenic persons with such delusions may eventually take action. They pester the supposed lovers with letters, come to see them, or demand an avowal at a public meeting or performance.

The love involved may be self-love, denied or projected onto another person, or it may be a defensive maneuver which substitutes a delusional heterosexual attachment for denied unconscious homoerotic trends. In the latter case, Freud's representation of the defensive maneuver is contained in the formulation, "I don't love *him*; I love *her* because she loves me."[35] For women, this would read, "I don't love *her*; I love *him* because *he* loves *me*." Fenichel maintains that the sex of the supposed lover seems unimportant in near-psychotic men. They sense vaguely an imminent object loss, he says, and because of this cling frantically to some love-object.[24] Many patients with this disorder express a narcissistic pleasure over their supposed predicament.

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Others, however, feel "persecuted by love" and protest indignantly, as in the classical case described by Tausk.[80] Persecution by love represents a special case of persecutory paranoid reaction.

Paranoid Grandiosity

Grandiose delusions that are neither part of a manic elation nor sufficiently disorganized to qualify as schizophrenic may be included among psychotic paranoid reactions. They are encountered much less frequently than are delusions of persecution, and they usually characterize the more severe paranoid illnesses. The favorite themes, like those of persecutory delusions, are usually taken from the patient's surrounding culture, including its current folklore and popular literature. The manifest delusions range in complexity from relatively simple convictions that one is enormously talented, attractive, or inspired, all the way to the most intricately systematized convictions that one brings revolutionary conceptions to mankind, as a great inventor, scientist, or prophet.

Paranoid delusions of grandeur tend to be stable, persistent, and well organized. As a rule, the patient behaves earnestly in accordance with his leading delusional convictions. We occasionally see a grandiose paranoid person able to take a significant part in some social, artistic, or scientific movement and, in rare instances, to initiate and support reforms. It is much commoner, however, for grandiose as well as persecutory paranoid persons to attach themselves zealously to fanatical movements, which express and at the same time defend against their denied and projected impulses. Paranoid delusions of grandeur are restitutional in function and represent a partially successful attempt at recapturing lost object-relations.

The greater frequency of delusions of grandeur among severe rather than among milder paranoid reactions may stem from the fact that a greater degree of denial of reality is demanded in maintaining grandiose delusions than persecutory ones. Any insecure person can find danger more readily than comfort in his surroundings. It may also be that paranoid grandiosity involves a more profound regression. Freud[33, 85] felt that paranoid delusions of grandeur represent a retreat to infantile megalomania, and a sexual overestimation of the ego as love-object. He proposed the formulation to represent this process verbally, "I don't love *at all*; I don't love *anyone*; I love *myself*." Delusional grandeur is common in classical paranoia.

Classical Paranoia

Classical paranoia is a rare form which represents the ultimate in systematization and fixity of delusional restitution. Perhaps its rarity is a function of the difficult combination of extensive involvement with preservation of relatively good object-relationships. That is to say, a patient with severe paranoia may be able to go about the ordinary business of life in spite of maintaining a complex fixed system of delusion, and without evidence of general disorganization and desocialization such as one sees commonly in extensive schizophrenic delusions. Sometimes this rare result is achieved by isolating the systematized delusion from the rest of the personality, thus leaving large areas free to operate normally.

The form and content of delusions in classical paranoia do not otherwise differ essentially from those in less severe paranoid reactions, excepting, perhaps, for the greater prevalence of grandiosity already mentioned. One meets patients who consider themselves, without question, great geniuses—inventors, scientists, and mathematicians on a cosmic scale; poets, writers, or artists; financiers; military or political leaders of mankind; gods, masters of powerful secrets and universal plans. It should be said that there has been an occasional genius whose delusional reconstructions and superior intellect have enriched mankind in actuality, for better or for worse. That is, there have been persons, apparently suffering from paranoia, whose fantastic plans have proved to be contributions which normal and neurotic persons could utilize.

It is obvious that the clinical picture of paranoia often reflects strength and superior intelligence. But the strength is one of rigidity,

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as well as organization, and the intelligence is usually pre-empted by a unique irrational belief, based upon *unsound* principles. The belief resists all potentially modifying influences. Experiences which might lead to reality testing and reorientation in a nonparanoid person are treated as nonexistent or beneath contempt, or else they are taken up in a distorted form to extend and support the system they should contradict. Great care and effort are often devoted to the task of maintaining the nuclear delusional structure intact, and of defending it insistently against anything that might weaken it. As might be expected, at the heart of this restitutional structure lie otherwise insoluble conflicts which, if they erupted, would plunge the personality into a regressive disintegration. Classical paranoia is generally considered to be incurable.

Folie à deux

Baillarger reported, in 1860, the admission to a hospital, on the same day, of two members of the same family suffering from similar delusions. Lasèque and Falret introduced the term *folie à deux* in 1877, and, within a decade, four subdivisions had been described and named. Of these four, two are still commonly used—the induced and the communicated forms. In addition, where more than two persons are involved, a variant term, such as *folie à trois*, may be employed. According to Dewhurst and Todd,[19] the subdivisions are neither necessary nor well founded. These authors suggest the term "psychosis of association" to cover all such situations, including those which involve many unrelated persons, as in certain religious cults.[5] Perhaps they would also include the panic that once developed over a supposed invasion from Mars.[17]

The typical setup seems to be one in which a dominant, psychotic person provokes a delusional development in a relatively dependent, submissive one. The dependent one usually recovers within a few months after the two have been separated. Paranoid reactions and paranoid schizophrenia are the usual psychoses reported in *folie à deux*, and the majority of delusions are persecutory. In his excellent review and case reports, Gralnick[40] emphasizes the preponderance in *folie à deux* of persons who have been living together in intimate contact for a long time. He reports the following combinations in 103 pairs: two sisters, 40; husband and wife, 26; mother and child, 24; two brothers, 11; brother and sister, 6; father and child, 2. He ascribes the greater susceptibility of women to their being obliged to play a restricted, submissive role in society, with narrowed opportunities in educational, business, and social fields. He rejects the possibility that women are inherently more inclined than men to assume dependent, passive roles. Actually, these two sets of factors are not mutually exclusive, but complementary.

Gralnick points out that a relationship of dominance and submission is probably always involved, although this facet of the relationship may be wholly unconscious. It is generally agreed that the process of transmission from dominant to dependent person—and usually from older to younger—is never a simple one. Deutsch[18] interprets delusion formation in the dependent person as an attempt to recover a lost object through identification with it, or with its delusional system. The simple fact that two persons live together may itself express unconscious bonds between them which underlie their developing the same delusional structure later on. In the final restitutive organization, two persons share a common paranoid pseudo community, of which one is the major architect and the other the minor one.

¶ Psychodynamics and Early Childhood

All of the clinical evidence now available indicates that a special vulnerability to adult psychotic paranoid reactions has its roots in defects in the emotional relationships of early childhood. There is not yet complete and final agreement as to the exact character of these early defects and exactly when they first arise. As we shall see, some experienced and sophisticated clinicians ascribe the traumatic events confidently to conflicts over attitudes toward the like-sexed parent in the third to fifth years. Others, with equal confidence, trace the diffi-

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culties back to the mother-child relationship during the first and second years, regardless of the child's sex. Some stress love and others hate; some stress sadism and others masochism. And these differences are of more than incidental importance for an understanding of paranoid reactions.

Difficulties in Reconstructing Childhood Origins

It is not hard to understand how such fundamental differences can continue for decades unresolved. In the first place, adult paranoid psychoses are complex phenomena with many facets. Some patients throw light on certain aspects of the illness with exceptional clarity, and some throw light on different aspects. The clinician must make his studies more or less incidentally in a situation which is always primarily therapeutic. He cannot create, and he must not precipitate, paranoid psychoses in an experimental situation. He comes upon a patient now and then in therapy who communicates some fundamental aspect clearly, or who provides a basis for what seems to be a valid conceptual interpretation. The accumulation of such experiences establishes a trend for the clinical observer, and this inevitably influences what he later observes and interprets.

Therapists are always participant observers, and their personalities inevitably enter into the situation. Moreover, our theoretical conceptions of paranoid psychoses have already gone through a long evolution, which is still actively in process. As in all sciences, what has previously been observed and interpreted becomes a part of the heritage of later generations of observers and interpreters. Depending to some extent upon personal and professional experiences, upon special skills and preferences, the later student of similar phenomena will seek: (1) to preserve and further substantiate what has been discovered, (2) to place a greater emphasis than previously upon one or another aspect of it, or (3) to change the conceptual structure radically. We shall see examples of each of these trends in what follows.

A final barrier to the resolution of our difficulties is one that we encounter in all psychoses, not only in paranoid reactions. It is the obvious fact that we cannot get direct evidence from infancy, or completely dependable evidence from what the patient or his relatives "recall" about his early childhood. The phases which all of us assume to be crucial for psychotic development belong to periods of grossly inadequate verbal communication. Little children cannot conceptualize their feelings and communicate them, as most adults can; and infants in arms cannot verbalize at all. Our present-day knowledge about early nonverbal communication is relatively slight. Even infant observation is still itself an infant science. As for recall, we all know that it is emotionally biased[71] and culturally conditioned.[4] Accordingly, all inferences about the early childhood of paranoid psychotic adults must be based, for the present, upon a series of reconstructions.

The best way to gain an orientation in relation to prevailing attempts at reconstructing the early childhood of paranoid psychotics is to follow the early theoretical developments, and then consider a representative of each of several current trends. After a restatement of the peculiar position of paranoid reactions, as psychoses with psychoneurotic features, we shall proceed to round out the picture of the evolution of present-day conceptions which we sketched briefly early in the chapter.

We can begin with the fact that, from a dynamic standpoint, the position of paranoid reactions is an anomalous one.[39] The presence of frank delusions which are restitutional phenomena, their tendency to expand, and their resistance to correction by reality contradiction, make the condition obviously psychotic. On the other hand, the paranoid patient is not nearly as out of contact as a correspondingly ill depressive patient; neither does he suffer the degree of disorganization and desocialization found in equally sick schizophrenics. Some paranoid patients, in spite of serious unshakable delusions, still function reasonably well and are in good contact in all but a limited area of personal activity. They often give the outward appearance of a normal or psychoneurotic adaptation.

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One of our patients, for example, required occasional brief periods of voluntary hospitalization because his fixed delusions got him into dangerous situations. Yet he managed to earn a large income, entirely through his own shrewd enterprise and realistic management, and to support his family in material comfort over a period of twenty-five years. Even his seeking refuge in a psychiatric clinic, which he did to keep from committing violence, was carried out in a well-planned manner, and in the face of his conviction that the clinic staff were blind to the "conspiracies" he saw around him. He continued to do business while living in the clinic, submitting his activities and correspondence to the censorship of a trusted staff member, but without ever being able to admit openly that he needed supervision. Many psychotic paranoid reactions, like this one, seem to be structured in most reality relationships like psychoneuroses.

Freud's Dynamic Interpretations

Freud indicated this double orientation when he called, in the same paper,[31] a paranoid case both a defense neurosis and a defense psychosis. He made it more explicit when he described Schreber's illness in terms both (1) of a repressed inverted oedipal conflict, and (2) of object loss and delusional world reconstruction.[35] In the latter paper he made his classical formulation of psychotic denial and projection, bringing into sharp focus (1) the initial fleeting conscious wish to be a woman in sex intercourse, which Schreber reported, (2) Schreber's subsequent denial and projection of the wish, and (3) its return in the form of a conscious expectation of sexual assault.[34] On the basis of this study, and other clinical material, Freud proposed a verbal approximation for the paranoid denial, "I do not love him, I *hate* him," and another for the projection, "He hates (persecutes) *me*, which justifies my hating *him*."

The psychodynamic picture that Freud sketched at this time can be summarized as follows. Faced with frustration, the patient withdraws libido and undergoes regression, which comes to a halt at early, deep fixation points. These fixation points—of which there is a multiplicity—are the results of abnormalities in childhood development. They mark the failure of certain libidinal components to mature, and, in consequence, their current always behaves as if it belonged to the "system unconscious."[32, 37] Up to the time of psychotic regression, the repressive defenses have kept the derivatives of these fixations out of consciousness, along with all later-appearing ego-alien trends related to them. With the psychotic regression, however, there is a resurgence of previously repressed impulses, and the paranoid personality tries to deal with these by stepping up his already too active projection. The now-irresistible internal perceptions, or feelings, after some distortion are projected and appear in consciousness as external perceptions. The love is turned into hate, and the patient now perceives the previously loved person as a dangerous persecutor.

Freud postulated a continuum of libidinal development in everyone's childhood, from auto-erotic through narcissistic stages to homosexual and ultimately heterosexual object-love. On the basis of his clinical findings, and those of Jung and Ferenczi, Freud concluded that the chief fixation points in paranoid reactions are at homosexual levels.[35] It is the projective defense, against a return of wishes from these fixation points, that determines the symptom picture of persecutory delusions which finally emerges. Through delusional transformations, the patient builds a restitutional world that allows him to regain at least some kind of object-relations. The new object-relations may be intense, but they are never as successful as the lost ones, because meanwhile, profound internal changes have occurred in the patient's mental organization.

What we have summarized so far was written more than a decade before Freud arrived at his final topographical conception of ego, id, and super-ego, and before he had realized the full significance of aggression for his theoretical structure. His writings continued to show a preoccupation with the problems of distortion, projection, and delusion (for example, Refs. 28, 29, and 33). Then he introduced his concept of a death instinct[27] and placed

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destructive drives on an equal footing with libidinal drives. Soon after this,[36] he traced the love of one's fellow men—whether sublimated or not—to reaction-formation against the early hate of siblings, who were rivals for the mother's love.

Finally, in *The Ego and the Id*,[30] Freud reformulated the transformation of love into hate and hate into love, in a new discussion of persecutory delusions, which may be stated as follows: Very early in childhood, the paranoid person must have developed intense hostility toward his sibling rivals. This intense hostility could not, of course, be gratified by assaultive action sufficient to discharge the angry child's destructive energy, but the intolerable tension thus built up had to be relieved somehow. The hostile attitude was, accordingly, replaced by a reactive loving attitude, because for the latter there was more possibility of gratification and relief by discharge. Both the strong hatred and the strong reactive love remain fixated, however, at infantile levels. Together, they form an intensely ambivalent attitude toward all love-objects, which the child carries with him into adulthood.

The account just given involves a paradox. It pictures the discharge of intolerable hostility through attitudes of love. Freud met this apparent paradox[30] by postulating a displaceable neutral energy, capable of joining forces with either erotic or destructive impulses.* In doing so, the displaceable energy makes it possible for a heightened cathexis and discharge, through a mere shift in energy. This is the process which he called the reactive shift in cathexis, and he applied this principle directly to the problem of persecutory delusions.

Something like a reversal of the reactive infantile shift seems to happen in the persecutory paranoid psychoses of adulthood. When a psychotic regression follows frustration, the original intense ambivalence reappears. The energy which is withdrawn from libidinal impulses, says Freud, is now used to supplement the hostile energy. A paranoid reactive shift in cathexis occurs, from love to hate in an originally ambivalent attitude. The hostility, thus reinforced by a shift in displaceable energy, is now projected as delusions of persecution. Whatever remains of this hostility, after projection, can be discharged in an attack upon the alleged persecutor.

Some Further Contributions Since Freud

From this point in the evolution of the psychodynamics of paranoid reactions, a number of different emphases have carried the general trend in different directions. We shall give briefly a few representative examples from among those who still seem to retain paranoid reactions as a more or less distinct group.

Excessive Love to Counteract Hate

Knight[57] carried this development further by stressing the intensity of paranoid love. The paranoid reaction, he points out, is *not* a new formation resulting from the projection of hate after love has been denied. Rather, the paranoid person suffers chronically from an excessive need for love in order to neutralize his tremendous unconscious hate. His love is actually dangerous; he is justified in fearing and denying it. At unconscious levels, the hate is already present in the patient before his persecutory delusions become manifest, and he already anticipates a retaliatory hatred from his love-object. The patient is caught in a net. He cannot keep away from the ambivalently loved person, because he desperately needs love to offset his ever-present hate. But the closer he gets to his love-object the greater becomes the danger of attack.

Delusional Masochism

Bak,[3] citing a hint from Nunberg,[67] has followed Freud's general lead in a different direction by stressing sadomasochistic trends. He redefines the paranoid reaction as delusional masochism. He distinguishes four major steps in its psychodynamic development: (1) a first ego-defensive action, consisting in a re-

* The hypothesis of displaceable neutral energy has been used fruitfully in a much more inclusive sense by Hartmann,[42,43,44,45] Hartmann and Loewenstein,[46] and Rapaport.[72] See also the lucid summary by Anna Freud.[26]

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gression to masochism; (2) a second ego-defensive action, consisting in withdrawal of libido for use against the masochistic threat, which now comes from the id because of the initial regression; (3) increased hostility toward the previous love-object, with sadistic fantasies; and (4) when mastery over this hostility fails, a final projection of part of the sadism as a delusional restitution. The inevitable result of projecting is that now the masochism returns. From his delusions of being mistreated and persecuted, Bak says, the patient obtains gratification of infantile masochistic wishes related to a father figure.

Infant Sadism and a Very Early Super-Ego

Also pursuing Freud's newer emphases upon aggression, Melanie Klein[54, 55, 56] comes to her own conclusions regarding the origins of paranoid reactions and the depth of paranoid regression. Whereas Knight called attention to the patient's excessive need for love (to neutralize excessive hate), and Bak stressed masochism, Klein focuses upon sadism, and she goes back for its sources to fixations in the first and second years of life. It is impossible in a few paragraphs to do justice to the wealth of clinical material and the imaginative richness in the work of Klein and her co-workers. Neither would it be profitable to enter into the controversies to which this work has given rise. It is enough to say that even her critics, if they are engaged in intensive therapy with psychotic and borderline patients, are able to gain illuminating insights from Klein's publications. For our purposes, we shall restrict discussion to one or two points specifically related to the childhood origins of paranoid reactions.

Klein conceives of persecutory delusions as modeled upon a phase of development through which, according to her, every infant passes during his first or second year. In this phase the infant feels persecuted by cruel, sadistic objects which actually represent (1) its own projected sadism, and (2) its fears of retaliation for its own sadistic fantasies. During such a process a very early super-ego is formed which incorporates these distorted representations of father and mother and is characteristically cruel and persecuting in relation to the infant ego. The extreme anxiety produced by this primitive super-ego in the infant, says Klein, is the same kind as that which is basic to paranoid psychosis in adults. Ordinarily, in later infancy, between the third and fifth years, a less primitive super-ego supersedes the earliest one, says Klein. And, even though much more harsh than the parents actually are, it corresponds more closely to their attitudes and is far more realistic than the one which it replaces.

A predisposition to paranoid disorders, according to Klein, rests upon a failure to advance securely beyond this very primitive phase, in which all infants are beset with fantastic fears and threatened by a terrifying super-ego. The more beneficent, more realistic super-ego —which should be established during the third to fifth years—is inadequately developed and precariously held in paranoid personalities. The evolution of ego identifications, which is also closely tied up with super-ego development, is seriously impaired from the start in these vulnerable individuals.

When, in adulthood, paranoid psychotic regression occurs, the terrifying fears return under the influence of the primitive, earliest super-ego, which again becomes dominant. The patient now fears fantastically cruel attacks, such as our patient did who expected to be tortured horribly and killed. These attacks, says Klein, are feared both from the super-ego, now projected, and from real people whom the patient endows with the old fantastic cruelty. Thus she pictures the paranoid pseudo community as being organized on the model of the terrifying anxiety in relation to objects, which infants are assumed to experience in their most helpless and sadistic phases.

When we turn to Glover's account, we shall see that he also ascribes the paranoid adult's persecutors to projected super-ego figures—an interpretation which both Klein and Glover take from Freud.[33] But he characterizes the persecutors differently and refers them to a later phase of infant development. Klein, at

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least by implication, rejects Freud's derivation of paranoid delusions from homosexual wishes,* and gives them a much broader, more diffuse, and more archaic origin (see, for example, Klein,[54] pp. 282–296).

SUPER-EGO NUCLEI

Glover[39] has presented one of the most comprehensive, albeit condensed, accounts of paranoid reactions from a dynamic point of view. He follows Freud in placing the first formation of a super-ego somewhere in the third to fifth years. He does not accept Klein's early first- or second-year super-ego, but he does assume disconnected precursors which he calls super-ego nuclei. These become integrated eventually into an organized super-ego. Glover also follows Freud in ascribing a predisposition to paranoid reactions to failure in establishing strong, stable heterosexual object-relations. When psychotic regression occurs, he says, the patient first abandons all object-relations, and then succeeds only in re-establishing them at homosexual levels, usually in the form of persecutory delusions.

The delusional restitution is more successful in regaining effective reality contact than in other psychoses. This success, says Glover, is due to major fixations which involve well-defined drives at a crucial developmental phase; that is, paranoid regression carries the patient back to a phase of primitive but relatively good ego integration. But in his attempts to restore lost object-relations and gratify desires, the patient brings back, in projected delusional form, the homosexual wishes—always unusually frightening to paranoid personalities. Glover relates the paranoid watchers, listeners, and persecutors to introjected parental figures, now reprojected, and especially to the frustrating parent of the same sex. He regards this pseudo community of external spies and persecutors as evidence that regression has carried the patient back to a phase before super-ego integration, that is, to a phase when super-ego functions were still largely performed by actual external parents.

DENIAL

As our last example we select Waelder's critique of theories of paranoid delusion and his attempt at a synthesis.[82] In all the preceding accounts it has been taken for granted that projection is the fundamental mechanism in delusions. Waelder comes to the conclusion that the fundamental mechanism actually is denial which, he says, plays the same part in psychotic symptom formation that repression plays in psychoneuroses. Projection is only a special form of denial. It is denial with a special countercathexis, a counterclaim which opposes the claim being denied.

Paranoid ideas are the result of unsuccessful denial. The denied returns in a distorted form, and fantasies are used to help strengthen the denial. But why are paranoid ideas inaccessible to reality contradictions? Because, says Waelder, they state an indestructible truth which has its counterpart in the indestructible power of instinctual drives. And the driving force in such a truth is an inescapable fear, the fear of being helpless in the face of dangers, unless one recognizes reality and watches it.

Waelder goes on to draw an interesting parallel, between the generally accepted formula for psychoneurotic symptom-formation (*conflict* between id drive and ego—*repression*, or similar defense, and *countercathexis—return of the repressed—compromise formation*), and a new one which he proposes for psychosis. In persecutory delusions we see the return of a denied drive. The resistance, however, is strong enough to prevent an undistorted breakthrough, and the result is that a violent delusional assertion appears instead. The warded-off drives return in forms that correspond to the original defense, for example, a denial returns as a related assertion (isomorphism). Waelder proposes the following formula for delusion formation: *conflict* between id and *ego—denial* and *countercathexis—return of the denied—compromise formation.**

* Among those who state their objections to this derivation more explicitly may be mentioned H. Klein and Horwitz,[53] Kant,[52] MacAlpine and Hunter,[60, 62] Grauer,[41] Sullivan,[70] and Ovesey.[68, 69]

* See also the discussion of denial and psychosis in Lewin[59] and Jacobson.[49]

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Summary and Extension

Areas of Agreement

In the foregoing discussion we have focused upon the differences in emphasis among those concerned with psychodynamic problems in paranoid reactions, but there are also large and fundamental areas of agreement. For example, nearly everyone now agrees that paranoid adults must have experienced unusual sadism in their early childhood, and that such experiences are re-enacted in their psychotic delusions. To what extent these experiences were actual sadistic frustrations imposed by mother figures, and to what extent they were infantile exaggerations, it is not possible to say with certainty. Clinical evidence points in the direction of actually cruel treatment in a great many cases—if we include under cruelty such treatment as maternal neglect, coldness, "awayness," and actual absence for long periods, repeated active interference with ordinary freedom of action, failure to relieve excessive tension and anxiety, and the creation of an atmosphere of suspicion, resentment, watchfulness, and accusation. Often the current, contemporary interaction of parent and adult patient provides valuable clues to the probable situation in infancy.

When we come to the primacy of homosexual fixations we encounter less contemporary agreement. Few seriously doubt the correctness of Freud's original interpretation. But in the light of his later emphases upon innate destructive drives, there has been a growing interest in parent-child interaction before the crucial third to fifth years. We saw that even Glover, who can be ranked as moderately conservative, felt obliged to postulate "super-ego nuclei" as precursors of an integrated super-ego, and to shift his attention to earlier phases of ego development. On the other hand Melanie Klein, who is ranked in this country as radical, still traced paranoid development from original hatred of the mother to ultimate hatred of the like-sexed parent. In paranoid women this was a continuation of the original sadistic fantasies about the mother, or a return to them before the fifth year. In paranoid men the hate was transferred, she said, onto the father figure, and fixated there. These contrasting views are not as irreconcilable as their authors think. Both assume an intense ambivalence toward the like-sexed parent, and tendencies for this to erupt in delusions of persecution during an adult psychotic regression.

No one today seriously questions Freud's formulation of a sweeping regression and a subsequent restitution in paranoid psychoses. Some experience of traumatic frustration, or a series of such experiences, is generally accepted as the precipitating factor, and the first reaction is a withdrawal from object-relations, followed by the replacement of the more realistic object-relations by unrealistic ones—ones less mature, less determined by present circumstances, and more determined by unrealistic fears, hates, or loves. The fantasies openly expressed in paranoid delusions cannot be accounted for today without assuming, as Freud did, that a profound internal regressive change has occurred in the patient. The same can be said of delusional reconstruction. Objectively considered, there actually is a return to relationships with the environment which, however, now include delusional distortions. Freud's assumption, that delusional reconstructions are essential to the psychotic patient's regaining reality contacts, seems inescapable, in the light of the vigor and tenacity with which patients defend their delusions against contradiction.

Mechanisms

What about the mechanisms involved in paranoid reactions? In their most simplified outline there is also general agreement, even though the directions of further elaborations differ. Whether or not we follow Waelder in giving denial first place, everyone seems to ascribe to denial and projection an abnormally large share in the defensive organization of paranoid personalities. Everyone agrees that repression in these individuals is seriously defective. When a psychotic regression carries the patient, in effect, back to primitive functional levels, repression becomes more than ever defective, while denial and projection become more than ever active. A general reduction in ego integration—which is inherent

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in all regression—makes what is denied and projected seem much more real than when ego boundaries are relatively intact, as they are before regression. And finally, the return of intensely sadistic attitudes—whether one regards them as primary or as a defensive reaction—gives the projected drives and fantasies their cruel, unbridled characteristics.

Social Interaction

The pseudo-community concept now comes into this evolution as an extension of the concept of reality reconstruction. Delusions of imaginary social interaction in a patient's surroundings are not a new group of delusions but an integral part of the restitutional process. In rebuilding his delusional object-relations, and trying to operate with them as a member of society, it is not enough for a patient to project his drives and fantasies onto appropriate individuals—who represent his own projected ego-alien trends and super-ego threats. It is inevitable that the synthetic function of the patient's ego should bind these individuals together into an interacting and interrelated organization, adding whatever imaginary persons are needed to complete the structure and to stabilize it.

The product of such paranoid ego synthesis and stabilization is an apparent community, the pseudo community which we described earlier in the chapter. Some of its members are always actual persons, to whom are ascribed imaginary functions, and some members are purely imaginary. The fantasied pattern of social interaction and interrelatedness does not correspond to social reality, that is, to the shared experience of the consensus. Instead, it corresponds to the needs of the patient's own internal dynamics—to his paranoid pattern of drives, threats, defenses, conflicts, fantasies, and solutions.[13] Against this fantasied social organization the patient may finally take action; or, as in the case we presented, he may try desperately to escape from it, even to the point of attempting suicide. It is usually some kind of overt action, or preparation for it, that brings the psychotic paranoid patient into therapy.

¶ Psychotherapy in Paranoid Reactions

The immediate therapeutic goal in paranoid reactions is the reduction of anxiety and the re-establishment of genuine communication. Excessive anxiety lies behind excessive paranoid projection, and both are intimately related to the regression and partial disintegration of personality which have occurred. The delusions are only the outcome and the indirect expressions of these fundamental processes.

It is often necessary, as in other psychotic episodes, to protect the patient from anxiety-provoking external stimulation. This may involve separating him from those relatives and friends who, for one reason or another, tend to raise his anxiety level, and from situations and places that increase his tension. Sometimes these objectives can be achieved without resorting to hospitalization; often they cannot.* But whether or not hospitalization is essential, there must be a clear policy of not interfering with the patient's freedom of choice and action any more than is absolutely necessary to prevent personal or community injury. Paranoid patients, more than any others, are sensitive to and humiliated by restriction of their liberty.

The process of re-establishing genuine communication goes hand-in-hand with tension reduction. As excessive anxiety and excessive projection begin to subside, the patient becomes, for a time, better able to express his fear and anger, the humiliations and misunderstandings he has experienced, the construction he places upon what seems to be going on around him, and his impulses to do something about it. What he needs most at this point is someone in whom he can safely confide, someone who is not driven by his own anxieties to belittle the patient's anxiety, to offer too much reassurance, or to argue.

It goes without saying that by this time all

* For criteria in evaluating the need for hospitalization, and for discussion of the special problems raised by hospitalized paranoid patients, see Noyes and Kolb,[66] Arieti,[2] and English and Finch.[21] Arieti also has an interesting discussion of milieu therapy.

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of the usual common-sense methods for dealing with fear and suspicion have already been tried without success. Friends, relatives, and others have used reassurance, contradiction, reasoning, demonstration, and ridicule—often with skill and perseverance—but to no avail. Now something quite different from ordinary common sense is required. The patient needs help that is based upon a better understanding of his underlying pathology than the layman has.

The most important therapeutic need at this point is for a therapist who is available for communication, who can not only gain the patient's trust but retain it. Here certain questions about the therapist's personality and interpersonal skills become immediately relevant. Can he tolerate psychotic anxiety, fear, and hostility in a patient? Can he understand the patient's feelings emotionally, without sharing them to a disturbing degree? Can he tolerate mistrust and suspiciousness directed at himself? Can he be reasonably comfortable with the patient's extreme sensitivity to criticism and hidden meanings, with his readiness to be defensively hostile and aggressive?

If, for example, a therapist is made uneasy by the unconscious conflicts and fantasies expressed in paranoid anxiety and fear, he may unwittingly increase his patient's tension instead of helping it subside. If paranoid aggression arouses the therapist's hostility, and he does not recognize it, his relations with his patient will be distorted by his own unconscious denial, counteraggression, and reaction-formation. Such a patient-therapist interaction is actually antitherapeutic. It is not a disgrace to be unable to treat paranoid patients effectively, any more than it is a disgrace to be unable to do brain surgery, but it may be just as important to recognize one's limitations in the one as in the other.

What therapist attitudes are most helpful to a delusional patient? There are differences of opinion. Some experienced therapists counsel a warm, kind, helpful approach. Others, on the contrary, advise that one assume strict super-ego attitudes and, in effect, act out a part in compliance with the patient's need for self-restraint, which he is now unable to exert himself. Some therapists enter into a patient's delusional system deliberately and aggressively. Others enter into it for purposes of mutual understanding, but make it clear to the patient from the very start that they do not accept the delusions as fact. Some therapists keep rigorously out of the patient's delusional system without, however, making an issue of acceptance or rejection. Others maintain a detached attitude, in which their judgment appears suspended, until such time as therapist and patient understand each other better.*

The writer favors an interested, attentive, relaxed attitude initially, with a certain amount of detachment and suspended judgment. The initial detachment is essential, because paranoid patients are suspicious of an intrusive, friendly stranger, and frightened of too much closeness. The suspended judgment is necessary because one actually does not know how much of what one listens to is fact and how much fantasy. Many things complained of by a paranoid patient merit complaint, and sometimes fantastic things have actually happened. Within this general framework one should be able to feel friendly, considerate, sympathetic, and accepting, without being driven to express these feelings in words. If such feelings are genuine, the patient will usually sense them on nonverbal and unconscious levels; if they are not, the patient will sense any deceit behind a mask of fair words. There is no difference of opinion among therapists as to the necessity for scrupulous honesty, truthfulness, and steadfastness in working with paranoid patients.

What the patient needs in therapy is not, of course, merely a chance to talk, to express himself and "ventilate" his feelings. He needs to break out of his isolation and share his frightening experiences with someone who does not take sides, and who therefore may stand out as the only neutral person in his pseudo community. If such an exceptional relationship becomes established, the patient

* For discussions of therapist attitudes in treating psychoses, see Mann, Menzer, and Standish,[62] Fromm-Reichmann,[38] Semrad *et al.*,[76] Brody and Redlich,[8] and Stanton and Schwartz.[78]

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gains a new point of reference, and begins at least to catch glimpses of his world from another person's point of view. The therapeutic aim at this level is to replace a generalized suspicion with a specific trust—trust in the neutral therapist—which can become a base for further explorations.

If these primary objectives are realized, some of the origins and ramifications of the patient's basic problems can be worked through sufficiently to allow him a wider range of interpretation than his psychosis has left him. The pseudo community may be modified or replaced by something approaching the shared social community. Rigid, highly individualistic perspectives may give way to more flexible social perspectives. Through his work with the therapist, the patient can become better able to represent to himself realistically how other people feel about things and look at things. In an atmosphere of mutual respect, the therapist can express his suspended judgment or his disbelief in delusional misinterpretations, openly, without endangering the relationship. But one must bear in mind that it is not the delusion which stands in need of treatment, but the hostile, frightened patient.

It is obvious to everyone that paranoid patients are operating in relation to their own internal stresses, and that the stress patterns do not correspond to what is going on in the socially shared situation. We can gain a good deal of knowledge about the nature of these stresses, during the therapeutic process, by studying the patterns of imaginary social interaction which the patient ascribes to his delusional pseudo community. The components of his pseudo community are often actual people, whom we ourselves can also watch and hear. It is the imaginary patterns of social interaction among these real components which then reflect the internal stresses behind the psychotic restitution. The pseudo community thus provides us with a picture, half real, half imaginary, which may enable us to reconstruct the internal dynamic situation.

It should also be clear that the patterns of internal stress, set up by the patient's regression and delusional restitution, have their roots in the residuals of early childhood experiences, involving real and fantasied aggressive and libidinal situations. If a relationship of reasonably good communication and mutual trust can be established between therapist and patient, it is often possible to relate present fear and hate to the probable childhood situations that originally provoked them, or fanned them into flame. In such exploration, however, one must never lose sight of the fact that psychotic patients are always in danger of further regression, and that their greatest need is for a firm anchorage in present reality.*

What Freud said about deep interpretation is as true today as when he wrote it. The psychotic patient is often able to interpret unconscious symbolic meanings more immediately and correctly than can his therapist, whose intact defenses hide meanings from him. Such psychotic insight is a misfortune, not a gift. With it goes the additional handicap, already described, of reacting to minimal unconscious and symbolic material as though it were maximal, conscious, and literal. It is not so much the deep unconscious meanings that the psychotic paranoid lacks access to, but the socially valid, realistic ones. Too much has already come to the surface in the paranoid restitutional process.

The ultimate goal of treatment, of course, is that of getting the patient to the point where he no longer needs therapy. The ideal goal, often reached, is that of helping the patient to attain a more stable and satisfying equilibrium than his premorbid one, and to have him feel that it is possible to find someone trustworthy, neutral, and frank, in case of future need. This last may be a completely new discovery for him.

The prognosis in paranoid reactions is always guarded. Many patients regress further and become schizophrenic. Some remain static at a chronically delusional level. A small minority develop a classical paranoia. A great many recover partially or completely. The depth of the initial psychotic regression and the length of time during which active delusional recon-

* It is not the purpose of this section to describe, step by step, the therapy of psychotic paranoid reactions. The interested reader is referred to Fromm-Reichmann,[38] Federn,[23] and Arieti.[2]

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struction has been going on will both affect prognosis. An insidiously developing, progressive restitutional process is more likely to have deeper roots, to be more stable and more difficult to remodel or replace, than a sudden delusional growth. Here, of course, we have to distinguish between a sudden change from relative health to paranoid delusion, and the sudden acute delusional attack which occurs in a long-standing, chronic paranoid reaction.

The most important limiting factor in the psychotherapy of paranoid reactions is the patient's basic personality organization—its ego-adaptive and defensive structure, its potentialities for change, for establishing fresh emotional relationships, for forming new ego and super-ego identifications. Self-evident as this statement is, it still deserves reiteration. There are wide individual differences among paranoid patients in these dimensions of personality, and the differences often do not become obvious until therapy is under way. The degree to which a patient can allow himself to communicate, to develop latent role-taking skills, and to include the perspectives of other persons in his own behavior will be a function of such individual differences as well as a function of therapeutic skill.

Today, more attention than ever is being focused upon the social settings in which patients develop psychoses and to which, if they are hospitalized, they return when they are well enough.[48] Community attitudes and community organization help determine the manner in which patients are introduced into therapy, the kind of therapy available, and the reception the patient experiences when he has recovered from his illness. We are still a long way from the development of intelligent public attitudes toward psychosis, and a long way from the development of adequate facilities for treatment. It is to be hoped that paranoid decompensation may one day receive as prompt and competent help as cardiac decompensation now enjoys, and that community attitudes and community facilities may one day reach the same level for the aftercare of compensated paranoid personalities as they already have for the aftercare of compensated cardiacs.

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CHAPTER 26

THE INVOLUTIONAL PSYCHOSES

Newton Bigelow

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ALTHOUGH THE INVOLUTIONAL DISORDERS were originally decanted from the manic-depressive psychoses by Kraepelin, and, later, a direct relationship to schizophrenia was delineated for some cases of the group, they were formerly classified officially as "due to disturbances of metabolism, growth, nutrition, or endocrine function." Currently they lie under the broad heading, "Disorders of psychogenic origin or without clearly defined physical cause or structural change in the brain." Nevertheless—by insertion of the old subheading directly thereunder, and apparently to compound the ambiguity—present emphasis still seems to be placed upon metabolic factors. It will be perceived, however, as the etiological mechanisms are unfolded, that this group is comprised of preponderantly functional disorders.

Involutional psychoses affect women, beginning in the fourth decade, and men, beginning in the fifth decade, in a ratio of about 3 to 1. Patton[12] states that the rate of admissions to New York civil state hospitals per 100,000 of the general population has varied from 2.6 in 1926 to 8.8 for 1956. Henderson and Gillespie[6] refer to the larger number of cases from the rural areas of Scotland.

It has been held that the prepsychotic personality is a major etiologic factor in these disorders, whether the reaction is of the melancholic or the paranoid variety. Titley[15] concluded that anal-erotic characters seem to predominate among persons who later develop involutional melancholia. Rigid compulsives were described for the same group by Fenichel.[4] Generally, there are evidences of an inhibiting super-ego and strong feelings of insecurity. But this perfectionistic rigidity of the personality seems to be "undone" by the physical, physiological, hormonal, and psychic changes of the menopause. That the appearance of reality may very well change for the patient at this time must also be stressed. For such an individual the knowledge that life—with respect to work, recreation, love, and procreation—is fast ebbing away presents a major threat to the ego. The further realization that some of the physical symptoms are actually due to the menopause is also threaten-

ing. MacCurdy[7] goes on to say that such a personality, finding little satisfaction in life, turns the more strongly toward his own ego and body. As a consequence, there develops a coincidental preoccupation with, and revulsion from, death. This underlies some of the symptomatology, namely, the hypochondriasis, insomnia, and anorexia. That endocrine factors are not completely responsible is shown also by the current therapeutic ineffectiveness of endocrine preparations. The common headache, vasomotor symptoms, neuritides, and bladder disturbances do contribute substantially to the illness, however. With further reference to physical disorder, no fructose intolerance was found in schizophrenic, manic-depressive, and involutional patients,[6] as had been reported earlier. Finally, in considering etiology, one must recall the rather frequent occurrence of a precipitating factor, such as retirement, financial reverses, the death of a love-object, or illness of the individual himself. An excellent paper by Barnett *et al.*[1] links the typical prepsychotic personality with the precipitation of the depression. "The precipitating factors are considered to be traumata which prevent the maintenance of characteristically rigid ego defenses." In the view of the authors, this agitated depression may be seen then as "the decompensation of an anal character."

Depressive, paranoid, and mixed reactions are classified under the heading of involutional psychoses, although involutional melancholia is the prototype for these disorders.

¶ Involutional Melancholia

Classically, involutional melancholia is an anxious, agitated, delusional depression of the menopause.

A prodromal period of up to several months in duration is not infrequent. The early presenting symptoms may be considered neurotic. Occasionally, they may be attributed to the menopause, and, indeed, some may well be so founded. Anxious anticipation, restlessness, insomnia, fatigability, and irritability are common. Anorexia, weight loss, and constipation are often complained of. The mood varies from pessimism to frank depression. These symptoms blossom into a severe, agitated, delusional depression. No more profound depression is seen psychiatrically, and attempts at suicide are common. Although Muncie[10] says, "The patient slumps into a state of relative inactivity," the agitation is generally great enough to make him pace about restlessly, weep unrestrainedly, and pick unendingly at his body. The writer has seen patients brought into the hospital in former years with extensive lesions of their necks, or with their nasal septa largely destroyed in this agitation. Frequently, there are concomitant stereotyped utterances. Strecker[14] refers to catatonic phenomena, and English and Finch[8] call particular attention to the early-morning insomnia.

In the face of an unusually clear sensorium, depressive misinterpretations and delusions are almost invariably encountered, their content sometimes approaching the absurd, often in a picturesque way. Strecker's[14] case loudly insisted that "I am to be boiled to death in a *solid gold kettle*." Somatic delusions to the effect that the intestines are stopped up, that the brain has withered, or that the liver has turned to stone are not uncommon. In fact, some have held that the fixed delusion maintained firmly by a patient, to the effect that his bowels have not moved for five days, is a pathognomonic symptom. Nihilistic delusions, namely, "The world no longer exists," "There is no more food," often go hand in hand with ideas of guilt. Frequently, with these patients, one hears "the unpardonable sin" equated to "the trifling indiscretions of youth."[11] The unshakable belief that one is to be "boiled in oil" or "left to die in the frozen snow" are appropriate accompaniments. Not a few patients used to say that death would not end their suffering because they knew they would live forever in hell. Ideas of persecution then are also common. It may be repeated that the wish for, and fear of, death is reflected in the loss of appetite and in the insomnia. Hallucinations usually support the trend.

Milici's[9] description of the clinical picture is a graphic one.

In keeping with the danger of suicide that has been cited, Milici considers that the full classical symptomatology culminates in a

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"death reaction." He traces its course from the early symptomatology, where the patient, overwhelmed by life's problems, begins to show

. . . signs of increasing dissatisfaction and distress . . . a growing moroseness . . . increasing introversion . . . difficulty in concentration and comprehension . . . complaints that the head "does not work right". . . .

With increasing depression . . . there is a sense of unworthiness, of uncleanliness and of wickedness. . . . He is dirty, filthy and he smells bad. . . . He has been false to God. . . . "I am a discredit to my religion. I am the scum of the earth. . . . I am not fit to live. . . ." Hostility comes increasingly to the surface. . . . "I hate everybody and everybody hates me. . . . Oh God, forgive me. . . ."

Increasingly vivid . . . is a feeling of unreality. . . . "My body feels as if it does not belong to me. It is like a piece of wood, of lead, of glass, a living stone." . . . At deeper levels, there are delusions of dying or of being already actually dead. . . . Finally the entire family, the neighborhood, the world, is dying or dead. . . .

The sufferer holds himself responsible for all this, feels that he is to blame for everything. He has infected, disgraced and harmed his family, has driven his loved ones "insane." . . . "I am the cause of all the ills of the world, for the death of trees and babies, for changes in the weather. . . . I barren things, the grass and the birds. I corrode the pipes. . . . I have killed the whole world. . . . Death would be better than a living death. I would be better off dead. I want to die. I am dying. I am dead. Everything is dead."

The following case is cited to illustrate the usual history:

After a suicidal attempt, E. D. entered the state hospital with an illness characterized by depression, self-condemnatory ideas, and somatic complaints of about one year's duration. She was then 58 years of age.

Her idolized father, a stern stonemason, enforced rigid discipline in the home. Owing to the father's attitude, the patient did not marry until forty-six. She is described as "dependable, honest, clean of mind and body, closefisted, hard to get acquainted with."

For this, her first psychiatric illness, several causes have been advanced. The patient later told of worry over early sexual indiscretions. Again she related her remorse that her husband's first coronary followed marital relations. However, her illness came soon after she had procured her sister's admission to the state hospital, after a long, agonizing, intense effort to care for her at home. For this she was berated soundly by another sister.

Filled with guilt over the course she had taken, this patient then voluntarily admitted herself to the observation hospital on the first of three occasions during the first year of her illness.

In general, she was agitated, depressed, distraught, and tearful on each admission. Loose stools, she believed, meant cancer, despite medical examination and opinion. She complained bitterly of insomnia, anorexia, dysuria, and sciatica. She was almost completely preoccupied with her physical condition and immediate need for medical attention. It should be added that, during her first admission, physical treatment of a leukorrhea and urethritis reduced her local and general complaints and rendered her generally more comfortable. In passing, one of her physicians commented upon the neurotic appearance of other expressed fears—that of riding on the bus or of leaving home. However, most prominent in her trend were the feelings of self-condemnation, inadequacy, and hopelessness. These led to a genuine suicidal attempt with an overdose of phenobarbital which took her into the observation hospital for the third time and on to the state hospital.

Electric shock therapy produced one remission. Thorazine seemed to give her good symptomatic relief. Its use was supplanted with Pyrrolazote at the state hospital from which she was released in four months, symptom-free.

Since then, the patient has done very well at home for more than a year, under care in the outpatient department on the same preparation. She has been discharged as recovered.

Upon most points—the prepsychotic personality, psychopathology, and clinical course—the history of this woman meets the usual criteria for diagnosis of the disease.

Formerly a number of types were described, and reference has already been made to those cases resembling manic-depressive psychosis or schizophrenia. Other types are seen rarely

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where, in the face of a profound depression, there is little trend and not too much obvious agitation. Earlier writers also gave prominence to a group complicated by the presence of arteriosclerosis—which hardly seems germane to the issue at hand.

The differential diagnosis of involutional melancholia is not difficult when there is a good history excluding earlier manic-depressive attacks. The patient with classical trends is not easily forgotten in making future discriminations between depressive states, psychoneuroses, and this illness. The absence of typical organic psychiatric signs and symptoms, and of the customary physical findings, should easily rule out psychosis with cerebral arteriosclerosis. As has been remarked upon by Henderson and Gillespie,[5] this writer, too, has seen a few young adults with clinical pictures indistinguishable from classical involutional melancholia. Despite the depressive cast of their symptoms, they appeared to belong to the schizophrenic group.

With respect to therapy, one of the first indications is for the prevention of suicide. This ordinarily means hospitalization with a full treatment regime. The introduction of electric shock therapy has transformed the entire outlook (and therapeutic plan) for this disorder, which was formerly chronic and caused untold human suffering. English and Finch[3] state flatly that in former days 25 per cent of these patients died by their own hands. Now, about 90 per cent of patients respond with remission to the usual course of fifteen electric shock treatments.

But psychotherapy is also strongly indicated in view of the underlying personality and the changing face of reality. English[2] puts it very well:

> This places a responsibility upon all those who treat the man or woman in the forties, to utilize an approach combining glandular replacement therapy and reeducational therapy in a ratio of 1 to 10. If one takes issue with this statement then more answers must come from the endocrinologist, internist, and practitioner who, having perfected their techniques in the use of internal medications, can use them objectively in practice and effect better cures.

Formerly it was held that only about one third of hospitalized cases "lived through their psychosis to survive." It should be repeated that we do not yet have in our therapeutic armamentarium an endocrine substance which ameliorates psychiatric symptoms in this disorder, although pure menopausal symptoms should be treated adequately by endocrine therapy. Nor do we have at this writing the ideal euphoriant drug to replace electric shock therapy.

Because most patients come promptly to successful treatment, persons with classical symptomatology are rare at the present time. Because of the clear-cut psychopathology which ordinarily stands out in high relief, such patients are most useful for clinical demonstration.

¶ Other Types

As the writer has said, paranoid and mixed states are also included in the involutional psychotic reaction. It must be confessed that this is an unsatisfactory grouping. Obviously, not all paranoid reactions occurring in the involutional age period should be included. Many are clearly schizophrenic, others are true paranoid conditions. These are discussed elsewhere. However, there are some individuals who present a paranoid trend in an involutional setting. There may even be some concomitant depression and somatic preoccupation. Here again, the prepsychotic personality can often be shown to be of considerable etiological importance, in that the individual seems to have been able to live behind his defenses until the climacterium, when his suspicious personality balloons into a paranoid state, with ideas of reference and actual delusions of persecution as the main trend. There is no deterioration here as may be seen in schizophrenia, however.

The following is an abstract of the record of a rather typical patient:

> At forty-nine years of age N. G., a married teacher turned factory worker, came to the observation hospital voluntarily, exhibiting an anxious, depressive, paranoid reaction.
>
> Eight weeks before admission she had become

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depressed, felt that fellow workers were plotting against her (hallucinations supported this trend), was tense, easily fatigued, and tremulous. Her physician had sent her to a general hospital for checkup, but beyond menopausal and psychiatric symptoms there were no findings.

At the observation hospital she wept, was seclusive, well oriented, and generally depressed. Among other things she said: "Everything seems too much. About last summer I went into panic. . . . I think that they have got my sickness mixed up in their products at [place of work]. It tires me to think of it. In the first place I don't know why I am that important. Why should they be fighting over me?" She thought that the people at her job were saying nasty things about her just as though they were appearing in her thoughts. She had guilt feelings saying that someone thinks she has done something wrong. "They are talking as though I was to blame for the layoffs."

There being no response to reserpine, she was placed on electric shock therapy (10) to which she reacted well, losing her trend and depression rapidly. She was discharged within six weeks at her family's insistence.

Five months later she was certified to the state hospital, presenting an agitated, paranoid reaction with little depression. She told of hallucinating the voices of the joint owners of her house from upstairs, to the effect that the wiring would affect her health to a degree that they would get her out of the way. She complained that "vibratory waves" from a generator "made her dizzy" and caused "a fire" in her head.

Later, as she improved, she handed her physician the following account of her trend partially in verse form (an avocation in which she had formerly been interested):

"The dead leaves clung upon the trees—they danced, they pleaded to be free—The wind came with a thousand tongues—He lipped, he lashed the vicious ones—Still dead leaves clung upon the tree—They danced, they pleaded to be free! A voice from her pillow, a babble scrabble of familiar voices, voices from upstairs—but why N. did not believe in voices from a pillow. Voices now came down in conversation—voices from upstairs! F. had put little fine wires in the pillow. R. from the shop wanted N. to think she heard voices. F. thought he could get the house—a sordid tale. N. lived in a dream world. F. said he had wired the house for Mrs. C. so he could investigate N.'s illness. It sounded impossible. Records played day and night. Records asking questions. One night a record told N. to lay on the studio couch. Then F. vibrated the studio couch. N. heard F. down cellar. One night voices said Mr. C. and Dr. R. were clearing up the investigation. They talked over a wire under the bed. It was just another trick of kids. It kept N. talking when she should have been asleep. It made a symptom. L. thought N. should go to Marcy [state hospital]. Her daughter was worried. One day two people came and took N. In the station wagon she heard voices. When she entered Marcy she heard voices. She thought it was a big setup. N. thought people were in a room upstairs. They were going to kill her with machines. She . . . with these people in her mind. Suddenly one day N.'s mind was free. She knew she had built a big story out of whole cloth."

Again she did not respond to reserpine but did well on Thorazine, being released during the fourth month. Despite an unfavorable home situation which includes an alcoholic husband and blind daughter, she adjusted well at work again, under outpatient clinic supervision for a year, when she was discharged as much improved.

This reaction was tied clearly to the menopause. It was noted that her prepsychotic personality was characterized as "easy-going but nervous and high strung." No obsessive-compulsive nor, for that matter, paranoid traits were described. The past history was negative. The diagnosis in this patient's case was that of involutional psychosis, paranoid type. The favorable response to treatment is not typical.

The case for the mixed involutional psychosis is still more tenuous, and this label should be employed only when there appears to be an almost equal admixture of depressive and paranoid features in an involutional setting.

The prognosis for both paranoid and mixed cases is much worse than that for involutional melancholia. Electric shock treatment, although less effective here, is still the method of choice. For the refractory mixed case Sainz[18] has proposed, in a preliminary report, the use of Pyrrolazote in gradually increasing dosage

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up to 200 mg. q. i. d. For the same group, Mezer[8] gives an improvement rate of 40 to 50 per cent with prefrontal lobotomy.

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CHAPTER 27

RARE, UNCLASSIFIABLE, COLLECTIVE, AND EXOTIC PSYCHOTIC SYNDROMES

Silvano Arieti
Johannes M. Meth

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ONLY AFTER CONSIDERABLE HESITATION was it decided to include this chapter in the *Handbook*. The hesitation stemmed from several factors. First of all, even a preliminary examination of several conditions to be described in this chapter (for instance, Ganser syndrome, collective psychoses, etc.), revealed that they cannot be considered psychoses without some reservations and that perhaps they should be more exactly termed "pseudo psychoses." Other conditions could be included in some already-known categories such as schizophrenia or paranoid states.

Original reports of collective psychoses are of historical or social character and lack clinical standards. In the case of the exotic syndromes the situation is even more difficult. Although one of us (J. Meth) had experience in the tropical part of South America, the account given here of the majority of syndromes comes not from direct experience but as a result of a compilation of the literature. The literature on exotic psychiatric conditions is scarce, inconsistent, and not too reliable. Some accounts are more anecdotal than scientific.

In spite of these deterring factors, it was decided to include the chapter, first, for the sake of completeness. At meetings and in discussions of atypical cases, mention is occasionally made of these rare conditions. It is thus worth while for the psychiatrist to have some acquaintance with them. Secondly, conditions such as the Ganser and Capgras syndromes present interesting theoretical problems as well as practical aspects. Although some of these are probably not psychoses, they have, nevertheless, a characteristic *psychotic flavor* of their own. Third, a brief account of

collective and exotic conditions may stimulate additional work in this field, which is needed for a better understanding of the nature-nurture problem as well as of many other aspects of social psychiatry. From an immediate, practical point of view we must also add that since the United States has extended her responsibilities into the farthest corners of the earth, American physicians are in increasing number called upon to diagnose and treat exotic conditions.

¶ Rare and Unclassifiable Syndromes

Ganser's Syndrome

Clinical Picture

In 1898 Ganser[34] described a syndrome consisting chiefly of what he called *Vorbeireden*, that is, "talking past the point" or giving only approximate answers. This syndrome has received much consideration in European literature. In the United States, Weiner and Braiman[89] wrote on the subject.

Although relatively rare, the Ganser syndrome is interesting from psychopathological and legal points of view. It is generally encountered in prisoners who have to face trial but also, occasionally, in patients in the general population who have to face unpleasant conditions. Jolly[45] reported that one third of his cases were noncriminal civilians. Of the six cases reported by Weiner and Braiman, only one was a prisoner. Dogliani[30] reported one case occurring after a relatively minor automobile accident. It has also been reported as not infrequent among the Negro soldiers in Africa.[16]

One finds, in the Ganser syndrome, a more or less acute loss of the capacity to reason normally. Many cases present total or partial amnesia. The patient is disoriented as to time and space and gives absurd answers to questions. Often he claims he does not know who he is, where he comes from, or where he is. When he is asked to do simple calculations he makes obvious mistakes—for instance, giving 5 as the sum of 2 plus 2. When he is asked to identify objects, he gives the name of a related object. Upon being shown scissors, the patient may say that they are knives; a picture of a dog may be identified as a cat, a yellow object may be called red, and so on. If he is asked what a hammer is used for, he may reply to cut wood. If he is shown a dime he may state that it is a half dollar and so on. If he is asked how many legs a horse has, he may reply, "six."

At times almost a game seems to go on between the examiner and the patient. The examiner asks questions which are almost silly in their simplicity, but the patient succeeds in giving a sillier answer. And yet it seems that the patient understands the question, because the answer, although wrong, is related to the question.

Other symptoms found in patients suffering from Ganser's syndrome are, in order of frequency: (1) mild degree of mental defect (dull borderline); (2) hysterical symptoms of various kinds, such as amnesia, analgesia, incontinence, confusion, etc., and (3) epileptic-like convulsions, tremors.

Diagnosis

Ganser's syndrome may be confused with voluntary malingering in prisoners who want to escape indictment. In some cases the diagnosis is difficult. The malingerer will at times lose the air of bewilderment and confusion when he is not watched, whereas the Ganserian patient remains in that state all the time. The malingerer is watchful, suspicious, and (although he appears indifferent) ill at ease all of the time, being conscious of the unreality of his symptoms.

The syndrome can also be confused with schizophrenia. The answers of the Ganserian patient are reminiscent of those given by schizophrenics, of those productions Cameron[8] calls metonymic distortions. The answers given by the Ganserian seem even sillier, however, almost as if a voluntary effort had been made to say something ridiculously inappropriate.

A third misdiagnosis easily made is one of mental deficiency or organic conditions. But a mental deficiency of a degree that would explain such absurd answers would have been known prior to the onset of the disorder. Similarly, an organic condition that might lead to these symptoms would have to be at

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a very advanced stage; again, there would be no difficulty in making the diagnosis.

INTERPRETATION

Is the Ganser syndrome a psychosis? Ganser himself, Kraepelin,[49] Bumke,[8] Henderson and Gillespie,[41] and MacDonald[59] felt that it is a psychoneurosis, similar to what Wernicke called hysterical pseudo dementia, and should be included in the group of hysterias. The conversion syndrome would consist in the patient acting as if he had lost his rationality. The secondary gain, of course, would be the avoidance of the indictment or of whatever unpleasant situation he has to face.

Other authors felt, instead, that the condition is a psychotic one (Moeli,[65] Weiner and Braiman,[89] Dogliani[30]). We must say that the syndrome indeed presents a psychotic flavor not usually found in psychoneuroses. The psychodynamic mechanism also seems surprisingly simple: it is obvious that the patient wants to avoid the unpleasant situation and the burden of responsibility. Perhaps, as Weiner and Braiman state, he wants to do more than that. By unconsciously selecting symptoms which make him lose his rationality and often forget his personal identity and his past, he wants to reject his whole self, his whole life history—a denial of his total self.

We encounter difficulties when we try to explain the symptoms from a formal point of view. The answers of the patient are related to the questions, although inappropriately, and are reminiscent of the metonymic distortions of the schizophrenic[9] and in particular of the negativistic answers of some catatonics. The similarity is, however, only apparent. The Ganserian seems almost to make an effort to give a silly answer: a catatonic would not say that a horse has six legs.

Many authors have reported that this condition occurs mostly among people who, although not mentally defective, were at least dull adults, of borderline intelligence, or high-level morons. It has never occurred in a person who, prior to the disorder, was of superior intelligence. This fact suggests the possibility that the low mentality of these people had made them aware of one thing: that at times in life it was convenient not to be smart. The mental defect, although not present, was within grasp or could be exaggerated.

Capgras's Syndrome

Capgras's syndrome is a condition that has received considerable attention in the European literature, especially the French and Italian. In the American literature, Davidson,[26] Stern and MacNaughton,[82] and Todd[84] have published articles on the subject.

In 1923, the French psychiatrist Capgras, in collaboration first with Reboul-Lachaux and later with several others, started a series of articles on what he called "*L'illusion des sosies.*"[11-13] *Sosie* is a French word meaning "double," a person who looks exactly like another one, just *as an identical* twin would resemble the other twin.*

The phenomenon (or syndrome) described by Capgras is the following: the patient will claim, on meeting someone he knows well, that the person is a double or an impostor who has assumed this person's appearance. For example, the mother of a female patient comes to visit the patient at the hospital. The patient claims that this visitor is not the mother but either a double of her or an impostor who has tried to assume the appearance of the mother in order to deceive the patient. The phenomenon is thus a complicated type of misidentification, much more characteristic and specific than the usual misidentifications occurring in schizophrenia.

Although the first publications reported cases of female patients only, a few cases among males have recently been described.

Is this condition, described by Capgras, a special syndrome, or just a symptom occurring in one of the well-known clinical entities? The problem is controversial. Generally, the French authors tend to give to Capgras's syndrome a special place in psychiatric nosology, whereas the German authors tend to see it as a symptom. From the cases reported in the literature,

* The French word *sosie* (*sosia* in Italian) derives from Plautus's play *Amphytreon*. In this play the god Mercury assumes the aspect of Sosia, servant of Amphytreon.

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however, it is obvious that, although the patients presented other symptoms, this particular delusion of the double was the center of the symptomatology.

The authors of this chapter have never seen a case as typical as those described in the literature. The senior author, however, has seen a patient, a paranoid with almost completely well-organized delusions, who doubted that her parents were her real parents. She felt that most probably her parents had died a short time ago (that is, at the onset of her illness) and the persons who acted as her parents were either impostors or reincarnations of her parents. The writer considered this delusion part of a paranoid condition (bordering on paranoia).

From an examination of the literature one gets the impression that the patients described could be classified under either paranoid schizophrenia or paranoid states. Capgras's syndrome thus should be more properly called Capgras's symptom. As a matter of fact, similar phenomena are described in the European literature in even rarer syndromes: for instance, the illusion of Fregoli, described by Courbon and Fail.[28] The patient identifies the persecutor successively in several persons—in the doctor, an attendant, a neighbor, a mailman, etc. The persecutor allegedly changes faces, as the famous European actor Fregoli used to do on the stage. Courbon and Tusques[84] have also described the delusion of intermetamorphoses. The patient believes that the persons in his environment change with one another: A becomes B, B becomes C, C becomes A, etc.

But, going back to Capgras's syndrome, several authors report that they have found the syndrome not only in schizophreniclike or paranoid patients, but also in manic-depressives.[82, 84]

Many patients reported recently in the literature have been treated with insulin or electric shock treatments, apparently with good results. Others retained their delusions and illusions or had relapses.

Interpretation

Even if we deny recognition as a clinical entity to the Capgras phenomenon, it deserves further study from dynamic and formal points of view. The already abundant literature seems to be preoccupied almost exclusively with classificatory controversies.

Cargnello and Della Beffa,[15] reporting an existentialistic analysis of the phenomenon, write that, in the delusional experience of the patient, three persons enter: the patient, the *alter* (the other, the person who was well known to the patient), and the *alius* (the double or the impostor). They conclude that actually it is the *alius* who is lived intensely in the *Erlebnis* of the patient and, although misidentified, is the closest to the ego of the patient.

A few things seem obvious in this syndrome: first, the person whose existence is denied is a very important person in the life of the patient—for instance, the mother. The patient rejects the mother, actually attributes very bad habits to her, but cannot allow herself to become conscious of this rejection because of concomitant guilt feelings or other ambivalent attitudes. What the patient feels about the mother is thus displaced to the double or impostor who allegedly assumes her appearance. Often the idea that the misidentified person is a double or an impostor occurs to the patient as a sudden illumination, or like that "psychotic insight" described in Chapter 23.

Capgras's syndrome thus may be seen as an unusual form of psychotic displacement. All gradations of displacements occur from normal states to neuroses and psychoses. In private practice, we often see how the young wife's resentment toward her own mother is freely displaced and freely expressed to the mother-in-law, for whom she has no ambivalent feelings.

In Capgras's syndrome the real person is spared the hate of the patient—even becomes sanctified, a model of virtue—and the impostor made the target. But the real person, the person whom Cargnello and Della Beffa call the *alter*, becomes a pale, peripheral figure. The patient is really concerned with the *alius*, the impostor.

More difficult than the dynamic is the formal understanding of the Capgras phenomenon. Often, in schizophrenia, the opposite

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process takes place: persons and things which, in thinking processes, should only be associated, are identified. In the Capgras phenomenon, not only is there no increased tendency to identify, but a person who should be easily identified is *not*.

The real person is almost divided into two parts (the *alter* or the good part, and the *alius*, the bad part), just as often happens in dreams. In the Capgras phenomenon the persons are different, but the body has the same appearance. There is thus not only a denial of the Aristotelian first law of logic (law of identity)—A is A—but also a denial of Von Domarus's principle (for instance, in spite of characteristics in common, the visitor is not the mother but an impostor [see Chapter 23]). Obviously the mother is identified with the impostor, but this identification remains unconscious.

It is the feeling of the authors that the phenomenon represents one of those difficult paranoid-paranoiac elaborations of thought which have not yet been fully explained.

Autoscopic Syndrome

CLINICAL PICTURE

Like the Capgras's syndrome, the autoscopic syndrome consists of the delusional experience of a double. In the autoscopic syndrome, however, the double is not a person from the patient's environment but the patient himself. The patient sees a person nearby who looks exactly like himself, talks, dresses, and acts as he does. Quite often this double seems exactly like a mirror image of the patient. Lukianowicz[58] reported an excellent study of this syndrome. Other important reports are those of Lippman,[56] Lhermitte,[52] Pearson and Dewhurst.[67]

The double may appear suddenly and without warning; at other times there are aural warnings. It generally appears in gray, or black and white, like images in dreams. Colors are seldom perceived. The patient occasionally reacts to the discovery of the presence of the double with sadness and amazement, but more often seems indifferent or even happy about it. In a few cases the double is constantly present; in the majority of instances, however, the appearance of the double lasts only a few seconds. Some patients have the experience of the double only once in their life; others repeatedly or constantly after an important event has occurred. Many patients experience the phenomenon only in the evening, at night, or at dawn. Although occasional instances of autoscopic syndrome have been reported in schizophrenia and in depressions, the majority of cases occur in patients suffering from migraine and epilepsy.

INTERPRETATION

The above described manifestations may be remotely related to, but certainly are not identical with, others which are encountered more often in psychiatric practice, such as eidetic images, hypnagogic hallucinations, or those imaginary companions about whom some patients, especially children, have enduring fantasies.

The term autoscopy was used by Schilder[75, 76] to describe the process by which the individual is capable of doubling his body-image and projecting it into the outside world. As used by Lukianowicz, the term refers to hallucinatory phenomena, predominantly visual. These hallucinatory phenomena have only a remote resemblance to those found in schizophrenia; they have a much stronger resemblance to the phenomena found in organic conditions, especially those involving the parietal and temporal lobes (Critchley,[25] Penfield and Rasmussen,[68] Gerstmann[36]), and in some cases of epilepsy.

The greatest resemblance is to those conditions in which a psychological picture is superimposed on an original organic condition, such as symptomatic epilepsy, cases of phantom limb,[48] duplications of parts of body, and denial of illness.[20]

There seem to be indications, however, that the psychogenic element is important in some cases. For instance, one of the cases reported by Lukianowicz was that of a 56-year-old woman who experienced autoscopic phenomena upon returning from her husband's funeral. These phenomena continued thereafter. Lukianowicz does not attempt a dynamic interpretation of the case, although no organic findings are reported. One could speculate that

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the hidden purpose of the symptom was to make the patient aware that, although the husband was dead, she did not need to feel alone: she could be her own companion.

Undoubtedly, much more research is needed on this interesting condition. At present, Lukianowicz's article is the best contribution on the subject and the reader is referred to it for further study.

Cotard's Syndrome (or Chronic Delusional State of Negation)

In 1880, at the meeting of the Societé Médico-Psychologique in Paris, the French psychiatrist Cotard reported cases of what he called *délire de negation* or delusional state of negation. Since that time controversy has continued as to whether this syndrome deserves a special place in the psychiatric classification or whether it should be included among recognized entities.

In 1892 a Congress of Neurologists, which took place in France, was devoted to this topic, but no definite conclusions were reached. At the present time it is only in France and in Italy that the condition continues to be described as a separate entity. But even in these countries there are many psychiatrists who deny its existence. In the United States the condition would probably be included in the paranoid type of involutional psychosis. This symptomatology is in fact somewhat rare in the United States. A brief description follows:

After an interval of anxiety, the patient, generally a woman in the involutional age, but at times even men and younger or older women, denies any existence to the surrounding reality. Nothing exists; the world has disappeared. After the cosmic reality is denied, the physical reality of the patient himself is denied. At first the patient claims that he has lost all sensation throughout his body; in some cases, he later claims that he does not exist. Everything is denied in this overwhelming delusional state. At times even the possibility of death is denied—the patient considers himself immortal. Other symptoms resemble the picture of involutional psychosis: the patient is depressed, may refuse food, has ideas of having been condemned by God. He may also hallucinate. He retains, however, the capacity to talk freely in spite of the depression and often is given to philosophical contemplations about his own life, life in general, and the world.

For further study the reader is referred to Cotard,[22] Ey,[31] Capgras and Daumezon,[14] Perris,[69] De Martis.[27]

Psychose Passionelle of Clérambault (or Pure Erotomania)

In the French literature and to a lesser degree in the Italian, the so-called *psychose passionelle* or "pure erotomania" is still given a distinct nosologic place by some psychiatrists. It is sometimes called Clérambault's syndrome, from the author who devoted many studies to it.[19]

The condition is not too rare, even in the United States, and the senior author has seen several cases of it. In the United States, however, the condition is generally classified as a paranoid condition, paranoia, or paranoid type of schizophrenia. Chapter 25 has dealt more extensively with this condition, under the heading of erotomania. For the sake of completeness, however, a brief description is reported here of those symptoms, which in some European psychiatric schools are generally considered part of Clérambault's syndrome.

The patient, generally a married woman, claims that another man is very much in love with her. The man, allegedly in love with the patient is generally of a social rank superior to that of the husband—at times, a very wealthy man or a prominent actor, lawyer, physician, etc. The patient would like to reciprocate this love, but the world, especially the husband, does not permit her to do so. This love becomes the purpose of the existence of the patient, and everything else in her life revolves around it. The patient starts to interpret everything as a proof of the love this man has for her, and a delusional system is thus built. For instance, one patient, the wife of a successful storekeeper, considered the business success of her husband as a proof of the other man's love for her: Because of his love, he was directing many customers into the husband's store, so that the husband would make a lot

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of money. Any gift the husband bought for the patient was interpreted by the patient as an indirect gift from the other man.

For further study the reader is referred to Clérambault[19] and Balduzzi.[4]

¶ Collective Psychoses

In old books of psychiatry, one can find reports of collective psychoses or "psychic epidemics" occurring in Europe, from the eleventh to the seventeenth centuries. These reports have to be read with more than a grain of salt, as they lack scientific rigor, although Hecker's volume,[39] published in 1832, is a valuable study.

We believe that many cases dealt not with real psychoses or neuroses, but with collective manifestations of fanaticism in members of particular religious sects. The Flagellants of the plague epidemics in the thirteenth and fourteenth centuries, trying to atone their sins, the Palamites who tried to touch the umbilicus with their head in order to see the glory of the Divinity, the Adamites who walked naked, can hardly be called "psychotic" in a medical sense.

Nevertheless, one gets the impression that actual "collective psychoses" or psychic epidemics occurred at times in the Middle Ages. In our opinion, these were not psychoses, but psychoneuroses of hysterical nature which were induced by the effect the crowd had on the predisposed person. The atmosphere of superstition, ignorance, and intense religiosity predisposed unstable individuals to this form of collective hypnosis. Perhaps a type of society that Riesman[72] has called group-directed is necessary for the occurrence of such epidemics.

Ferrio,[32] from whom most of this information is taken, reports that between the eleventh and the fifteenth centuries a psychic epidemic of St. Vitus's dance occurred, especially in the German and Flemish countries. People affected by the disease gathered together in the vicinity of churches, dancing and singing for several days and nights until they lost consciousness. Many of them had convulsive seizures. In the midst of this excitement some women were made pregnant. In the year 1278, when two hundred of these patients gathered upon a bridge on the Rhine at Utrecht, the bridge collapsed. Many of them perished. According to Ferrio, it seems that the name St. Vitus's dance comes from the fact that some of these patients were kept for treatment in a chapel dedicated to St. Vitus, in Zabern.

A similar epidemic occurred in the south of Italy in the fifteenth century. According to Zilboorg,[84] it was first described scientifically by Baglivi, under the name *tarantism* or *tarantulism*. The name has nothing to do with the name of the Italian city Taranto, as some believe, but with the fact that the patients were thought to have become sick because they had been bitten by a special spider, *Lycosa tarentula*. The patients presented convulsions and general excitement. It was also believed that music would be an effective treatment for it—thus the melody tarantella was created, a popular dance music still played in Italy.

Perhaps, of all the collective psychoses, the most important is *lycanthropy*, some cases of which are said to occur even now in some mountainous villages of Italy. According to Zilboorg, lycanthropy has been described and reported in the medical literature of their times by Marcellus in the third century, by Paré, Pomponazzi, Leloyer, Weyer in the sixteenth century, and by Sennert in the seventeenth century (all quoted by Zilboorg). People affected by this condition considered themselves transformed into animals, especially wolves. They saw themselves as animals and acted as such. Many of them committed crimes while they were in this state. People recognized as affected by this condition were often arrested and executed. According to Ferrio, a French judge named Boguet prided himself on having condemned to death about six hundred people suffering from lycanthropy during an epidemic that occurred in France in the department of Giura.

Although some of these lycanthropous were probably schizophrenics, it seems possible that the majority of them were suffering from some kind of collective hysteria. The conviction that men could be transformed into animals is very ancient; such transformations are often described in the myths and literature of various peoples. Nebuchadnezzar, King of Babylon, thought he was a wolf, and St. Patrick is re-

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ported to have transformed Veneticus, King of Gallia, into a wolf.

A strong feeling of guilt and unworthiness, experienced so deeply as to make the individual feel that he did not deserve to belong to the human race, found this concrete expression in a suitable cultural atmosphere. In a certain way lycanthropy is a counterpart of other neurotic symptoms, such as phobias, obsessions, etc. In phobias, the patient is apparently afraid of a danger coming from the outside world, in lycanthropy he is afraid of undergoing a metamorphosis. Later the patient must act out the metamorphosis by behaving like an animal. He acts hysterically or impulsively rather than compulsively, but in order to do so he must receive the assent of a group of people who behave as he does. This group replaces his usual social self or super-ego.

Other collective epidemics are said to have occurred in convents, where all the nuns would suddenly become possessed by the illness, abandon the religious discipline, and give vent to hysterical and bizarre actions. Ferrio reports that around the year 1700 the nuns of a convent near Paris started to mew as if they had been transformed into cats.

Today, lycanthropy is a term reserved to describe the delusions appearing in isolated cases of schizophrenia and paranoia of having been transformed into animals.

For further study the reader is referred to Zilboorg and Ferrio.

¶ Exotic* Psychiatric Syndromes

General Considerations

All the mental disorders known in the Western world have been found among primitive† people also.[16, 17, 21, 29, 42, 44, 49, 50, 57, 66, 71, 81, 85, 87, 93] What varies is their relative frequency and, to a lesser extent, the manifest content of the symptomatology. It has been said repeatedly that the frequency of emotional disorders increases with the increase of complexity of a culture, but this statement has not been substantiated consistently.[2, 37, 38, 43, 62, 64, 87] Seligman, for example, was unable to find cases of psychoses among the Papuans of New Guinea and concluded that the absence of serious mental disorders is due to the primitivity of the Papuan culture.[77] Van der Hoeven, on the other hand, observed a fair number of psychoses and psychoneuroses among the same Papuans.[42] It is, therefore, evident that general statements about the absence of psychiatric disorders in primitive people cannot be accepted unless carefully evaluated and checked. There are, however, some statistical data available which seem carefully prepared and creditable, for instance, those of Carothers, who estimates that the incidence of psychoses among Negroes in Kenya, East Africa, is one tenth of that found in England and the United States.[16, 17] On the other hand, Lin has observed, in an equally well prepared study, that the rate of psychoses among some tribes in Formosa is equal to that of a German population in Thuringia.[54] Psychiatric disorders among the Ojibwas of Southern Ontario and among the Aiviliks of the Northern Hudson Bay are frequent and severe.[18, 51]

We must furthermore remember that under the category of "primitive cultures" we arbitrarily lump a large group of cultures some of which may, and some may not, have a beneficial effect from the point of view of mental health.

Another important point to consider, when computing the incidence of mental disorders in primitive people, is that many of these people are not prone to report or hospitalize a person whose behavior is not grossly abnormal or intolerable. It must also be kept in mind that hallucinations and delusions, which we consider almost pathognomic of psychoses, are normal and frequent occurrences in many exotic people during their trance states.[6] Hallucinations in these states, however, have a different character and significance from those occurring in a psychosis. They are generally benign and not persecutory in content, last only as long as the trance does, and are most often visual, not auditory. Many tribes choose their shamans and witch doctors among people suffering from mental disorders, since they are

* The word "exotic" is used to mean something foreign to Western cultures.

† "Primitive" in the following pages refers to peoples who have had little or no contact with technology.

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more apt to achieve the dissociative states of trance and possession which are required in the ceremonies of many primitive people.

It is unfortunate that no detailed personal histories of psychiatric patients of primitive societies have so far been reported. Many authors have stressed the uniformity of the emotional climate in the childhood of exotic people. And yet, from recent anthropological protocols, it can be gleaned that such uniformity is as uncommon for the children of primitive societies as for our children. The same conditions detrimental to mental health may occur. The parents may be domineering, too indulgent, unreliable, indifferent, cruel, hypercritical, etc. There may be a preponderance or absence of one or several of these conditions in different cultures, but no generalization valid for all primitive societies is possible. It is likely that the organization of a culture influences the type of mental disorder prevalent in that culture—for example, the conspicuous rarity of obsessive-compulsive neuroses in many exotic societies may be related to the fact that the many rules and taboos which govern people's lives allow expression of compulsiveness and protect the members of these societies from the anxiety of making decisions.

The belief that the mental health of primitive people has deteriorated whenever they have come in contact with Western cultures has proved untenable. It is true that, in some parts of Africa, Europeans have disrupted old social orders—with detribalization, uprooting from the soil, destructive prejudices, destruction of old beliefs and rituals without adequate substitutes—and that in these areas the incidence of mental illness has increased.[16,17,18,85] But it is also true that in some parts of Polynesia a wise colonial administration has left the native population relatively undisturbed in their tribal systems and customs and, by eradicating cannibalism (for example, on the Fiji Islands), has transformed an extremely suspicious and hostile people into a trusting and friendly one.[53] A more or less temporary impairment of mental health has been observed in people who have been transplanted into different populations—Wedge reports that the incidence of mental disorders among Okinawans who emigrated to the Hawaiian Islands is much greater than among those living on their home island.[88] Since the Okinawan mothers continue their prolonged breast feeding and mothering attitude in Hawaii, Wedge uses this observation as an argument against the importance of the emotional climate in childhood for the development of mental health. One may argue, however, that the mechanical continuation of an attitude is no guarantee that its spirit also continues. The transplantation into a strange and hostile environment may create anxieties in the mothers which are communicated to the children and which may account for the increase of emotional disorders. This increase of mental illness has been reported also among Western people who have emigrated to foreign countries.

When dealing with people living in tropical or subtropical climates, the possibility of an organic etiology for a mental disorder must be kept in mind perhaps even more than it must in our Western practice. The differential diagnosis between a functional and infective psychosis may be very difficult. Positive laboratory findings of an infective agent are not decisive in populations in which those infections are very common. The most important organic conditions to rule out, before diagnosing a functional psychosis in tropical countries, are:

1. Malaria, which, according to Carothers, accounts for 3.4 per cent of first admissions to mental hospitals in Kenya.[16] The pernicious type of malaria, especially, can produce neuropsychiatric symptoms such as confusional states with excitement or stupor, meningeal signs, coma, or epileptic attacks (see also Arieti[3] and Chapter 60).

2. According to Tooth, trypanosomiasis is "the commonest cause of mental derangement throughout large areas of West Africa."[85] The first symptom is usually a change of habits. The patient becomes increasingly irritable, apathetic, morose. A fine tremor may appear in the tongue and lips, extend to one extremity, and finally to the whole body. The speech is low and tremulous. Sleep disturbances occur in 60 to 70 per cent of the cases. Delusions, hallucinations, and manic attacks have been reported. According to Tooth, every symptom of every type of schizophrenia may occur. The

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end stage is that of an euphoric dementia with impulsive behavior.[33, 85]

3. Syphilis. General paresis, which once was believed to be exceptional in primitive people (for instance by Kraepelin), is not uncommon.[49] Carothers has seen a fair number of cases in Kenya.[16] He stresses the remarkably high proportion of expansive cases.

4. Massive infestation with *Ascaris lumbricoides.* One of us (Meth) has observed confusional states, carpopedal spasms, and epileptic attacks in several children in Ecuador.

At this point it should also be mentioned that psychiatric conditions due to nutritional deficiencies, particularly pellagra and kwashiorkor must be considered in the differential diagnosis.[16, 35, 80] Pellagra (see Chapter 62) is not unusual among primitive people. It may be difficult to diagnose in spite of its classical triad (dermatitis, diarrhea, dementia) because the typical skin lesions may be absent or not easily recognized in colored people, and because diarrhea is such a common symptom in warm climates that it is often overlooked. Kwashiorkor is a disease caused by protein deficiency. It is characterized by retarded growth, mental changes, visceral changes, and skin lesions. The high mortality of African children between the ages of one and three years may be due to kwashiorkor. The mental symptoms are apathy and peevishness. The remarkable change in African children from a liveliness equal to that of European children to the frequent apathy after the first year of life has been attributed to protein deficiency. It is not observed in tribes who have an ample supply of animal proteins (milk or fish) or of protein-rich beans.[16]

Psychiatric disorders of the primitive may also be due to toxic causes. Alcoholism is, in most areas, an import of Western civilization. It is not an extensive problem in those parts of Africa where the tribal organization has remained intact; it has become a serious one among detribalized people. Some statistics show that the overwhelming percentage of major crimes has been committed by natives under the influence of alcohol. Meth has made the same observation among Indians of South America, who commit violent crimes almost exclusively when intoxicated.[50, 66, 71, 79]

Drug addictions are common in some countries. Addiction to *Cannabis indica,* or hashish, is frequent in India and in Arabic countries, addiction to *Cannabis sativa,* or marijuana, is prevalent in Central and South America.[29, 50] Hallucinations due to the use of peyotl and dried blossoms of mescal have been reported among the Indians of the Southwest in the United States.*[40]

The Incas and other South American Indians used to snuff the powdered seeds of the tree Piptadenia peregrina, which they called *cohoba,* and as a consequence experienced delusions, hallucinations, and excitement states which made it necessary for the wives to tie up their husbands to prevent them from committing violence. The active principle is *bufotenine,* which is also contained in the skin and salivary glands of the toad *Bufo bufo* and in some mushrooms (*Amanita muscaria,* or fly agaric, and *Amanita pantherina*). In some parts of Siberia the shamans used to eat the mushroom in order to fall into a trance state more easily. The Mexican mushrooms teonanacatl (*Stropharia cubensis*) and *Psilocybe caeruleus var. mazatecorum* produce hallucinations and disorders of visual perception, characterized by changes in the perception of space and colors.[40]

The possibility of infective diseases is wrongly suspected at times in primitive people in whom schizophrenia frequently occurs in acute paroxysms; these may simulate the acute hallucinosis and confusional states of infective deliria. Not uncommonly, the primitive schizophrenic may appear normal after a paroxysm, like the patient who has recovered from an infective hallucinosis. The dementia state of our chronic schizophrenics is uncommon in primitive people. In Africa a Ganserlike syndrome has been described as occurring between psychotic attacks.

The rarity of the simple type of schizophrenia among primitive people may be more apparent than real and is possibly due to the greater tolerance of deviant behavior and the lesser demand for judgment in these societies.

In spite of all these diagnostic difficulties or

* Hofmann's discovery of LSD has revived interest in mescaline and other hallucinogenic substances long known to some exotic peoples (see Chapter 84).

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differences, schizophrenia is recognized as the most common psychosis all over the world. Some statistics of mental disorders among primitive people quote its incidence as 60 per cent of all psychoses. Affective disorders and suicides vary in their frequency. They are unusual in most parts of Africa, South America, Australia, and Polynesia. Especially rare are the depressed phase of manic-depressive psychosis and involutional psychoses, whereas the manic type is relatively more common. Among the Papuas of New Guinea and some Eskimo tribes, melancholia and suicides are not infrequent.

Functional Psychiatric Syndromes

LATAH

Latah is a syndrome first described in Malaya, but recognized later on in many parts of the world. The etymology of the word *latah* is not known. It may derive from the Malayan words for love-making, ticklish, or creeping. In Malaya this syndrome has been known for many centuries and is regarded more as an eccentricity than a disease. It occurs mostly in middle-aged or elderly women. In other parts of the world it is equally frequent in men. Sometimes it has occurred in epidemic form.

Similar syndromes have been described in Siberia under the names of *myriachit* and *tara;* in Hokkaido (Northern Japan) among the Ainu as *imu;* in Siam as *bah-tschi;* in Burma as *yuan;* in the Philippines as *mali-mali;* in Madagascar as *ramenajana;* in Nyasaland as *misala;* in Congo as *banga.* It has also been reported from Somaliland, the southern part of the Sahara, and from Tierra del Fuego without any particular name.[1, 44, 92, 93] Yap[92] feels that the syndrome described by Beard under the name of "Jumping Frenchmen of Maine" or "shakers" or "barkers" or "holy rollers" belongs to the same clinical entity. Contrary to many other authors, he does not include Gilles de la Tourette's disease, also called tic convulsive.

Clinical Picture

The patient, generally a middle-aged or elderly woman of dull intelligence and compliant character, becomes increasingly fearful and seclusive. The disorder may start with a sudden fright. Among the Ainu of Northern Japan, the illness often begins when the patient has actually, or imagines having, seen or stepped on a snake. The patient may at first repeat some of his own words or sentences several times; later on, he will repeat the words or sentences of other people, particularly of persons in authority. Still later, the patient, in a pantomime fashion, repeats or imitates gestures and acts of other people, even if this results in harm to himself. At other times he does the exact opposite of what other persons do. The next symptom is coprolalia. At first the patient utters incomprehensible sounds, which later become clearly obscene or curse words which he never used before. The echolalia, echopraxia, and coprolalia are entirely uncontrollable.

Latah patients are often the butt of jokes. Adults and children may tease them, until they tearfully beg to be left in peace or, less frequently, until they become violent.

In other parts of the world the latah syndrome acquires additional characteristics. In Africa the patients may run into the forests; in Tierra del Fuego they may climb dangerous cliffs without regard to their safety. During these fugues, the patients, who are usually males, become violent and present a picture similar to "running amok" (see page 557).

The "Jumping Frenchmen of Maine," who, according to Yap, were suffering from latah, belonged to a sect—The United Society of Believers in the Second Appearing of Christ—which came to this country from Wales in the eighteenth century and settled along the eastern coast. During their rites and at the height of their religious ecstasies, one member started to jump, shake, roll around on the ground, and utter barking sounds, and the others followed suit. For most of them, this behavior ended with the close of the religious ceremonies. Some, however, remained in this state, so that any sharp command or even the pointing of a finger started them jumping, shaking, etc.

It is the opinion of the present writers that the clinical picture of the "Jumping Frenchmen of Maine" is more reminiscent of the

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collective psychoses than of the latah syndrome.

Gilles de la Tourette's disease (also called *tic de Guinon, maladie des tics impulsifs,* myospasia impulsiva, multiple tics with coprolalia, or imbacco) starts in children between the ages of five to fifteen years with spasms of the orbicularis oculi. It later spreads to other muscles of the face, then to the neck, upper extremities, and at times to the whole body. Soon all the symptoms of the latah syndrome are added.

The course of the disease is unpredictable. Some patients have become progressively worse, ending with a severe obsessive-compulsive neurosis or even with a psychosis. In other cases, the symptomatology has remained static. The disease may run a paroxysmal course, with the paroxysms lasting for weeks or months.

Again, it is more than doubtful than Gilles de la Tourette's disease is a special form of the latah syndrome. Perhaps it is a combination of the two conditions.[60, 61]

Various interpretations of the latah syndrome have been attempted (see Yap for a good bibliography and discussion). The latah patient is a compliant, self-effacing person who, even before becoming obviously ill, had tried to solve his conflicts by blotting out all expansiveness. Latah may be interpreted as an attempt of the patient to free himself of his anxieties by surrendering himself totally to others. The compulsive utterance of obscene words may indicate that he is not wholly successful in his endeavor. Frightened children often mimic other people. The mimicking may be a primitive anxiety-relieving mechanism, still available to children and primitive people, but not to adult Western man.

Amok

Amok, or "running amok," is a syndrome first described in Malaya, but found also in other parts of the world—for instance, in the Philippines, in various parts of Africa, and in Tierra del Fuego. The "going berserk" of the old Vikings may be an identical or at least similar syndrome. In Malaya it was frequent until the beginning of this century. According to Van Wilfften Palthe,[86] it occurred often among the patients of Batavia Hospital until 1914, when the old hospital building and old methods were replaced by a modern structure and modern medical care. Since then, running amok has become exceptional. Van Wilfften Palthe has never observed or heard of a case of amok among the many Malayans living in European countries.

In the early days of American occupation of the Philippines, a number of American soldiers became victims of amok Moros. The Moros were a primitive Mohammedan tribe. When their level of education was raised, amok disappeared.[16, 20, 29, 42, 49, 83]

Clinical Picture

Amok occurs in males who have a schizoid personality. During a short prodromal period these persons become even more withdrawn than usual. All of a sudden, their brooding is interrupted, they jump up, sometimes with a terrifying yell, grab their dagger, and slash into anyone and anything they encounter on their way. They end up, after having killed several people and animals, either by being killed by the frightened neighbors or by killing themselves. Those few patients who have escaped death, generally because they have made themselves helpless by self-mutilation, either showed complete amnesia for the episode or described a feeling of blackening of eyesight from which they tried to slash their way out.

Kraepelin felt that amok has no uniform etiology and that it may be caused either by an infectious disease, particularly malaria, or by epilepsy and schizophrenia.[49] Perhaps a sociopsychodynamic interpretation of amok is possible. A person who has repressed his rage to the point of appearing apathetic finally bursts out and gives expression to it within the culturally acceptable framework. When this cultural acceptance is withdrawn because of Western influence, running amok becomes rare. Among the Bantu a contributing factor may be the belief that a person destined to die may escape death if someone else is killed in his place.

The multiple violent acts occasionally committed in Western countries by persons with a schizoid personality resemble the clinical picture of running amok and may have similar psychodynamic mechanisms. Such apparently

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unmotivated outbursts of violence have been artistically described in the European literature by fiction writers (for instance, Gabriele D'Annunzio and Albert Camus).

Although violent acts committed by paranoid or catatonic schizophrenics may have some resemblance to running amok, the differential diagnosis is generally not difficult. In schizophrenia, there is no amnesia for the violent episode; other symptoms which are present, such as delusions and hallucinations, are absent in amok.

Pseudo amok is probably a hysterical syndrome in which the patients are excited and grab their dagger as in real amok, but seem to avoid, skillfully, hurting anybody. When cornered, these patients give themselves up meekly, whereas persons affected by real amok never surrender.

Koro

Koro is a phobia known among the Buginese and Macassarese in Celebes and West Borneo. The Chinese call it *shook yong*.[88] Kobler reported the occurrence of this condition in Southern China. Van Wilfften Palthe[86] observed it in a Chinese man hospitalized for tuberculosis.

It generally starts suddenly. The patient becomes fearful that his penis will disappear into his abdomen and he will die. To prevent this from happening, he has to grip his penis firmly; when he gets tired, his wife, relatives, and friends help him. The Chinese have a special wooden clasp constructed for this purpose. At times, fellatio practiced immediately by the patient's wife can stop the phobia. This condition can last days and even weeks. The Chinese believe that it is due to the prevalence of what they call "female factor," or *Yin*. Therefore, a medicine belonging to the "male factor," *Yan*, must be administered—for instance, powdered rhinoceros horn. Linton[55] reports a female equivalent of koro in Southeast Asia. Some female patients in Borneo feel that their breasts are shrinking and their labia sucked inward, thus losing female secondary sex characteristics.

This syndrome seems to exemplify how a particular culture introduces specific symbols into psychodynamic processes which are identical to those existing in our civilization. Our patients, however, express castration fear, dependency needs, and inferiority feelings with other symbols.

Whitico Psychosis

The whitico psychosis is a peculiar syndrome occurring among the Eskimos living around Hudson Bay, particularly the Cree Eskimos (southern Hudson Bay). Among the Ojibwas of southeastern Ontario it is known as windigo.[20, 51]

Clinical Picture

The patient's first symptoms may be anorexia, nausea, vomiting, diarrhea. At the same time, the patient may fall into a brooding mood, fearing that he has been bewitched. He becomes afraid that he may crave human flesh—that is, that he may become a whitico. A whitico is a supernatural figure, a giant skeleton, made of ice, which devours humans. The patient becomes more and more melancholic, withdrawn, inert, refuses to eat, is sleepless. The frightened family calls on a good shaman to counter the bad shaman's spell. Most often the patient improves after appropriate magic is applied. But, at times, particularly in isolated areas where no "good" shaman is available, the patient may coldly kill one or more members of his household and eat them.

Cannibalism has been a recognized extreme means of survival among Eskimos. Therefore, the use of cannibalism as the content of a phobia in this culture is understandable. Up to this point the syndrome should be called whitico phobia. It becomes a psychosis when the patient actually kills and eats his relatives. This may have the following psychodynamic interpretation: if cannibalism can be life saving in an emergency (extreme famine), then it can also save the life of the patient who is suffering from an emotional emergency.

Voodoo Death (Thanatomania)

Voodoo death is known among most primitive people.[10, 12, 19] The patient dies without any discernible organic cause when he becomes aware of having transgressed a taboo or when he fears having been bewitched. The following

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is a typical case report: A sorcerer in New Guinea had been offended by a young Papuan. In revenge, he told the young, healthy man that a few days ago he (the sorcerer) had put a *bofiet* (an object poisoned by witchcraft) into the young man's path. The young Papuan immediately appeared extremely ill. He did not talk and seemed entirely removed from his environment. Within two days he was dead. The sorcerer was indicted by a Dutch court which, recognizing the bewitchment as cause of death, condemned the man—who, by the way, admitted his guilt freely—to several years of imprisonment.[42]

The interpretation of this condition is difficult. Death from fear is not unknown in the West. We use the phrase "frightened to death," although we generally use it in a metaphorical sense. What has puzzled Western observers of voodoo death is its relative frequency among primitive people and the fact that it seems to occur for unbelievably trifling causes. Of course, these causes are as little trifling for the primitives as those symbols which have become charged with explosive meaning for our patients.

In the Bible (II Sam. 6:6-8) it is reported that Uzzah accidentally touched the ark of God, while it was shaken by the oxen which were carrying it. Nobody was supposed to touch the holy ark, and Uzzah is reported to have died immediately, because of "the anger of the Lord." This account is hardly reconcilable with previous statements in the Bible where great care was made to differentiate voluntary crimes from involuntary ones (Numbers, Chap. 35; Joshua, Chap. 20). It is probable that Uzzah died a voodoo death because of his expectancy of death.

Death resulting from expectancy of death is not uncommon in villages of Western countries. Arieti has heard from reliable witnesses that, in the village of Pomarance in Italy, an elderly man used to say that he would die when the several-centuries-old tower of the village fell down. During a storm the tower was hit by lightning and did fall. Shortly after hearing this news, the man died.

Although we recognize that fear of death, expectancy of death, etc., must be strongly felt in primitives and in people living in extremely religious or superstitious surroundings, it is hard to understand how these emotions can lead to death. It could be that a process of autohypnosis succeeds in altering some vital physiologic mechanisms, presumably through some functional alterations of the autonomic nervous system. It could also be that Selye's[78] reaction to stress fails in some of these cases. The few autopsy reports in these cases have shown only signs of vasomotor paralysis.

¶ Psychiatry in a Historical-Geographical Perspective

These accounts of collective and exotic syndromes, although brief, may help to visualize psychiatry in a historical-geographical perspective. We have seen how certain rare diseases or special syndromes appear and disappear in the course of history and how even the incidence of the well-known psychiatric disorders vary in different areas of the world. One could easily yield to the weight of the factor of cultural variability and conclude that culture is by far the most important element in the etiology of mental conditions.[2,5,6,7,17,28,37,38,48,64,72,73,77] If it were so, there could be no universal psychiatry, and a Western psychiatrist of the twentieth century would be unable to recognize mental disorders in members of other civilizations or study psychiatric reports of previous ages. Actually, there is a great uniformity in the psychiatric nosology of people whose cultural norms vary widely. In this chapter, for sake of completeness, we have emphasized what was different. We must remember, however, that the majority of psychiatric cases of all times and all places are similar to ours.

One of the difficulties encountered in the study of psychiatry in different cultures arises from a confusion between the concept of normality versus abnormality and the concept of mental health versus mental illness. Although these two concepts overlap to a considerable extent in what they connote and denote, they are not identical.

Psychiatry has been defined as the science of abnormal behavior, but this definition seems inadequate in a historical-geographical perspective.

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In all cultures a concept of normality exists, but what is considered normal differs widely. Here are some examples: In the West, suicide is considered a sign of emotional disorder; in Japan, it is normal for a samurai in certain circumstances. Among the islanders of Dobu (Melanesia), no sane woman leaves her cooking pots unguarded for fear of being poisoned. To us this behavior would indicate paranoia. Among some Eskimo tribes, the mother accepts the killer of her son in her son's stead. Among the Papuans it is traditional for an uncle and nephew (mother's brother and son) to practice homosexuality. In Tibet a group of brothers inherits their father's second wife when he gets old. A Navajo male may marry a widow with a daughter; later he discards the mother and marries the daughter. It is not unusual for an Arapesh to marry simultaneously a mother and her daughter.[5,6,43,61] These are a few behavior patterns which we consider abnormal, but which are entirely normal in other civilizations.

Ruth Benedict defines normality as "primarily a term for the specially elaborated segment of human behavior in any culture and abnormality a term for the segment that that particular civilization does not use . . . normal is that which society has approved."[5,6]

Benedict's definition of normality of behavior seems to have pragmatic value. Perhaps we may paraphrase it and state that normal is behavior that does not deviate from the established norms of the society in which the individual lives and abnormal is behavior that deviates.

Mental illness, however, is not necessarily a deviation from the norm of society and does not necessarily coincide with abnormality—if by mental illness we mean the failure of the adaptive psychological mechanisms of an organism to counteract adequately the stimuli and stresses to which it is subjected.

For instance, the Melanesian woman who fears poisoning is normal from a Melanesian point of view, abnormal from ours. But, although she is abnormal from our point of view, she is not mentally ill. On the other hand, the paranoid patient who is afraid of being poisoned is both abnormal and sick, because his fear is the expression of the failure of his adaptive mechanisms. The disturbance of the psychological function is manifested in some special basic *forms* which are more or less typical of the whole human race. Sets of formal mechanisms, which recur together with a certain regularity, are at the present time considered as constituting the various clinical entities (see Chapter 23).

These remarks should not make one think that the authors give no importance to social, historical, and geographical factors in the engendering of mental illness. The opposite is true.

The culture is important in at least three aspects. First of all, in predisposing to or in preventing a given mental illness. The over-all cultural climate and the specific ways in which children are raised may bring about some psychodynamic mechanisms which lead to one mental disorder more often than to another. For the importance of culture in predisposing to or preventing manic-depressive psychosis, see Chapter 22 (see also Chapters 6 and 86).

Primitive societies in particular offer excellent opportunities to observe and compare differences of child-raising patterns and their psychiatric impacts. There are some islands where tribes exposed to the same racial, geographic, and economic conditions have developed rather different attitudes toward their children and interpersonal behavior. The Arapesh and Iatmul are tribes who live near each other on New Guinea. The Arapesh treat their children with great gentleness. Passive dependency is encouraged from infancy on. Adolescent boys have a warm affectionate relationship with each other. Homosexuality is not recognized; there is no transvestitism in their ceremonies. Among the Iatmul, hostility is aroused from infancy on. Food is not offered, but must be strongly demanded. The mothers are domineering and the relationship between parents and children is cold. Ceremonial transvestitism is frequent and so is homosexuality, although passive homosexuality is tabooed. The Iatmul use members of other tribes as passive homosexual partners.[64] These are interpersonal relationships quite similar to those we observe in the backgrounds of our homosexuals. The assumption of a cause-effect relationship between this particular family constellation and emo-

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tional climate on the one hand and homosexuality on the other has received valuable confirmation by such observations.

The study of exotic cultures may thus be very useful from the point of mental hygiene in helping us find a psychological attitude which allows the freest development of inherent human potentialities. Biology has rediscovered the concept of progress and so, we believe, has psychiatry. We subscribe wholeheartedly to Sapir's exhortation: "Perhaps it is not too much to expect that a number of gifted psychiatrists may take up the serious study of exotic and primitive cultures . . . in order to learn to understand more fully than we can out of the resources of our own cultures, the development of ideas and symbols and their relevance for the problem of personality."[73]

The second respect in which the study of culture is important is in understanding the content and the particular choice of symptoms. It is obvious that some of the manifestations described in this chapter (for instance the fear of becoming a cannibal) may occur only in a certain environment. Until a few generations ago, schizophrenics believed that ghosts and witches were responsible for the subjective experiences which they could not understand. Today they blame radio, television, hidden dictaphones, and radar apparatuses. The third reason culture is important for the field of psychiatry concerns the responsiveness of the culture to mental illness. We have seen, for instance, how such conditions as amok occur because, in a certain way, they are implicitly accepted by the culture. On the other hand, the greater capacity for tolerance of a certain population may make the recognition of the illness more difficult (for instance, simple schizophrenia in certain parts of Africa) and alter statistics and other data about morbidity, hospitalization, and therapy.

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PART FOUR

Psychopathic Conditions, Deviations, Addictions

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CHAPTER 28

PSYCHOPATHIC STATES

Hervey M. Cleckley

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SEVERAL DIFFICULTIES prevent the formulation of a precise definition of our subject. The term "psychopathic personality" was for decades, and until recently, the official and technically correct designation for a large group of disorders regarded by many psychiatrists as having too little in common to justify their being grouped in a single category. Here, all classified together, were patients with schizoid traits and with cyclothymic or paranoid tendencies, sexual deviates of all types, as well as those with antisocial behavior disorders, gross inadequacies of character, and numerous other difficulties. Despite its official status, the term was seldom used among psychiatrists to designate this motley group. Along with its less formal equivalent, psychopath, it has continued to appear in regular discourse among physicians as a means of indicating not the heterogeneous group but one, and one only, of the types of disorders listed therein.

Several years ago the term "psychopathic personality" was discarded in a revision of the nomenclature, and "personality disorders" was chosen as an appellation for approximately the same group as that mentioned above. In the new and currently approved terminology we find this category:

Personality Disorders[7]

- Personality pattern disturbance
  - Inadequate personality
  - Schizoid personality
  - Cyclothymic personality
  - Paranoid personality
- Personality trait disturbance
  - Emotionally unstable personality
  - Passive-aggressive personality
  - Compulsive personality
  - Personality trait disturbance, other
- Sociopathic personality disturbance
  - Antisocial reaction
  - Dyssocial reaction
  - Sexual deviation; specify supplementary term
  - Addiction
    - Alcoholism
    - Drug addiction
- Special symptom reaction
  - Learning disturbance
  - Speech disturbance
  - Enuresis
  - Somnambulism
  - Other

Despite these changes, the terms "psychopathy," "psychopath," "constitutional psychopathic inferiority," "psychopathic personality," and "psychopathic states" remain in use among psychiatrists. These terms, unless carefully qualified, do not, in ordinary discussion, refer to primary sexual deviation. I have never heard them employed to designate a schizoid personality, a cyclothymic personality, or someone troubled with somnambulism, speech disturbance, or enuresis. Most of the conditions under this general heading of "personality disorders" are regarded by many observers as chronic and deeply ingrained in what some might call the character or essence of the person. This much they have in common. Thus, also, they contrast with the ordinary psychoneurosis or psychosis which is generally regarded as a pathologic process that may arise in a heretofore well-adjusted man or woman. Some who do not assume that these so-called personality disorders are hereditary or necessarily congenital feel that they are constitutional in the sense that they are basically rooted in the subject's identity. Often these conditions are regarded as borderline states, as falling in an area between psychoneurosis and psychosis or, perhaps, between ordinary conduct and criminal behavior. In the long list of items in "personality disorders," we find that sociopathic personality disturbance, antisocial reaction is defined as follows:

> This term refers to chronically antisocial individuals who are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group, or code. They are frequently callous and hedonistic, showing marked emotional immaturity, with lack of sense of responsibility, lack of judgment, and an ability to rationalize their behavior so that it appears warranted, reasonable, and justified.
>
> The term includes cases previously classified as "constitutional psychopathic state" and "psychopathic personality." As defined here the term is more limited, as well as more specific in its application.[7]

Some feel that it is unnecessarily confusing to place such a disorder as this, which is, of course, the psychopathy so long familiar to clinicians, in the same general category as such minor and usually unrelated problems as somnambulism, enuresis, and speech disturbance. Perhaps in unspoken recognition of the inadequacies of our official schemes of classification, psychiatrists in practice continue to use the discarded term and to understand the specific disorder that each means to designate by it. At a meeting of the American Psychiatric Association, or at a staff conference at a state hospital, if a physician expresses an opinion to one of his colleagues about a psychopath, it is clearly, and at once, understood that he is not speaking of a cyclothymic or schizoid personality or of ordinary homosexuality but of the grave character and behavior disorder so familiar to most psychiatrists as a distinct and easily recognized entity. What can be correctly said about a psychopath in this sense has little or no relevance to most of the other conditions lumped willy-nilly together under the general category "personality disorders."

Let us then confine our chief attention to this entity, to what is now officially listed as the "sociopathic personality disturbance, antisocial reaction," but what, for brevity and convenience, I shall continue to call the disorder of the psychopath. In their recent and interesting study, McCord and McCord[20] gave this definition: "The psychopath is an asocial, aggressive, highly impulsive person, who feels little or no guilt and is unable to form lasting bonds of affection with other human beings." Few who are familiar with the subject would disagree with this accurate statement. Some might, nevertheless, say that these words could be used for other types of maladjustment—that to depict the astonishing entity of the real psychopath more details must be given. But no matter how much we may add, it is difficult, if not impossible, to convey in language the paradoxical, complex, and subtle elements of the psychopath's behavior to one not thoroughly familiar with it directly by experience.

Let us note here a few features, not with confidence that they will give a firm definition but in the hope that they may suggest some aspects of a serious and baffling disorder. The psychopath does not give the impression, even

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on careful psychiatric examination, of being ill mentally, or handicapped, or disturbed emotionally. Nor does he, typically, show any attitude or outlook that would indicate he lacked conscience or chose rebellious or antisocial aims. His reasoning is excellent. What he tells of his fealties, his aims, and his understandings indicates that he is normal, reliable, and utterly sincere. Despite this, his past conduct and what will follow is very likely to bear out the truth of Lindner's statement that here we encounter "the most expensive and most destructive of all known forms of aberrant behavior."[27]

¶ Historical Background

Some students of the psychopath's disorder trace his appearance in the literature back to Pinel's observations of *manie sans délire* well over a century ago. Pinel was apparently confounded to discover, in patients who showed no disturbance of their reasoning abilities, behavior as maladapted to ordinary human goals as that exhibited by many who were psychotic in the ordinary sense. As quoted in Maughs's[31] excellent historical review, Pinel thus expressed himself: "I thought that madness was inseparable from delirium or delusion, and I was surprised to find many maniacs who at no period gave evidence of any lesion of the understanding."

It is probable that Pinel included in the group he designated as "mania without delirium" other types beside the psychopath we encounter today. Many paranoid patients and perhaps some with major hysteria or psychomotor epilepsy might also have exhibited highly logical reasoning abilities despite their aberrant manifestations. Long afterward, another observer, Trélat, expressed something similar about the psychopath in his paradoxical descriptive phrase, *la folie lucide*. Benjamin Rush's observations also strongly suggest that he observed with surprise patients who, without the influence of delusion or the handicap of irrational processes of thought, carried out inappropriate, unrewarding, and self-damaging acts. He assumed that the explanation must lie in a disorder of the "will."

J. C. Prichard,[40] who is generally credited with the formulation, in 1835, of the concept "moral insanity," encountered patients who, despite freedom from intellectual disorder, behaved in such a way as to force him to the conclusion that in them,

> . . . the moral and active principles of the mind are strongly perverted or depraved; the power of self-government is lost or greatly impaired and the individual is found to be incapable not of talking or reasoning upon any subject proposed to him, but of conducting himself with decency and propriety in the business of life.[31]

Few definitions arrived at today can better convey some important aspects of the psychopath.

The concept of "moral insanity" or "moral imbecility" was extremely influential throughout the latter part of the nineteenth century. Henderson[18] points out with regret that a state of "moral defectiveness" is still legally recognized in Great Britain. During the decades when phrenology was ascendant, faculty psychology was popularly regarded as having been well established by scientific methods. Various disorders were logically but unrealistically described as attacking "the will," the "moral affection," "the emotions," the "sense of deity," and numerous other faculties that were regarded by many scientists of the times as discrete and compartmentalized functions which could, in isolation, become diseased or destroyed. Among the clergy, and elsewhere, voices were raised against these new concepts. An American physician insisted that they were designed "to break down all the safeguards of our Christian civilization, by destroying if possible, all ground for human responsibility." A professor of medical jurisprudence, Dr. Ordronaux, in 1873 concisely summarized the argument of those who denied the existence of "moral insanity" in the following statement: "Our moral nature is, like the mind, a special endowment. It feels, it is conscious. . . . Moral nature knows no alterations in rhythm, craves no rest, never sleeps voluntarily. The only disease to which moral nature is subject is sin."[31]

The concept received support from many outstanding psychiatrists, however, among them,

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Maudsley, who believed that the emotional balance of a person could be so disordered by illness that he lost the capacity to appreciate moral issues and to conduct himself in a socially acceptable manner, despite his retention of normal cognitive functions. Mercier also came to the conclusion that: "There are persons who indulge in vice with such persistence, at a cost of punishment so heavy, so certain, and so prompt, who incur their punishment for the sake of pleasure so trifling and so transient, that they are by common consent considered insane although they exhibit no other indication of insanity."[18]

Despite the fact that faculty psychology has been discarded long ago, some of the issues that arose out of the concept of "moral insanity" have a substantial resemblance to some of the problems still unsolved today by those who support the M'Naghten rules, or by those who argue that these are obsolete and believe criminal responsibility can be better determined by the rule followed in the recent Durham case. It is of interest that the early psychiatrists who noted that serious personality disorder could exist without a "lesion of the intellect," seemed to regard it as a genuine illness or disability and to distinguish it from ordinary tendencies to depravity, folly, or crime.

Late in the nineteenth century Koch offered the term "psychopathic inferiority" as a designation for patients with severe behavior disorder. This term in its various forms, "psychopathic personality," "psychopathic state," and "psychopath," through the years developed some curious and ironic implications. Though the term "psychopathic" literally conveys the idea of a sick mind, of mental illness, those so diagnosed have been officially regarded as mentally competent and legally responsible, in contrast with the psychotic. In fact, the practice has been followed in some state and federal institutions of classifying patients under the two diagnostic terms: (1) no nervous or mental disease, and (2) psychopathic personality. The purpose of such an apparently paradoxical conclusion is to stress the point that such a person is not eligible for compensation because of a genuine disability, and that he is also to be held legally responsible for antisocial conduct.

We have noted that even in the time of Pinel other, and often unrelated, types of personality disorder were classified along with what we now regard as the psychopath or sociopath. This tendency has served to promote confusion. Until approximately the last decade, the chief efforts devoted to psychopathic personality seemed to consist of gathering more and more essentially dissimiliar entities under a single and vaguely defined label and then, with great academic labor, subdividing the heterogeneous mass into meticulously differentiated types and subtypes. In these serious efforts to make fine differentiations in minute parts of what was not actually a homogeneous entity, Kraepelin[25] listed seven types of psychopath and Schneider[43] ten.

Some of the subclassifications in these categories, such as *The Liars and Swindlers* and *The Antisocial*, seem to apply to all psychopaths, while others, such as *The Depressive, The Insecure*, and *The Asthenic*, seem not to apply to any type of psychopath but to people with profoundly different emotional difficulties. Kahn,[20] whose textbook *Psychopathic Personalities* was for more than a decade regarded as the chief exposition of the subject, lists sixteen types. Actually the disorders described include all the familiar psychoneurotic reactions and a rich variety of human eccentricities and frailties. Only a very determined reader will be able to find anything in this classic study about the psychopath himself. This is no reflection on the excellence of Kahn's work but rather a commentary on the confusion that can arise when psychiatric usage demands that diverse things be designated by the same term.

Adolf Meyer[32] played an important part in separating behavior disorders from the well-known psychoneurotic reactions. Partridge, approximately three decades ago, carefully distinguished the true psychopath and did much to focus attention on his disorder as an entity.[36, 37, 38, 39] Henderson's study, presented in the Salmon Lectures of 1938,[18] stimulated wide discussion and gave a long-needed emphasis. Karpman, over a period of many years, has discussed the psychopath's peculiar in-

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ability to develop a major and lasting emotional attachment to another person and his persistent failure to grasp in any practical sense the meaning of responsibility.[21, 22, 23]

Characteristic Clinical Features

The typical psychopath is a person who appears to have at least average, and often unusual, ability and who seems to be clearly aware of the amenities and to affirm the moral code. Frequently he demonstrates superior intelligence and other assets and succeeds brilliantly for a while in work, in studies, and in all his human relations. But inevitably, and repeatedly, he fails, losing his job, alienating his friends, perhaps losing his wife and his children. It is difficult to account for these failures. Seldom can one find adequate motivation to explain why such a person has, in the midst of success, grossly shirked his immediate responsibilities, perhaps abandoned his work at the behest of impulses that seem to the observer no more compelling than a trivial whim. However effective he may show himself to be over a limited period, when given sufficient time he proves himself inadequate. His failures deprive him of what he tells us are his chief objectives, and also bring hardship, shame, or disaster to his wife, his children, his parents, and to all those closely concerned with him.

In addition to such relatively passive types of failure, most fully developed psychopaths also commit aggressive antisocial acts. They forge checks, steal repeatedly, lightly indulge in bigamy, swindle, and show little or no compunction about their sexual behavior, no matter what the consequences may be. Some who have attracted wide public attention have committed murder or other shocking felonies, usually with little or no provocation, often without comprehensible motivation. The majority, despite many conflicts with the law, appear to avoid crimes sufficently grave to result in their being removed from society for long prison terms.

It is difficult to illustrate briefly this striking pattern of repeated failure and willful antisocial conduct. Let us, however, consider one case.

A man in his twenties, who has been arrested seventy or eighty times, as a child was often truant from school. Occasionally, he stole from his parents some object such as a watch or a piece of table silver. These acts never seemed prompted by a keen desire or ordinary temptation. He often sold for a pittance the object he had stolen. When truant from school, he did not engage in anything that the ordinary boy might regard as high adventure. He wandered about, engaging, apparently without enthusiasm, in petty mischief such as setting fire to a privy at the edge of town or shooting at chickens with an air gun. Often he hung idly about a drugstore and, vaguely bored, read comic books. During his teens he bought many articles for which he had no particular use and, without asking permission, charged them to his father. Neither punishment nor reasoning influenced his conduct.

Always this young man seemed to understand that he had done wrong, and he solemnly agreed never to repeat the errors that were causing his family so much sorrow. His appearance of sincerity at such times was impressive. After being apprehended, he freely discussed the gravity of his misdeeds and the importance of avoiding anything similar in the future. His stated resolutions did not seem perfunctory or sullen but rather reflected good judgment, insight, and the utmost candor. Despite this, his maladjustment continued. In the late teens he several times drove off in the automobile of some neighbor or in one he found parked downtown. His father, who had considerable financial means and who was influential in the community, faithfully made restitution for his thefts and other damaging acts. His schoolteachers and the minister joined his parents in efforts to influence him.

Those who dealt with him came, in time, to feel that such a continual pattern of misbehavior must differ profoundly from ordinarily motivated rebellion. After he became old enough to obtain a driver's license, his father, thinking that he might have some strong and specific desire to possess an automobile, bought one for him in the hope that it would influence him favorably. Not long afterward, while out driving, he parked the new car, crossed the street, and took possession

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of a battered and inferior vehicle which he later abandoned in the country after a minor accident. Subsequently, after driving another stolen car across a state line, he fell into the hands of the federal authorities.

After months of imprisonment he was granted parole. He appeared to have gained real maturity and expressed the most appropriate intentions about his future. For a while he seemed industrious, confident, and happy in work that he had obtained. Then, without warning to his parents (with whom he was living), he disappeared. Approximately a week later his father received a telephone call from a city on the other side of the state, informing him that his son was in jail. Numerous forgeries and swindlings now came to light, as well as an episode of disorderly conduct in a low dance hall. Our subject had there provoked a quarrel and, after a deplorably unpleasant scene in public, had inflicted a minor injury on one of the waitresses who was trying to restore order.

This habit of casually leaving his parents' home at the behest of any whim persisted over the years. He expressed strong natural affection for both father and mother and was most convincing when he spoke of being willing to do anything to avoid causing them sorrow or distress. Nevertheless, after saying he was going down to the drugstore or perhaps to a moving picture, he would sometimes not return that night or be heard from for many days.

Once a friend of the family, who was thought to be very influential with younger people, set out to counsel him about his problems. The older man was astonished, and also gratified at what appeared to be the frankness and courage with which the younger man faced every issue. So impressed was he with the attitude of our subject that he could not restrain admiration. As plans for the future were discussed, the counselor found himself increasingly influenced by the other's expressed aims and his wise analysis of life and its potential values. In fact, he found himself beginning to give thought to his own status and to possible changes that might enable him to live more meaningfully. After this heartening interview the older man drove the younger to his parent's home. Full of confidence, he departed as his new disciple walked in the front gate. The latter did not, however, enter the house. Strolling casually around it, he went out of the back gate and sent no word to his parents until he was again in the hands of the authorities.

The persistence of this young man's inconsiderate, callous, and antisocial conduct is remarkable. Though his parents have many times paid fines for him and otherwise made restitution, they have not been able to prevent him from repeatedly receiving punishment that would be likely to cause an ordinary person to mend his ways. He appears to learn nothing important from experience. Like many psychopaths he is quite familiar with the correct ethical criteria. He claims allegiance to such criteria and can in words formulate excellent rules and plans for himself to follow. One could scarcely imagine that, in the full sense of the word, he is sincere in all this. Yet, like many other psychopaths, he does not seem to be simply lying, or at any rate to be quite aware that he is lying, or even to grasp emotionally the essence of what is falsehood. Perhaps such people mean for the moment to do what they promise so convincingly, but the resolution passes almost as the words are spoken. Perhaps, like other psychopaths, he can foresee and accurately describe the disastrous consequences of the serious misbehavior that he nevertheless repeats time after time.

This young man illustrates several other features that I believe are typical and highly characteristic of the psychopath. He expresses normal reactions (love, loyalty, gratitude, etc.) with a most impressive appearance of sincerity and depth, but the emotional ties and the attitudes he claims fail to deter him from deeds that continually contradict his verbal profession. There appears to be in him a strange lack of insight, or perhaps a total lack of one of the dimensions that make up insight, for after innumerable lies he still speaks of giving his word of honor. He speaks of this in such a way as to indicate that he expects such a pledge to be taken very seriously, despite the fact that he is addressing a group of psychiatrists to whom he has repeatedly demonstrated his untrustworthiness.

Like many other psychopaths he has demonstrated, sometimes over considerable periods, adequate general abilities and occasionally has

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shown indications of extraordinary talent. But he always throws away what he has gained, what he insists are his chief objectives. No adequate motivation can be demonstrated, or even readily imagined, to account for such conduct. Often the conceivable temptations that appear to underlie his failures and socially self-damaging deeds are extremely trivial, scarcely sufficient to prompt more than a whim if any positive impulse at all. Yet they evoke actions that cause the loss of fortune and the respect of friends, the destruction of marriage, and repeatedly bring about the necessity of his confinement in jails and psychiatric institutions.

The callousness with which this young man ignores the anxiety and distress of his parents suggests an almost total immunity to remorse or feelings of guilt. In situations where one would think his own personal pride is involved he seems similarly immune to shame. Once, while idly seeking an evening's bawdy amusement with several other men, he is said to have legally married a well-known prostitute whose professional services he and his companions had often shared. Neither in anticipation of this step nor afterward did this incident appear to cause him real embarrassment.

Distinctions Between Psychopathy and Other Psychiatric Conditions

Perhaps a comparison of the psychopath's maladjustment with that observed in other psychiatric disorders may help to etch more clearly the strange and puzzling pattern of his conduct.

The Psychotic

No matter how poorly adapted to handle his affairs competently, and no matter how much the psychopath's irresponsible behavior may endanger the lives or property of his fellows, he is technically regarded as sane and cannot be controlled or protected by the legal measures that are utilized to deal with patients suffering from ordinary psychotic disorders. Unlike the psychopath, most psychotic patients show evidence of irrational thinking that can be demonstrated in court. Many are influenced by delusional ideas or by hallucinations that make their aberrant behavior more understandable and, in an important sense, more rational. If a schizophrenic patient hears a voice that he genuinely believes to be God's voice telling him to kill or to commit some other grave offense, and if his delusional ideas furthermore afford him reason to do so, his proceeding to carry out such a regrettable act is not logically incomprehensible. On the other hand, we see the psychopath repeatedly carry out acts as self-damaging, disastrous, and inappropriate as many that are considered characteristic of schizophrenia, without the delusional or hallucinatory prompting. In contrast with the psychotic patient, the psychopath shows no disorder of cognition at verbal or theoretical levels. Nor does he show the profound depression or the overmastering elation that helps us understand much of the irrational behavior of the melancholic or manic disorders. It is, in fact, remarkable how little capacity the psychopath seems to have for normal feelings of depression even under circumstances where one might deem such a reaction natural and inevitable.

The Psychoneurotic

The patients in this category, though they may suffer severely from unreasonable anxiety, have phobic dreads, disturbing obsessive thoughts, and other unpleasant subjective symptoms, behave rationally in their relations with others and often succeed in achieving consistent success in their work. They are no more likely to carry out antisocial activities than is the average law-abiding citizen. Perhaps there is no symptom so common in this group of reactions as anxiety. Here we have a sharp and profound contrast with the psychopath, one of whose most basic characteristics is relative freedom from anxiety and apprehension. This feature of the psychopath appears to be related to his incapacity for genuine remorse and an inability to avoid repeating actions that would ordinarily produce remorse.

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The Ordinary Opportunist, Lawbreaker, or Criminal

Most habitual criminals probably show some features of the psychopath. On the other hand, most of them work more consistently toward obtaining their ends and seem to keep in view some definite goal, however socially undesirable it may be. The ordinary lawbreaker seems also to utilize his gains (for example, the money from a robbery) more understandably than does the psychopath, who often makes little or no use of what he attains as the result of deeds that eventually bring him to disaster. Most antisocial activity, however wrong, is purposive in comparison with that of the psychopath. Many criminal acts, such as, for instance, obtaining a million dollars from the bank by embezzlement, are readily comprehensible in terms of strong motivation. The psychopath, on the other hand, often steals small sums or forges little checks while he is affluent and despite the fact that he can, if he stops to consider the situation, clearly foresee that it will cause him to lose an excellent job and disgrace him among his fellows. Even a fleeting whim, a gesture by which to pass an idle moment, may lead the psychopath to squander the only funds available for his family's livelihood during the next month, to commit bigamy, or to attempt the seduction of his best friend's wife.

The ordinary criminal is usually more consistent than the psychopath in avoiding the consequences of his antisocial acts. The psychopath is often ingenious, and his lack of anxiety or feelings of guilt, as well as his appearance of absolute candor, often enable him to avoid detection. He is likely, however, after many cleverly arranged thefts or swindles, to lose interest in safeguarding himself and to carry out another act under circumstances where his detection is inevitable.

Many criminals show loyalty to other members of their group, and some appear to have a firmly held creed of defiance to law and society. In contrast, the typical psychopath shows no loyalty to anything or anybody. He seldom has a formulated and sincerely held attitude of rebellion but usually claims full allegiance to the principles of law and morality.

Schizoid, Paranoid, and Cyclothymic Personalities

These conditions, as we have noted, are grouped together with the psychopath (or sociopath) as if all were types of a basic disorder and deserved the same generic label. Technically, the schizoid personality is someone who manifests, in a milder degree, tendencies and traits characteristic of schizophrenia, but who is not sufficiently abnormal to be called psychotic. The paranoid and cyclothymic personalities are regarded as standing in a similar relation to paranoia and manic-depressive psychosis. Some would also say that the schizoid features in schizoid personality are static, whereas the disorder in schizophrenia is a process of pathology that is likely to progress or perhaps to remit. Cases diagnosed as schizoid personality sometimes prove to be what has been called ambulatory pseudoneurotic schizophrenia.[19]

Though free of hallucinations and distinct delusions, and able to carry on work in the community, some persons of this sort are profoundly disordered within, despite their deceptive surface of rationality and conformity. I have seen a considerable number of these masked schizophrenics who were more dangerous and, in an important sense, more psychotic, than some of the most obviously ill patients in an ordinary state hospital. The schizoid personality, like the psychopath, has a rational surface and is free from the classic evidences of psychosis. Nevertheless, schizoid people show oddness and peculiarity. They often become fanatically concerned with a cause or even a hobby, and may persevere in it indefinitely. In contrast, the typical psychopath outwardly shows nothing at all that suggests oddness or anything that seems to be a clue to any disability. He is, typically, affable, confident, in every way impressive. Though both schizoid personality and psychopathy may be thought of as masked disorders, the mask of the psychopath is far more deceptive. It is infinitely less suggestive of what lies behind it.

In his interesting novel, *Compulsion*, Meyer

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Levin[26] presents Artie Straus (the character based on Loeb) as behaving and apparently feeling as a real psychopath does. On the other hand, Judd Steiner (the representative of Leopold) appears, at least to this writer, as a person who was afflicted with masked schizoid disorder.

Specific Sexual Deviation

No one familiar with the psychopath will deny that his sexual attitudes and activities are far from normal. While it is true that some homosexuals and many sadists may also show features of the psychopath, it seems to me misleading to try to identify the two groups. My own experience has led me to conclude that most psychopaths have a heterosexual orientation but that, as in all major activities, their relations with the other sex are extremely superficial, impersonal, and, in comparison with those of the ordinary human being, virtually meaningless. Here, as with parents or with children, they seem incapable of loyalty or of deep need. None of the emotional attachments they claim are genuine or lasting. Typically, they give the impression of sincerely devoted lovers and often evoke the loyalty of mates who suffer repeated outrages and betrayals at their hands.

Some psychopaths indulge occasionally in deviated sexual acts with real homosexuals, probably less through a specific tendency in this direction than through lack of restraint and compunction toward acts generally regarded as distasteful or dishonorable. A few psychopaths I have known sometimes resorted to homosexuals in order to obtain easy money at times when it was not readily available elsewhere. When the suffering and humiliation every psychopath brings upon his mate are contemplated, one might be tempted to say that all of them are truly sadistic. It is my impression, however, that the usual psychopath does not derive specific erotic pleasure either from physically hurting a sexual partner or from causing his wife to suffer through his neglect, his criminal or disgraceful acts, or his gross infidelity.

If true sadistic tendencies are combined with the psychopath's lack of compunction, a formidable menace to others results. According to evidence brought out at the trial of Neville G. C. Heath, this man followed an extremely irresponsible career for many years.[5] On several occasions he was court-martialed and discharged from the military service. Forgeries, thefts, housebreaking, impersonation of an officer, fraud, and many elaborate episodes of swindling brought him repeatedly to the attention of the police. The history available about this handsome, attractive delinquent prior to his two sadistic murders strongly indicates the typical psychopath.

These murders were acts of memorable brutality and horror. Each of the two young women tortured and killed by Heath within a period of three weeks was cruelly butchered. The sexually sadistic quality of Heath's behavior on these two occasions is made plain by the nature of the mutilations. A nipple was bitten entirely from one girl's breast. With the other girl, this had almost been accomplished. At the autopsy both showed that some instrument, perhaps a poker, had been thrust with violence into the vagina, rupturing it and damaging the abdominal viscera. One body had been lashed severely. The abdomen of the other had been ripped open. Heath is described as being extremely calm and poised after these deeds, and entirely free of remorse. After the first murder he spoke with great interest about accounts of it in the newspapers, expressed opinions about how the gruesome wounds might have been inflicted, and even communicated with the police, offering to help them discover the murderer.

It is my opinion that only a small proportion of typical psychopaths commit murders. Those who have this propensity are probably the most dangerous and the most ruthless of all criminals. They are also the most likely to repeat their crimes, no matter what reformation they claim to have achieved. They are unmatched in giving the impression of profound sincerity, in swearing a convincing allegiance to all that is good and lawful.

The Mental Defective

Ordinary mental defect, the simple lack of sufficient intelligence to foresee accurately the

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consequences of one's acts in all the complications of this life, readily accounts for repeated failure in some people, and also for some crime, misdemeanor, and folly. If the deficiency is severe, it may render the person incompetent to carry out the ordinary affairs of life. The results of such a handicap as this are easily comprehensible. In contrast with the psychopath, mental defectives show poor judgment and reasoning power that can be demonstrated in theoretical situations. They cannot construct, in words, brilliant plans for the future or discuss their affairs in such a way as to give a convincing impression of wisdom.

The typical psychopath, in contrast, shows no evidence of a cognitive defect that might account for the failures and follies of his career. Not only on psychometric tests but also by his actual accomplishment during periods when he is putting his abilities consistently to use in constructive projects, he may demonstrate superior intelligence. His disorder cannot be detected except through study of the full conduct of his life, the goals he actually seeks, what distracts him from ordinary aims, his affective relations with family and friends, and his detailed interaction with society.

Other Character and Behavior Disorders

Though delinquency is not primarily a medical term, it is useful to designate milder, less persistent, and more circumscribed disorders of behavior and frictions with the social group. The word suggests a maladjustment not expressed in felonies or other major transgressions but in a repetitious series of annoying improprieties, failures, misdemeanors, or derelictions of duty. As with the psychopath, adequate motivation is not often obvious for the pursuit of these milder patterns of delinquent behavior. Close study may, however, reveal conflicts, frustrations, and dissatisfactions that are prompting such conduct as a revolt or protest against an unpleasant situation. Healy long ago was impressed by the purposive nature of delinquency and pointed out that under similar conditions of rejection or insecurity one child withdraws and develops anxiety, while another, apparently in response to the same stimulus, becomes defiant and engages in various types of mischief.[16,17] It is quite possible that the true psychopath's grossly self-defeating and antisocial way of life may also represent some graver and more persistent revolt of this sort. Convincing evidence for this is, in my experience, much more difficult to find in the psychopath.

Probably most people, in the process of growing up, engage in destructive pranks and other socially unacceptable acts. In a good many who later become well-adjusted and law-abiding members of the community, such behavior during adolescence may include some truly regrettable deeds and may extend over a long period of time. Some adults show persistent delinquency about paying bills but do not show the psychopath's generalized irresponsibility. Others conduct themselves promiscuously and deceitfully in sexual matters but remain reliable in financial affairs. The milder and more circumscribed behavior disorders, particularly those manifested in the teens, should not be precipitately identified with psychopathy.

The Alcoholic

Psychopaths, when drinking, often indulge in outlandish or outrageous behavior. Some of them, of course, become alcoholics. On the other hand, though the alcoholic often neglects his responsibilities and fails in his goals because of the disabling effects of excessive drinking, he does not usually show the incapacity of deep affection and the callousness that careful scrutiny reveals in the psychopath. Many alcoholics drink too much because of anxieties and emotional stresses to which the psychopath is immune. The impulse in the alcoholic to evade his problems by the influence of drink often leads to a vicious circle whereby his lack of sobriety makes additional problems for him or makes worse his old ones. Often, serious patterns of self-defeat develop. When the psychopath drinks excessively he is seldom, if ever, driven by distress and conflict but seems to use alcohol to catalyze his unengaging and socially unacceptable antics.

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¶ Medicolegal Status

The psychopath, by whatever term he might be labeled, has been almost universally judged sane by the courts and regarded as free from psychosis by physicians. In the determination of both legal competency and legal responsibility, it is, traditionally, the subject's reasoning abilities that are investigated and evaluated. Though competency and responsibility are often thought of as approximately equivalent, there are some important legal differences that the physician should consider.

Urgent questions of competency sometimes arise when it is thought by a patient's family that he is in need of treatment in a hospital. If he denies this need and refuses to go, as indeed many psychotic patients do, before it is possible to send him to a hospital for treatment against his will he must be pronounced incompetent by the court. If such a patient shows a gross derangement in his reasoning, expresses delusional ideas, and reports hallucinations, there is little chance that the court will fail to commit him to an institution. Few will question the incompetency of a man who expresses himself thus: "Gentlemen will you come to . . . and idenafy none ministrative body that receives the life generated by fourth patented generator below sound. . . . Until you gentlemen decide further What my occupation is you may as well announce me as comforting 35 Whirlpools below sound."[3]

The man who, in clear, well-formulated language, claims that the Masons or the Knights of Columbus are persecuting him because of the uranium in his blood will also be considered insane. Though such derangements of reasoning usually play the chief part in technically establishing incompetency, there are often other factors that may exert considerable influence on the lunacy commission. Prominent among these are such questions as: Is this man a serious menace to himself and others? Is he incapable of sustaining his life if left to his own devices?

As all psychiatrists realize, many patients who maintain bizarre delusions and continue for years to experience hallucinations do no harm to themselves or to others. These manifestations, it is true, indicate that they are psychotic. But some psychotic people are able to adjust themselves as unrestricted members of the community, to avoid harmful or annoying conduct, and even to support themselves. Among numerous examples known to me is a woman who has been hearing a voice for many years. She believes it comes from her stomach. Often she heeds its advice, which, on the whole, has been fairly sensible. If this woman developed tendencies that threatened her own safety, such as refusing to eat, or meditating half the night in the privacy of her own back yard clad only in a nightgown during a blizzard, the fact that she has auditory hallucinations would ensure and expedite her commitment.

The psychopath whose competency is questioned will show no defect in his reasoning in so far as this can be demonstrated in court. He remains free of delusions and hallucinations, and everything he says is likely to give the impression that he has excellent judgment and the best of intentions. If he opposes efforts to send him to a hospital, it is impossible to show technically valid grounds for commitment, even though he has demonstrated for years a far greater maladjustment in the community than has the average patient who is sent to a state hospital. Since there may be good reason to believe that he will seriously injure or even kill his wife, and a virtual certainty that he will continue in fraud, larceny, and forgeries, impoverish his family, seriously disturb the normal development of his children, and otherwise gravely and persistently damage society, the need to bring him under some sort of control often far exceeds such a need in patients belonging to any other diagnostic group.

It is true that the wife whose life is threatened may take out a court order in an effort to protect herself. A true psychopath is not likely, however, to be deterred by such a measure if his fancy really prompts him to kill her. Those who are unfamiliar personally with the psychopath are likely to think that his forgeries, thefts, assaults, and other repeated conflicts

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with the law will keep him sufficiently controlled through imprisonment. This does not usually occur. Only those who have followed the career of many psychopaths over the years can appreciate the magic skill by which they evade lasting confinement and return again and again to their old damaging pursuits.

The psychopath characteristically makes an excellent impression in court when he wishes to avoid commitment. He makes a similar impression before parole boards. When on trial for a legal offense, if it serves his purpose to appear afflicted with disorder, many psychopaths are able to point out that they have been in mental hospitals a half-dozen or a dozen times. Some very cleverly simulate the manifestations of ordinary psychosis. A good lawyer, reviewing the formidable record of purposeless folly and self-defeat, seldom finds it difficult to persuade the jury that the defendant is not normal, that mentally or emotionally he is unbalanced and should receive treatment, not punishment. Time after time, decisions are made to send these people to a psychiatric institution instead of to jail. There they are diagnosed as sociopathic personalities and promptly released. The families of many psychopaths, still clinging to the hope that they will change, repeatedly pay fines and make restitution to those who have been damaged. Such kindness and hope result in the psychopath's remaining free to do additional mischief. If the wife and parents of such a man finally decide to let him take the consequences of his actions, there are usually several women at hand whom he has somehow charmed into the belief that he is at heart a most honorable gentleman, who is misunderstood and now in need of their support. They use every influence available to help him evade legal consequences and have "another chance."

I do not maintain that real psychopaths never serve terms in prison. Those convicted of felonies undoubtedly are segregated from society, sometimes for long periods. It remains, however, a remarkable fact that so many psychopaths repeatedly evade penalty and restriction and remain free to continue their damaging conduct. During recent years, in some courts with which I am familiar, extremely disordered psychopaths have occasionally been pronounced incompetent and sent to psychiatric institutions against their will. In such instances concrete evidence in their behavior was carefully weighed and apparently regarded as of more pertinence to the question than the intact verbal reasoning demonstrated by the psychopath.

In decisions about competency and commitment, a person is ordinarily examined by a lunacy commission appointed by the court and consisting of two physicians and a lawyer. When the psychopath is on trial for breaking the law, he is ordinarily tried before a jury. As we have noted, under these circumstances he often succeeds in using the impressive accumulation of outlandish misconduct in his past to evade or partially evade punishment. When the psychopath commits a maximally grave felony, such as murder, the question not of competency but of responsibility emerges as a crucial issue. This is a question to be decided not by a commission of experts but by a jury of laymen. In the past, typical psychopaths have nearly always been adjudged as having full legal responsibility and thus as being subject to the ordinary penalties for their crimes.

In most of the United States and elsewhere in the English-speaking world, the jury determines responsibility by the well-known M'Naghten rules. According to Hall, the core of these rules lies in these words:

> . . . to establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was laboring from such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.[14]

Interpreted literally or narrowly, these rules seem to confine attention to pure cognitive processes which, in the psychopath, certainly show no demonstrable disorder. Thus interpreted, the rules would also establish legal responsibility in many schizophrenic patients. Surely every psychiatrist has seen delusional and hallucinating patients who could clearly

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express their knowledge that it is wrong to kill and also to steal. Such patients, unlike the psychopath, may also apply this knowledge to their conduct and refrain from malfeasances small and great.

The rules have, in rare instances, been interpreted so narrowly that a psychotic person driven to murder by his delusions has been adjudged as legally responsible. Guttmacher[12] cites the case of a schizophrenic man who was heard to say that he knew it was wrong to kill but that he must (for delusional reasons) nevertheless kill a man he held responsible for his wife's death. Voices kept telling him that it was imperative for him to carry out this deed in order for her spirit to obtain peace. Because of this man's having said he knew it was wrong to kill, the court held that he was a responsible agent.

Generally, the M'Naghten rules are not so narrowly interpreted. If the defendant is influenced by delusions, or hallucinations, most jurors today are likely to concede that his appreciation of the nature of the act he committed was probably distorted. Evidence of so grave a mental disorder would be considered by many as necessarily interfering with adequate evaluation of his conduct.

In a relatively small number of states the concept of "irresistible impulse" may also be brought forward as grounds for establishing the legal irresponsibility of a defendant. Though such a concept may be thought of as a step to avoid confining the judgment to a theoretically disparate faculty of cognition, in the opinion of many, it leaves the door open for dubious and sometimes specious arguments that can extend all the way into the philosophical areas of free will and determination. When the presence of an irresistible impulse is claimed, the thoroughgoing determinist may find it difficult logically to maintain that any defendant under any circumstances is legally responsible.

True folly can arise when one attempts to examine a "will power" verbally isolated from the integrate of human functioning and to localize illness in such a hypothetical faculty. The question of whether a criminal impulse is pathologically strong or whether what attempts to resist it is pathologically weak can lead readily to debates of great impracticality and irrelevance. Jerome Hall makes an excellent point when he emphasizes the fact that a widespread use of the concept of irresistible impulse to confer irresponsibility for crime would have the effect of making "irresistible an impulse which now is resistible and resisted because of penal laws."[14]

Many psychiatrists and others concerned have condemned the M'Naghten rules as unrealistic, worthless, and misleading. It has often been said that they are based on long obsolete concepts of human personality function, that they completely ignore important scientific discoveries of psychiatry, which, if utilized, would now enable us to determine responsibility with far more accuracy. Some opponents of these rules are sweeping in their rejection. Zilboorg[47] expresses himself thus:

> When they . . . ask me whether the defendant in the dock is in my opinion insane, I must candidly state, if I am to remain true to my professional knowledge and faithful to my oath, first that I do not understand the question and, second, that since I don't understand the question I do not know whether the defendant is insane or not. I admit the situation is embarrassing and puzzling to all concerned, but it is beyond my knowledge, and power to remedy or alleviate it.

Opponents of the M'Naghten rules have hailed as a major step forward in medicolegal matters the decision of Judge Bazelon in the Durham case.[15,29] In coming to this decision, the court formulated a new test of criminal responsibility which has been enthusiastically acclaimed as a means of allowing scientific facts to be applied to this problem. Judge Bazelon expressed the opinion that "in attempting to define insanity in terms of a symptom (i.e. irresistible impulse or moral knowledge), the courts have assumed an impossible role, not merely one for which they have no special competence." The essence of the new test is contained in these words, "An accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect."[8]

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This test apparently broadens the field of inquiry and gives the psychiatrist-witness all the freedom he has been demanding to apply his modern scientific knowledge of the human mind and its disorders. Some psychiatrists, however, are less confident than others that today we possess sound knowledge that regularly affords us the final answer to such a question. Despite the optimism with which many psychiatric writers, who condemn the M'Naghten rules, speak of the scientific facts that modern psychiatry can bring to bear in efforts to determine responsibility, there are others who would grant that the outstanding neurologist Walshe is not entirely in error in the words that follow:

It is important to realize that there is no generally accepted body of psychiatric doctrine or practice, but that there are, on the contrary, many conflicting and incompatible schools of both, while the psychiatric body is rent with fierce intestine feuds on matters both of theory and practice. There is no science of psychological medicine in the sense in which the term "science" is used by natural scientists. Psychiatry and psychological medicine is, in fact, not a branch of natural science, and, if it has any scientific affiliation at all, it is with historical science. . . . Thus we see psychiatry swinging perpetually between allegory and machinery in its theory and practice, from the attempted exegesis of dreams to what in a barbarous neologism is called psycho-surgery.[5]

Jerome Hall[14] maintains that the M'Naghten rules, if used sensibly and in the light of concepts generally agreed upon in psychiatry today, constitute a valuable instrument which should not be discarded. Psychiatrists today do not think of personality function in terms of abstract and isolated faculties. It is difficult to conceive of a person "thinking" without also "feeling." One is not likely to experience volition entirely free of emotion. What has been observed of human function strongly indicates that it is integrated, that it cannot be broken down in actuality into the fragments such words as those above indicate. With this in view, Hall makes some excellent points in support of these rules:

This view of the participation of the rational functions, including evaluation, does not imply any depreciation of the role of the instincts in normal conduct. For consistently with this theory, one asserts the fusion of various aspects of the self. This means that moral judgment ("knowledge of right and wrong") is not reified as an outside, icy spectator of a moving self; on the contrary, the corollary is that value judgments are permeated with the color and warmth of emotion, as is evidenced by the usual attitudes of approval that coalesce with right decisions. Indeed all action, especially that relevant to the penal law, involves a unified operation of the personality. . . . The M'Naghten rules provide an analytical device for dissecting this action.[14]

In my opinion the questions of responsibility and competency, as far as the psychopath is concerned, should be considered separately. I strongly believe that any patient's demonstrated incapacity to handle his responsibilities and to avoid bringing serious trouble to himself and others should be given weight in decisions about competency and commitment. In this I am in agreement with McDougall[30] who wrote that the true criterion for all such decisions should be: "Can the patient be trusted to look after his affairs without undue risk to himself and others?" He then adds, "And there is no other criterion." I do not think it will ever be possible to bring the psychopath under sufficient control to make practical efforts toward the solution of the grave problem he poses until this criterion is regularly given due consideration in questions of commitment.

If one follows the new rule devised by Judge Bazelon, the question of responsibility in the psychopath would depend chiefly on whether one found it correct to define his abnormality as a "mental disease or mental defect." It has long been customary in psychiatry and law to distinguish sharply between this abnormality and all the conditions to which the terms "mental disease" or "mental defect" are applied. Few psychiatrists could doubt that crimes committed by a psychopath are the product of his aberration. The psychiatrist-witness's opinion would, inevitably it seems, depend on whether or not he classified this aberration as mental. This decision, it seems to me, would in turn substantially depend on whether or not this term is limited

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in its meaning to an assumed disparate faculty of cognition. Thus, as far as the psychopath is concerned, it would appear that the psychiatrist in court is faced with essentially the same decision, whether he testifies under the M'Naghten rules or the Durham test. Either may be interpreted narrowly and confined to mere cognition or more broadly, as Jerome Hall[14] suggests that the M'Naghten rules be interpreted. Despite some very important achievements in the last half century, psychiatry does not today, in my opinion, possess newly discovered and well-established facts which afford a scientific answer to the ultimate questions that arise in determining responsibility.

¶ Diagnostic Criteria

Perhaps it may be useful to list the major points that I have found particularly characteristic of the typical psychopath whose life pattern might be taken as the core of a general concept of this disorder.

Unexplained Failure

There is no cognitive deficiency in the ordinary sense but usually at least average and often distinctly superior intelligence, as determined in psychometric examination or by the easy achievement of temporary success in studies or business for as long as his abilities are consistently employed. Despite this, he inevitably fails in every constructive activity he undertakes.

Undisturbed Technical Intelligence

The good reasoning abilities with which he is endowed are not disrupted or disorganized, as in psychosis, nor are they distorted by the influence of delusions or hallucinations. Nothing is demonstrable in his thinking at a theoretical level that accounts for the irrationality of his conduct in life.

Absence of Neurotic Anxiety

He is not handicapped by anxiety, phobias, obsessions, hypochondriacal preoccupations, or other manifestations commonly regarded as psychoneurotic. He is often poised and at ease in many situations where the average person would be tense and apprehensive.

Persistent and Inadequately Motivated Antisocial Behavior

Nevertheless, he persistently follows a pattern of antisocial behavior that is usually also self-defeating and frustrating to all the aims he claims to pursue. No adequate motivation can be found for such behavior, and often the stimuli that provoke it seem scarcely comprehensible.

Irresponsibility

Despite the strong impression he gives of being a steadfast and reliable person, he will, eventually, ignore even the gravest of responsibilities and often for the most trivial of reasons. Such failures do not, of course, occur immediately or uniformly. Not all his checks bounce. He is not arrested daily. But, after gaining security for himself and the confidence of others, he will invariably shrug off his major obligations and throw away all that he has gained.

Peculiar Inability to Distinguish Between Truth and Falsehood

His disregard for truth is remarkable. Usually, he seems confident and at ease when making a solemn promise he will never keep, or when attempting to exculpate himself from charges of misconduct. Whether there is a good chance that he will get away with a lie or whether detection is almost certain, he shows no sign of perturbation and coolly maintains his position. While committing the most serious of perjuries, it is easy for him to look anyone calmly in the eye.

Often the solemn falsehoods he perpetrates are entirely unnecessary. For example, a psychopathic husband, already divorced by his wife, wrote in the footnote of a letter to her matter-of-fact instructions about the insurance policies he was sending under separate cover to provide for her and their children. There

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were no insurance policies and he had never seriously considered providing for his family in this way or in any other. He was well aware that he would soon be found in falsehood about this, and he had nothing to gain materially by such a lie.

Inability to Accept Blame

Though he brings disaster repeatedly upon himself and others, he never accepts responsibility for it. As long as possible, he denies any part in what has occurred. When the facts are too plain for this, his expressions of regret may be eloquent and convincing, his plans for restitution admirable. His actions, however, indicate that no appreciable remorse has been experienced. It is doubtful if he is capable of feeling sufficient guilt or shame to influence him beyond the moment.

Failure to Learn by Experience

Despite the unimpaired reasoning ability that he demonstrates in theoretical situations and the foresight with which he describes his plans for the future, he shows extremely defective judgment when he becomes an actual participant in the affairs of life. No matter how many times he comes to frustration or disaster, he does not learn by such experience to avoid the type of conduct responsible for his failures.

Incapacity for Love

Though often cordial and apparently affectionate, the psychopath's behavior strongly indicates that he is incapable of genuine love, that he cannot form enduring personal attachments. This is not to say that he does not react with minor and ephemeral affect of this sort. He is also often eloquent and convincing in speaking of his devotion and his personal commitments. Psychopaths of both sexes, through this appearance of warmth and sincerity, often win the loyal love of a mate who endures repeated outrages in the relation. Though the psychopath may show transient generosity in many small matters, in crisis and in the continuing pattern of his conduct a formidable egocentricity emerges. Despite a ready and sparkling display of shallow feelings, particularly in trivial relations, in all his major affective relations there emerges evidence of astonishing callousness.

Inappropriate or Fantastic Reactions to Alcohol

It has been noted that the ordinary alcoholic should not be identified with the psychopath. Though some psychopaths do not drink at all, many indulge in sprees during which alcohol seems to catalyze their tendency toward uninviting, buffoonish, or destructive behavior. Often a small amount of drink will bring out in psychopaths what would never emerge from a normal person, even in extreme intoxication. One psychopath, after two highballs, began spitting on the floor of his host's living room. Another, after more liberal use of stimulating potations, climbed a tree in the residential section and, in broad daylight, undressed himself, while hurling imprecations at a policeman below.

Lack of Insight

Though many observers regard the psychopath as having insight because of what he can express in words about himself and his situation, his actions repeatedly demonstrate that his grasp or realization of what he has expressed is insubstantial. Often, it seems little more than an empty verbalism, not really insight but a clever mimicry of insight. He is remarkably lacking in the capacity to see himself as he appears to others and to view his conduct as others see it, to evaluate the sorrow he brings and the damage he does to others. The nature of this limitation has been several times illustrated for me by brilliant psychopaths, who knew me to be painfully familiar with their astonishing records of dishonesty and irresponsibility, but who nevertheless submitted my name as one to recommend them for positions demanding trustworthiness and stability.

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Shallow and Impersonal Responses to Sexual Life

The sexual life, in both male and female, is almost inevitably promiscuous. Some have concluded from this that the psychopath is driven by extraordinarily powerful sexual urges. I believe that this is unlikely. Even the feeblest of urges would have no difficulty in gaining expression against what forces of compunction or shame might, in the psychopath, be mobilized against it. Usually, psychopaths seem no more strongly motivated in their sexual irregularities than in petty thievery, the passing of a bad check, or the numerous other disloyal, shameful, and dishonorable acts they commit of a nonsexual nature. The sexual experiences of these people are probably impersonal, emotionally trivial, and poorly integrated with their alleged goals.

Suicide Rarely Carried Out

A few decades ago, most psychiatric textbooks described the psychopath as often having strong suicidal tendencies. The percentage of suicides among the group classified as psychopathic personality reported by some observers was indeed impressive. I am inclined to believe that such statistics reflect not a tendency to suicide in a psychopath but in others included, as I have noted above, under the same general category. The psychopath, or sociopath, in the sense to which I am restricting the term, often threatens suicide or even carries out sham efforts, sometimes with high drama, to give the impression he has tried to end his life. As a group, these patients have impressed me as lacking the capacity for remorse, true depression, or the deep realization of failure that forces patients with other disorders to suicide.

The position in which a psychopath sometimes finds himself, after a succession of self-imposed failures, acts of deep disloyalty, public episodes of disgraceful behavior, or serious crimes, is often one that would cause limitless despair in a normal person, that would make strong impulses toward suicide readily understandable. Having thrown away all that man ordinarily desires, with his family in disaster and himself in confinement, the psychopath, though he detests the restriction of prison or hospital that he has brought upon himself, appears almost immune to the sort of anguish and despair that would be inevitable in another. It is my belief that the rarity of suicide among true psychopaths is an important characteristic.

Persistent Pattern of Self-Defeat

Many psychopaths, it has been noted, succeed for a while, sometimes brilliantly, in various worth-while pursuits. In surveying the long and impressive record of failures, disorderly activities, and arrests that accumulate behind a psychopath, these temporary periods of industry and effectiveness are sometimes overlooked. One of the truly remarkable features of this life pattern is that a person who shows so concretely the ability to succeed will throw away all he has gained, and apparently what he desires, for no reason comprehensible to others. Sometimes these people, after periods of excellent adjustment and apparent contentment, seem deliberately to go out of their way to bring disaster upon themselves. The intricate pattern of gratuitous folly, nonsensical failure, and unprovoked social aggression repeated over and over may indeed impress one as an expression of madness. The careful observer may be forced to ask himself: If this is sanity, can it be more than sanity in name only?

¶ Etiologic Factors and Attempts at Interpretation

For many decades it was generally assumed that the psychopath's abnormality must be the result of hereditary defect. Numerous statistical studies seemed, indeed, to furnish convincing evidence for this assumption. Almost all the early investigations of this sort were made on heterogeneous groups. Many included patients with gross physical defects and other signs thought to be indicative of neuropathic taint. Even in more recent studies,

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it seems likely that other patterns of delinquency as well as schizoid, paranoid, cyclothymic personalities, and other conditions listed under the general category "personality disorder" may be included with the primarily sociopathic reaction. Many of the reports during the last few decades on investigations to determine the influence of hereditary factors have been contradictory. Nevertheless, the very recent work of Newkirk,[34] indicating that hereditary factors are probably important, deserves careful consideration. Thompson[46] also has presented evidence to support the contention that organic neurologic disorder underlies psychopathic behavior.

Some electroencephalographic studies[10, 44] suggest that a significant proportion of psychopaths show abnormal tracings. These findings certainly imply an organic basis for the disorder. Other reports, however, indicate that no higher incidence of abnormality appears in the electroencephalographic records of this group than among normal people.[45] It is difficult, at present, to maintain that the electroencephalographic investigations have established generally accepted evidence for or against a neurologic basis for psychopathy.

During recent decades increasing emphasis has been placed on the influence of environmental or psychogenic factors. Some observers appear to be convinced that these play the major part in causing the psychopath's disorder. Positive statistical evidence to support this explanation, as far as I know, is also lacking. Numerous dynamic explanations of the psychopathic pattern of behavior have been brought forward, and through analytic methods some investigators have found what they regard as the primary causal influences in early childhood or infantile experience. Of such efforts the work of Franz Alexander[2] has probably been most influential. Through psychoanalytic investigation he came to the conclusion that severe unconscious conflicts are within the typical socially destructive patient, that these give rise to impulses that are acted out in behavior rather than, as in ordinary psychoneurosis, experienced as anxiety. Alexander used the term "neurotic character" to designate such a disorder, and many psychiatrists have regarded this as a synonym for the psychopath. Others make a distinction.

Lindner[28] reported investigations by hypnoanalysis through which he believed he discovered the origin of a psychopath's disorder in an incident that occurred when the patient was between six and eight months of age. Lindner felt that he obtained evidence under hypnosis, through preverbal memory, that the patient was at this tender age terrified by the sight of his father's penis (during intercourse between the parents), and that castration fear was a major factor in his adopting a psychopathic mode of life. Karpman,[22] though he believes that some patients regarded as psychopaths are constitutionally abnormal, maintains that the behavior of most represents a reaction to unconscious neurotic conflict. Some physicians have regarded the psychopath as a product of extreme parental spoiling. Others have concluded that convincing evidence shows early parental rejection often to be a crucial factor.

My own experience with psychopaths certainly does not suggest that they appear only in families of inferior moral or intellectual levels. A good many of the most seriously disordered psychopaths I ever encountered had successful and sometimes very distinguished antecedents. I have not regularly encountered any specific type of error in parent-child relation in the early history of my cases. This, of course, does not afford proof that such specific errors may not play the regular and important role in causation assumed by some observers. I am increasingly impressed with the difficulty in obtaining objective and reliable evidence of what was felt twenty or thirty years ago between a child of one year (or of three) and his parents. Assumptions about infantile, and even intrauterine, experience are sometimes made solely on the basis of analogy and symbolism. These methods can be used with such elasticity that it is not difficult to "discover" in the unconscious virtually anything the investigator chooses to seek.[4] I do not believe that convincing evidence of the causal factors and developmental pattern of psychopathy has yet been established.

Aside from its possible causes, the nature of the psychopath's disorder brings up puzzling

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questions. Why should a person who demonstrates all the adaptive facilities needed for a successful life regularly come to such egregious failures? In his outer aspect he appears to be functionally perfect. Yet his behavior suggests that a deep disorder, involving the basic sources of emotion and judgment, must prevent him from utilizing correctly the intact outer mechanisms of personality that he so clearly possesses. This concept may be clarified by a comparison with semantic aphasia.

In this deep, and one might say concealed, speech disorder, the patient can often speak words and sentences correctly or even fluently. Yet such a patient does not understand what he has put into language. Though his peripheral mechanisms of speech function and produce the words as sounds, they do not really express their apparent meaning. In fact, it is probably accurate to say that speech in this disorder, however well formulated, has no meaning and is not language at all. In the sense in which the term is used to designate this type of speech disorder, one might conceive of the psychopath as being disabled by a *semantic* personality disorder. The true abnormality is thoroughly masked by the surface, by the unimpaired mechanical operation of all functions that can be perceived by the observer. But, lacking the connections with, and the correct motivation from, a normal inner core, these peripheral facilities are not sanely employed. They produce, instead, only a mimicry or illusion of true sanity.[3]

¶ Treatment

The successful treatment by Freudian psychoanalysis of patients regarded as psychopaths has occasionally been reported.[42] Lindner,[28] using hypnoanalysis, also reported remarkably good results with several cases in relatively brief periods of therapy. Karpman[22] has expressed optimism about the beneficial effects of prolonged psychotherapy on the majority of those classed as psychopaths, who, he maintains, are actually neurotic. A minority, whom he designates anethopaths, are regarded by him as being emotionally abnormal at the core of the personality and thus unamenable to treatment. A very few workers have reported worthwhile results with electric shock treatment and with lobotomy operations. Rarely, one encounters statements that improvement was obtained by the use of drugs, by counseling, and by various other methods of psychotherapy.[29] It is generally agreed that punitive measures such as imprisonment are not likely to produce favorable changes in the real psychopath.

The work of Aichhorn,[1] Redl,[41] and others with milieu therapy, particularly in dealing with youthful delinquents whose behavior suggests that of the adult psychopath, has attracted a great deal of attention. Some who have used these or similar methods are more optimistic than most psychiatrists who have dealt extensively with adult psychopaths. The McCords,[29] in their recent book *Psychopathy and Delinquency*, attempt to evaluate the curative effects of milieu therapy on very young boys (average age eleven years) at the Wiltwyck School in New York where in "a warm permissive environment . . . individual and group therapy combine their techniques." After a painstaking study, including the application of psychological tests designed by the authors specifically to measure psychopathic tendencies, the McCords conclude that, "the Wiltwyck environment, 'a new situation' causes radical alterations in personality." They add: "When the children return to their homes (generally in slum neighborhoods) the 'situation' again changes, and their attitudes and actions may change with it. Yet the extent of change in the boys' characters offers substantial hope that the effects of treatment are permanent."

Though, as noted above, a few have been encouraged about psychoanalytic treatment for psychopaths, other analysts are far from optimistic. Phyllis Greenacre[11] points out that favorable changes are often illusory and quickly vanish, leaving "the fundamentally unsound organization of the personality of the psychopath . . . not . . . much influenced or even touched." On the basis of my own experience with patients of this type who have been treated by competent analysts, I find myself today in agreement with O'Malley who in

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1924, after reviewing the results of analytic treatment in psychopathic personality, had to conclude that it "has proven a failure."[35] All other methods available today have been similarly disappointing in well-defined adult cases of this disorder with which I am directly acquainted.

It seems to me, nevertheless, that important steps can be taken toward arriving at a better solution for the many problems posed by the psychopath than any existing today. First of all there is needed a more general recognition of his disorder as a genuine illness or psychiatric abnormality, a specific pattern of malfunctioning that, in severe cases, causes maximal disability and makes it impossible to maintain his role as a responsible member of the community. If the laity could become more familiar with the ever-accumulating sorrow, damage, despair, confusion, farce, and disaster that each psychopath leaves in his path, organized efforts might be aroused to devise adequate medicolegal means of restraining him in his now virtually unhindered career of destruction. At present, most psychopaths elude restriction. Neither penal institutions nor psychiatric hospitals possess the means of holding them long enough to afford the community protection or to give an adequate trial to the various therapeutic measures that are attempted. Though the record of their extreme incompetency may facilitate obtaining exoneration or leniency in the courts when faced with imprisonment, it does not, as matters now stand, enable society, through commitment, to keep them under psychiatric supervision.

Let us here put aside the questions that arise concerning criminal responsibility in murder and separately consider what legal means can be obtained to bring psychopaths, who are obviously and grossly disabled, under better control. In order to do this, it will be necessary for the facts of their conduct to receive adequate attention in estimating their status. In attempts to determine his competency, or incompetency, the examination must not be confined to the psychopath's abstract powers of reason—to his judgment as an outsider in theoretical situations. Full consideration should be given to what he does as well as to what he says. This type of disorder, like schizoid, cyclothymic, and paranoid disorders, occurs in varying degrees of severity. The courts do not commit relatively well-adjusted people with distinctly schizoid or cyclothymic abnormality. So, too, no sensible person would argue that people showing evidence of mild behavior disorders and delinquencies should be identified with the maximally disabled psychopath and pronounced incompetent.

If a means became available of obtaining adequate control over psychopaths who plainly show themselves not fitted for unrestricted freedom in the social group, it would be possible to set up facilities specifically designed to deal with their problems. Our large state and federal psychiatric institutions, organized for the treatment of patients psychotic in the traditional sense, are not well adapted to handle the psychopath. The numerous private hospitals primarily designed for the needs of psychoneurotic patients lack the means of restraining him and are unable to deal adequately with the problems he creates. The establishment of institutions primarily for psychopaths would not be advisable until legal means of controlling them are available. The expense of building and operating specialized institutions of this sort would be large. There is good reason to believe, however, that it would be far less than what the psychopath is costing the public today.

Even if no really curative treatment should be discovered, despite organized efforts over the years in institutions specifically adapted to the problems of the psychopath, a great deal might be accomplished through careful supervision and control of destructive activities that today seem to run virtually unchecked. Pinel, Esquirol, and other early psychiatrists are honored today for the profound changes they brought about in the care of psychotic patients. Let us remember that these men did not discover any specific treatment for the psychoses. They introduced sensible and humane ways of handling patients and discarded inappropriate and futile measures that had been causing great and unnecessary suffering. Systems of parole and probation specifically set up for the

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psychopath, carefully designed in the light of his needs and his proclivities, could give each patient as much freedom from restraint as he showed himself capable of utilizing safely. In a properly controlled situation, it might be possible for many psychopaths to use their excellent abilities constructively and achieve a much better adjustment than is possible for them today.

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CHAPTER 29

SEXUAL DEVIATIONS

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BROADLY SPEAKING, we designate as sexual deviations or perversions any patterns of sexual behavior which differ from normal coitus and serve as major sources of sexual gratification rather than as foreplay to coital activity. Union of the genitals is either absent or subordinate. There may be an "anatomical transgression" whereby other body parts assume the dominant role, or an excessive lingering on foreplay activities, or any combination of the two.[78]

In defining perversion, however, a distinction must be made between perverse acts and perversion as a psychopathological condition. A person whose primary mode of gratification is one of normal coitus might, nevertheless, derive some additional gratifications from acts that in themselves would be classified as perverse. As long as genital gratification in coitus is dominant, such a person would not be defined as a pervert.

Historical Remarks

Attitudes toward perversions have always varied widely from culture to culture. Among the ancient Greeks, who tended to look on women as inferior beings without souls, erotic relationships between adult men and young boys (pederasty) were culturally sanctioned and were praised in poetry and philosophical writings. In these relationships the older man typically played the masculine, the younger the feminine role. They were regarded as aesthetically superior to the relationships between men and women, which were seen as serving merely the reproductive function.

Moreover, the Greek institution of pederasty must be viewed within the context of Greek culture, which permitted a relatively free expression of sexual impulses. As Freud[78] stated:

> The most striking distinction between the erotic life of antiquity and our own no doubt lies in the fact that the ancients laid the stress upon the instinct itself, whereas we emphasize its object. The ancients glorified the instinct and were prepared on its account to honour even an inferior object; while we despise the instinctual activity in itself, and find excuses for it only in the merits of the object.

In contrast to the Greek conception, the Judeo-Christian tradition maintains that pro-

creation is the only legitimate aim of sexual activity, and hence tends to condemn all forms of sexual activity not directed toward this aim. Mosaic law is explicit in its prohibition of homosexuality and of intercourse with animals, prescribing the death penalty for these offenses (Leviticus, 20:15–16, 23; Exodus, 22:19).

The strongest religious sanction against these two sexual practices has been derived from the story of Sodom and Gomorrah, as given in the Book of Genesis, in the assumption that such were the sins for which their inhabitants were punished; hence the term "sodomy," which to this day is used to denote both. This assumption, however, differs distinctly from the traditional Jewish interpretation that the sin of Sodom and Gomorrah was primarily one of hostility to strangers, and it has also been questioned by some Protestant and Catholic theologians. But whatever the author or authors of the original story might have intended to convey as to the nature of the sin, the fact is that, upon the basis of its interpretation in terms of anal or animal intercourse, the medieval church as well as secular powers inflicted extremely severe punishments—including death by burning or by being buried alive—upon persons convicted of sodomy. Hence the charge of sodomy was often raised against heretics, without basis in fact, as a convenient way to discredit heresy.[10, 50, 181] *

Nevertheless, it seems that homosexuality, already rather widespread among the Teutonic tribes in the pre-Christian era, continued to be practiced extensively in Germany during the period of Church domination; and, indeed, it is said to have been quite frequent in the religious-military Order of the Knights Templars. In a manner somewhat reminiscent of the Greek notion, it later found expression in certain nineteenth-century German poetry written in praise of young boys.

Although forbidden by the Koran, homosexuality is reported to have been widely practiced also in some Moslem countries, but there the pattern appears to have taken rather a bisexual form, adult males having been attracted both to young boys and to girls.

Perverse practices seem to be widespread among various primitive tribes. Not rarely, such acts—for example, intercourse with animals—form part of their religious ceremonies. Anal intercourse, in particular, plays an essential role in the initiation rites of certain tribes.[152, 184] *

Not until the second half of the nineteenth century did the phenomena of perversion begin to receive serious psychiatric attention. The pioneering step was taken in 1870 by Westphal,[182] who published a case study of a homosexual patient in his newly founded *Archiv für Psychiatrie* and suggested the term "contrary sexual feeling" (*Konträre Sexualempfindung*) to describe attraction to persons of the same sex.

Krafft-Ebing,[127] Kraepelin,[126] and other leading psychiatrists of the late nineteenth and early twentieth centuries considered sexual perversion to be essentially a form of "degeneracy" caused by a hereditary "taint" and often associated with physical stigmata of degeneracy. In his later writings, Krafft-Ebing modified his views by placing greater emphasis —as did Binet[26] and Bloch[27]—upon accidental causes. Kraepelin's discussion in *Clinical Psychiatry*[126] does not deal with "perversions" as such, but only with "inversion." Essentially, however, his approach is similar to that found in Krafft-Ebing's earlier formulations.†

* A major step in the direction of more humane treatment of homosexuals was taken in France, at the beginning of the nineteenth century, when the Napoleonic Code abolished all penalties for homosexual acts occurring between adults in private and without violence. Similar laws were subsequently enacted in several European and South American countries, and a proposal along such lines is currently under consideration in Great Britain.

* More detailed data on perverse practices in various cultures can be found in the writings of Ellis,[50] Chevalier,[35] Bloch,[27] Westermarck,[179, 180, 181] Devereux,[40] and Ford and Beach.[59] The works by Ellis and by Bloch served as the principal sources for the above account.

† Also similar in its implications, though less directly concerned with sexual perversions, was the theory of Lombroso,[145] who maintained that the "congenital criminal" was either an atavistic or a degenerate type, and that such atavistic or degenerate characteristics could be detected by means of physical stigmata. Like Krafft-Ebing, Lombroso, in his later writings, modified his views in the direction of a more environmentalist approach.

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The view that sexual perversions are a result of "degeneracy"—either in the constitutional or in the sociological sense—was vigorously challenged by Bloch.[27] Although he agreed with Krafft-Ebing that perversions often are combined with pathological states, such as epilepsy or syphilis, Bloch pointed out that they can be found also in the absence of organic or mental pathology. He likewise argued against the notion that sexual perversion is a result of civilization, maintaining not only that perverse practices are, if anything, more frequent among some primitive tribes, but also that there are no differences in their frequency among the various social classes.

Bloch agreed that genuine homosexuality (as distinguished from pseudohomosexuality, of which he recognized several types) might be due to congenital predisposition, but he insisted that such predisposition can and often does occur in individuals who are physically and mentally healthy. He suggested—in this respect anticipating, as did Freud, results of much more recent endocrinological research—that the organic factor predisposing to homosexuality is essentially a chemical factor connected with the production of sexual tension rather than with the functioning of the reproductive organs. Genuine homosexuality, he stated, makes its appearance very early in life. (As an illustration of its supposed independence of environmental influences, he added that it has been known to develop in males brought up in a feminine environment!)

The ultimate cause of sexual perversion, according to Bloch, is the need for variety in sexual relationships which is characteristic of the human species. Taking a view similar to the one already formulated by Binet,[26] he attributed particular importance for the development of perversions to accidental occurrences in childhood. Among factors which strengthen the perversion, he mentioned repetition, suggestion, and imitation, the latter applying particularly where perversions have become a national custom.

A theory, advanced by Hirschfeld[103,104,105] and adopted later also by Krafft-Ebing,[127] conceived homosexuality to be an intermediate category between the two sexes. This hypothesis was attacked by Bloch, who pointed out that it failed to account for all cases, for example, those of male homosexuals with strongly masculine characteristics.

Hirschfeld,[104] in a paper he contributed to the *Encyclopaedia Sexualis* shortly before his death in 1935, vigorously defended the view that homosexuality is based on hereditary predisposition. One of his many arguments was that homosexual feelings develop spontaneously, "despite the powerful suggestion of the environment in the opposite direction." He also considered that, if homosexuality were caused by external factors, "it would be possible not only for the heterosexual individual to become homosexual, but also for a homosexual to become heterosexual," an assumption he deemed to be "at variance with the results of abundant experience."

Space does not permit a discussion of the work of all those who have contributed to the human and scientific understanding of sexual deviation—or sexual perversion, a term expressing essentially moral condemnation and social disapproval—but brief mention, at least, should here be made of the important role played by Moll,[150,151] Mantegazza,[147,148] Rohleder,[162,163] Chevalier,[35] Hamilton,[96,97] Davis,[37] and, in more recent years, by Kinsey and his coworkers[123,124] in weakening the barriers of the taboos on open discussion of these sexual phenomena.

¶ Psychodynamics: General Remarks

The publication, in 1905, of Freud's *Three Contributions to the Theory of Sex*[78] marked a milestone in the scientific investigation of sexuality. In this fundamental work Freud formulated, for the first time, his concepts of infantile sexuality. This formulation was in sharp contrast to the traditional views which equated sexuality with genitality and with the reproductive function, and according to which sexuality first makes its appearance at puberty. Freud found that the sexual development begins at birth. "Sexual" is a quality, and the whole body is able to provide the infant with

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sexual sensations. Freud designated the energy attached to the sexual instinct as "libido."

Describing the various steps or phases of libidinal development, Freud could show that originally the child's sexuality is not centered on the genital organs but on other parts of the body. The development of the libido starts with an "oral" phase in which interest is centered around the mouth. This is followed by a period when the main interest is focused around the anus, thus ushering in the "anal" phase. In the third, the "phallic" phase, it has shifted to the phallic organ which is the penis or the clitoris. But other parts of the body, such as the eyes, skin, etc., also have their sexual charge and become particularly sensitive to certain stimulations to which they respond with sexual sensations. Their ability to generate such sensations was Freud's reason for referring to all these organs as "erogenous zones."

The nongenital sexual impulses, which exist side by side in a loose connection and are not yet integrated into a unified instinct, are referred to as "partial" or "component" drives. The infantile sexuality is at first auto-erotic, that is, it is directed toward the child's own body. It is a relatively undifferentiated state; excitement can be aroused by any of a wide variety of stimuli, and there is no sharp distinction as yet between excitement and gratification. The sexual impulses at this stage find expression in various activities, such as looking, exhibiting, and a preoccupation with anal functions. The sum total of all undifferentiated, pregenital drives is characterized by Freud as "polymorphous perverse." One of the characteristics of the polymorphous phase is that the performance of physiological functions, such as sucking or defecation, provides gratification of the component drives. Even though interest in the genital organ develops quite early, it is only gradually that the genitals assume a more specialized function, by serving as means of discharge of excitation which has been aroused through other erogenous zones.

Looking at the process of psychosexual development from the standpoint of object-relation, one can likewise say that the child remains for a long time in a polymorphous perverse state. When his initially auto-erotic sexual impulses become directed toward other persons, they continue at first to be polymorphous perverse in character. This means that the earliest impulses directed toward others are not yet genital impulses but impulses relating to the component drives. This can be seen, for example, in the young child's interest in the feces of other persons.

Sexual maturity is reached only when all the component drives have become integrated and subjected to genital primacy. Although they continue to play a role in adult sexuality, normally their function is one of foreplay (kissing, looking, exhibiting, etc.) leading to coitus. However, if one of the component drives becomes the predominant source of sexual gratification, we speak of perversion. The nature of such a dominant component drive is usually reflected in the content of the perverse act. Thus, a predominance of the anal component may give rise to anal intercourse or to coprophilia; the impulses to look and to exhibit may lead to voyeurism and to exhibitionism; etc.

A perversion may come about either through arrest or fixation at a pregenital stage of the libidinal development, or through later regression to such a stage. But, whereas the child's sexuality is unorganized and polymorphous perverse, the sexual life of the pervert is organized and under the dominance of a partial instinct. Moreover, unlike the child, the pervert is capable of achieving genital orgasm.

Freud's theories on perversion found further crystallization in his later writings. *Leonardo da Vinci: A Psychosexual Study of an Infantile Reminiscence*[73] and "A Child is Being Beaten"[66]—published in 1910 and 1919, respectively—are here mentioned as most important in the development of his ideas. That the "impulse of cruelty" plays a significant role in the psychosexual development of the child, he had stated already in the *Three Contributions*, but the study of aggression and of its vicissitudes, as related to the Oedipus complex, showed the perversions to have a defensive function as well.* Freud's original view that

* The reader is particularly referred, in this connection, to the excellent studies by Sachs[164] and Gillespie.[84]

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neurosis was the negative of perversion underwent considerable modification. It became clear that the latter represented only a narrow, conscious part of a much larger, unconscious system. In perversion, only one particular part of the pregenital sphere is consciously retained; the others are repressed, as in neurosis.

In perversion as in neurosis, the factor that disturbs genital primacy is castration anxiety.[52] Under its influence a regression takes place, whereby a specific infantile drive component becomes predominant. Unlike the neurotic symptom, the perversion provides a means of genital discharge, albeit one which fails to equal the gratification attainable by the normal person.

The important role of final gratification in many perverse acts was recently emphasized by Balint,[15] who describes them as "deceptive measures" intended to deflect attention from the genital pleasure and thus to protect the pervert against castration anxiety. In many instances, masturbation subsequent to the perverse act is needed for the attainment of orgasm.

An essential difference between neurosis and perversion is found in the attitude of the ego. As we know, the neurotic looks upon his symptom as a hindrance or a painful affliction and consciously defends himself against it, whereas the pervert accepts his sexual deviation as a source of gratification. According to Nunberg,[156] in perversion "the mental representative of the object is repressed, but the instinct is not only conscious but also capable of action"; he contrasts this particularly with the phobias, where the object is repressed and the instinct is disguised by displacement. Thus, both in perversion and in neurosis, there is repression with respect to the oedipal object of the sexual strivings.

Eidelberg[48] showed, on the basis of case studies, that the perverse act "is not identical with the component instinct" but, like the neurotic symptom, "represents a compromise and contains elements both of instinctual gratification and of frustration" and also "satisfies the demands of the superego." The real content of the instinctual gratification remains unconscious in the perversion, just as it does in the neurotic symptom.

In contrast to the nondynamic theories, particularly to those regarding the perversions as constitutional inferiorities, the psychoanalytic concept emphasizes the universality of the elements from which perversions may develop. Freud wrote:

> If it is correct that real obstacles to sexual satisfaction, or privation in regard to it, bring to the surface perverse tendencies in people who would otherwise have shown none, we must conclude that something in these people is ready to embrace the perversions; or, if you prefer it, that the tendencies must have been present in them in a latent form.[72]

This, in very brief outline, is the substance of psychoanalytic thinking on perversion in general. As we shall see, defense against castration anxiety is the main function in every perverse syndrome.

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Special Pathology

The psychoanalytic classification distinguishes between deviations with respect to the sexual object and deviations with respect to the sexual aim. But this differentiation has more theoretical than practical value; there is actually no sharp demarcation between the two aspects. Hence we shall find it more useful to deal in greater detail with the most frequent forms of perversion and to make but brief mention of some encountered less commonly.

Among the major sexual perversions we include overt homosexuality, pedophilia, fetishism, transvestitism, exhibitionism, voyeurism, sadomasochism, zoophilia, coprophilia, and necrophilia. Masturbation, even though it plays a part in some perverse acts, is not itself considered a perversion unless it constitutes the preferred mode of sexual gratification.

Overt Homosexuality

The term "homosexuality" (literally, "same sex") refers to the choice of a love-object of the same sex.

Not all individuals who at one time or another engage in homosexual activity are homosexuals in the full sense of the term.* Persons capable of sexual intercourse with partners of either sex are described as bisexual. Overt homosexuality denotes a predominance of homosexual activity as a source of sexual gratification. The occurrence of homosexual acts in the history of an individual does not, in itself, constitute this condition. Conversely, the existence of latent homosexuality does not necessarily result in overt homosexual behavior but may lead, for instance, to paranoid delusions arising from projection of homosexual tensions.[65]

In discussing the causation of homosexuality, let us first consider the problem of constitutional predisposition. As already noted, some sexologists, particularly Hirschfeld,[104] regarded homosexuality as largely due to constitutional and hereditary factors. Others, for example Ellis,[50] insist that, in addition to a type of acquired homosexuality, there also exists a type which is due primarily to constitutional factors.

In the *Three Contributions*[78] Freud summarized his view as follows:

> The nature of inversion is explained neither by the hypothesis that it is innate nor by the alternative hypothesis that it is acquired. In the former case we must ask in what respect it is innate, unless we are to accept the crude explanation that everyone is born with his sexual instinct attached to a particular sexual object. In the latter case it may be questioned whether the various accidental influences would be sufficient to explain the acquisition of inversion without the co-operation of something in the subject himself.

The biological experiments of Steinach[174, 175]† supported Freud's theory of bisexuality. Coming back to this problem in his paper "The Psychogenesis of a Case of Homosexuality in a Woman,"[77] Freud stated:

> It is not for psycho-analysis to solve the problem of homosexuality. It must rest content with disclosing the psychical mechanisms that resulted in determination of the object-choice, and with tracing the paths leading from them to the instinctual basis of the disposition. There its work ends, and it leaves the rest to biological research. . . . Psychoanalysis has a common basis with biology, in that it presupposes an original bisexuality in human beings (as in animals). But psycho-analysis cannot elucidate the intrinsic nature of what in conventional or in biological phraseology is termed "masculine" and "feminine": it simply takes over the two concepts and makes them the foundation of its work.

While thus recognizing that constitutional factors may to some extent be responsible for the degree of susceptibility to psychogenic influences, psychoanalytic theory holds that the latter are essential in the development of homosexuality. In the following paragraphs the psychoanalytic theory of the psychogenesis of homosexuality will be briefly outlined.

In the psychoanalytic conception, one of the main causes of male homosexuality is castration anxiety. The awareness that the woman has no penis implies a threat of castration. Moreover, the female genital may be

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* According to Kinsey *et al.*[123] approximately one third of American males go through one or more overt homosexual experiences at some time in their lives. (Some earlier estimates of the number of homosexuals in the United States are summarized in the Kinsey report.) Even though this estimate is subject to a wide margin of error owing to inadequacies in Kinsey's methods of sampling and analyzing data,[17, 88] undoubtedly the actual figure is very substantial.

† In these classical experiments Steinach showed that, by grafting the puberty glands of the opposite sex on castrated animals, it was possible to produce an inversion. More specifically, after the graft the animals tended to manifest behavior which would be more characteristic of the opposite sex, and also to direct their sexual activity to animals of their own sex. Further evidence that the individual organism usually combines some masculine and some feminine characteristics was found by Goldschmidt[87] in his studies of the gypsy moth. Varying proportions of masculine and feminine characteristics could be produced by crossbreeding of several varieties of the insect. Goldschmidt explains this finding by assuming that the chemical factors in the chromosomes, which determine sexual differentiation, are of different strengths in the different varieties of the insect. Thus, in the light of Goldschmidt's experiments, sexual differentiation becomes a relative matter dependent on chemical reactions. It may be of interest here to mention Fessler's[58] report on the case of a male transvestite whose manifest symptoms developed after removal of testicles. Fessler was able to show that in this case a psychological readiness, so to speak, had antedated the traumatic loss of testicles; the trauma acted as a trigger which mobilized the patient's deeply repressed feminine identification.

perceived in oral-sadistic terms as a castrating instrument.[52, 110] While the fetishist and the transvestite (as we shall see later) deny that the female lacks a penis, the homosexual accepts this fact but feels threatened by it. Hence the majority of male homosexuals are attracted by women, yet reject them as sexual (genital) partners. This attraction often is reflected in the choice of boys with feminine traits, as in Greek pederasty, or of male partners showing some characteristics of the subject's mother or sister.

In some instances identification with the mother leads to the choice of adolescent boys who represent the subject himself at a comparable age; he re-enacts toward them the maternal role, with the tenderness he had wished to receive from his own mother. This type of object-choice is narcissistic in the sense that such individuals bestow their love on themselves.

In other cases the identification with the mother, which follows the oedipal disappointment, takes the form of a wish to obtain sexual gratification in the same way as the mother. The anus here serves as a substitute for the maternal vagina, and the father becomes the object of passive-receptive strivings. In cases of this type, the manifest behavior pattern is of the "feminine" and tender kind, but there may be considerable latent hostility toward the father, with unconscious ideas of castrating him through homosexual intercourse.[52, 155] Traces of archaic oral identification with the father may likewise be present in the idea of submitting to him through anal intercourse. The passive-receptive love for the father also may develop as a reaction to the oedipal castration fear. It may, in its turn, give rise to castration anxiety.*

Nunberg[155] describes a type of male homosexuality in which aggression against the male (the father) "is not warded off, but . . . makes up an integral part of the subject's homosexual love." This is illustrated by the case of a patient who, since childhood, had suffered from ideas of physical weakness and had practiced gymnastics to overcome this weakness. He felt attracted primarily by strong men, with the idea that through homosexual contact he would gain some of their strength. In the homosexual act one not only appropriates to himself the strength of the partner (representing the father) but also symbolically "makes a woman out of him and subsequently feels himself sufficiently masculine to take possession of his mother." Nunberg suggests that this type of homosexuality is closer to paranoia than are the others "and possibly represents something intermediate between neurosis and psychosis." According to him, aggressive impulses are characteristic of many types of homosexuality.

Identification with the strong male was conspicuous in many of my homosexual patients. One of these was a young man who, since early adolescence, was attracted by strong men on whom he desired to perform fellatio so as to absorb their strength. As a child he had been physically weak and fearful, shying away from athletic activity and any kind of competition. His mother had died when he was two and a half, and he had slept in the same bed with his father until the age of thirteen. The father then married a girl only slightly older than the boy, and about whom the latter had entertained sexual fantasies. The patient's overt homosexual behavior dated from the father's marriage. The analysis showed that his homosexual striving corresponded to the type described by Nunberg; namely, that it represented the wish both to be and to castrate the father.

In female homosexuality one of the causal factors is likewise the castration complex, which results in anxiety at the sight of the genital of the opposite sex.[52] However, there is an important difference. Since the infant's earliest attachment is to the mother, the first love-object of the little girl is a homosexual one. Thus, in the woman, a homosexual attachment represents a regression to this early stage.[40, 52, 132] Hence female homosexuality carries more archaic traces than does male homosexuality, and "brings back the behavior patterns, aims, pleasures, but also the fears and

* Ferenczi,[54] who used the term "homo-erotism" instead of "homosexuality," distinguished sharply between two types: "subject homo-erotics," who act and behave like women, and "object homo-erotics," who are conspicuously masculine and merely exchange a female for a male object in their sexual choice.

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conflicts of the earliest years of life."[52] This probably explains the fact that oral eroticism predominates in female homosexuality.[52]

As in male homosexuality, a distinction can be made between the narcissistic type and the one determined by the negative Oedipus complex.

The types here described, or some combinations of them, constitute the vast majority of overt homosexuals.

A phenomenological differentiation of passive and active is as relative for male homosexuals as is the distinction of masculine and feminine with respect to female homosexuals. That no sharp demarcation exists between activity and passivity is shown by the reversal of roles between the same partners on different occasions.[149] The common notion that homosexuals are recognizable by their physical appearance is certainly fallacious. Those who are ostentatious about their sexual leanings, and who can easily be identified by their clothing or manner of walking, represent merely a very small minority. Such ostentation or exhibitionism may be an expression of opposition to the prevailing code, an opposition based upon resentment of society's attitude toward homosexuality. To some degree this resentment is actually present in all homosexuals. Indeed, notwithstanding the intense object attachments characteristic of many homosexual relationships, their alliances often seem to be motivated more by spite and aggression than by libidinal strivings.

The feelings of resentment might be less virulent if the penalties against voluntary homosexual contact between adults were abolished.* In our culture the disapproval of female homosexuality tends to be less severe. Affectionate manifestations, such as kissing, are socially permissible among women but arouse offense in the case of men. In this connection it is also important to remember that male homosexuals tend to be more promiscuous than homosexual women. There are some cases on record of male homosexuals who had overt contacts with hundreds of partners.[127] This promiscuity and the insatiable need to seek repeated orgastic experiences bring to mind Freud's[72] compassionate statement when speaking of the difficult life of the pervert: "In reality, perverts are more likely to be poor devils who have to pay most bitterly for the satisfactions they manage to procure with such difficulty."

To conclude this cursory outline, brief mention at least must be made of the alleged correlation between homosexuality and specific sublimations. Ellis[50] and others have amassed impressive data of illustrious men, throughout history, known to have been homosexuals. The problem of a possible affinity between this perversion and particular talents or sublimatory pursuits has engaged a great deal of interest in recent years.* It has become the subject of promising psychoanalytic investigations whose results, however, still must be awaited.

Pedophilia

Pedophilia (literally, "love of children") is the term applied to sexual activity involving a sexually immature object. A pedophile may be homosexual, heterosexual, or both in his choice of objects, and, theoretically, his activity can take almost any of the forms characteristic of heterosexual or homosexual activity with an adult partner.

In actual fact, however, a large proportion of male pedophiles are either partly or totally impotent, so that their pedophilic activity does not usually include intercourse but is more likely to involve masturbatory-exhibitionistic practices. This is especially true of those whose objects are very young children. Occasionally, the child may suffer major physical injury, as in a case reported by Krafft-Ebing[127] where

* Homosexuals tend to compensate their feelings of guilt and inferiority by projecting them onto others; hence their belief that the world is full of homosexuals. In the course of analytic treatment, it very often transpires that the patient ascribes homosexual leanings particularly to his own father.

* Of interest in this connection may be Alexander's[4] assumption as to the relationship between sublimation and perversion in general; namely, that the specific partial instinct dominant in a perversion cannot find more sublimated forms of expression. Thus the sexual sadist, for instance, would lack self-assertion in social relationships; the voyeur would not develop an interest in exploration or scientific research; etc.

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the attempt at anal intercourse with a one-and-a-half-year-old child caused an injury to the baby's anus. But since the pedophilic activities are often confined to fondling, exhibitionism, and masturbation, such instances are comparatively rare.

The typical pedophile's impotence and lack of interest in intercourse support the assumption that pedophilia reflects a feeling of genital inadequacy and a resulting fear of dealing with adult love-objects. This fear is strikingly illustrated in the case of a male patient, described by Karpman,[114] where, at the age of seven, a subsequently repressed seduction by a woman led to a fear of intercourse with women who had pubic hair and, as a result, to the preference for young girls still devoid of it.

Apart from the fear of dealing with an adult object, pedophilia has still other determinants, such as narcissistic identification with the immature object. These factors have been noted by Fenichel[52] and other authors.

Fetishism

In this perversion the object of the sexual drive is either a part of the human body (*pars pro toto*), such as hair or a foot, or an article of apparel, most typically a shoe, associated with a person of the opposite sex. Fetishism occurs much more often in men than in women, and it is the feminine foot or the feminine shoe that may be described as a typical fetishistic love object.* Discussing the (unconscious) symbolic thought connections which may determine the replacement of a human object by a fetish, Freud[78] remarked: "The foot, for instance, is an age-old symbol which occurs even in mythology" (adding in a footnote, "The shoe or slipper is a corresponding symbol of the *female* genitals.") and "no doubt the part played by fur as a fetish owes its origin to an asssociation with the hair of the *mons Veneris*."

In a sense, fetishism may be described as an exaggeration of a phenomenon which is present to some extent in normal love relationships —the lover's affective overvaluation of some feature or body part, or of some article associated with the love-object. Normally, such special attachments are subordinate to one's interest in the actual person, but in fetishism the situation is reversed; attachment to the fetish assumes the primary role, and the presence of the fetishistic object is indispensable for the occurrence of orgasm.

In the case of some fetishists, to look at the fetish or to touch it is sufficient to produce orgasm, without supplementary overt stimulation; others resort to coitus or masturbation in the presence of the fetish in order to bring about an ejaculation.

Binet's[26] theory concerning the role of "accidental" circumstances in childhood in the genesis of the fetishistic perversion has already been mentioned. Another early theory was that of Krafft-Ebing,[127] who maintained that foot fetishism is really a variety of masochism, since the lover lowers his own status in relation to the love-object by focusing his attention on her foot. Ellis,[50] taking issue with this view, cites cases of foot fetishists whose attitudes toward women gave no other evidence of self-abasement, but he agrees that foot fetishism may sometimes be a sadomasochistic manifestation.

From the psychoanalytic point of view, choice of the fetish is determined on a symbolic basis. Thus the foot, having a phallic significance, serves as symbolic reassurance of the existence of a female phallus.[1,70] The pregenital, especially coprophilic, significance of the fetishistic object was stressed by Freud[70] and later by many other authors. Strong olfactory sensations emanating from the foot, which are largely repressed, probably account for its frequent choice as a fetish. In recent years, increasing emphasis has been placed upon the aggressive element underlying fetishism and most of the perversions in general.[14] The mag-

* Probably the earliest recorded case of foot-and-shoe fetishism is that of the French writer Restif de la Bretonne (1734–1806). According to Ellis,[50] de la Bretonne was the first to give a detailed phenomenological description of the development of his fetishistic tendencies, both in his first literary success, *Le Pied de Fanchette*, and in his autobiography, *Monsieur Nicolas*. In his case the preoccupation with the fetishistic object was not a full-fledged perversion, since a desire for normal intercourse continued to be present. (His fetishism apparently reached its highest point as a result of desire for a woman who was inaccessible as a genital object.)

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ical significance inherent in some fetishistic manifestations, especially in those which involve mere looking, is self-evident. In her paper on "Respiratory Incorporation and the Phallic Phase," Greenacre points up the fetishistic attachment of a patient to certain objects and the magical value they represented in early life (*see* Ref. 92, pp. 259–292).

Since both fetishism and male homosexuality can be viewed as means of dealing with castration anxiety, it might be instructive to compare the two perversions in this respect. Lorand, examining these relationships in his paper "Fetishism in Statu Nascendi,"* has aptly remarked that "fetishism saves the individual from becoming homosexual, but saves him at the same time from becoming normal which would bring the danger of castration" (*see* Ref. 146, pp. 11–24).

Transvestitism

The term "transvestitism" (literally, "cross-dressing") was coined by Magnus Hirschfeld. It refers to a sexual perversion in which sexual gratification is obtained by wearing the clothing of the opposite sex and by genital contact with such clothing. There is often a certain tendency to feel and act like members of the opposite sex. This was well expressed by a boy of twelve who had developed a habit of putting on his mother's silk nightgown over his naked body. Referring to this habit once by way of free association, he said that it felt "as silky and velvety as mother's skin."

Some authors classified male transvestites as homosexuals, a view which derived some support from the observation that transvestites showed effeminate traits. But Hirschfeld[108] challenged this view. According to him, transvestitism is a completely distinct perversion, since most transvestites tend to be attracted to persons of the opposite rather than of the same sex. While this phenomenological approach seems correct as far as it goes, it is also true that in many case histories of homosexuals we find episodes of transvestitic manifestations dating back to childhood or adolescence.

The psychoanalytic view of transvestitism,[28, 53] may be summarized as follows. Here too, as in many other perversions, there is an attempt at reassurance against castration anxiety. This arises from the infantile belief that the woman has lost her penis as a result of castration; hence the subject, too, might become a victim of castration. By donning female clothing and by continuing to receive sensations from the penis, the transvestite unconsciously identifies with a phallic woman whose penis is hidden by her clothing. But his identification with the phallic woman does not extend to imitating her object-choice; as already mentioned, most often his choice is directed toward persons of the opposite sex. The phallic woman, besides being his identification figure, represents also the transvestite's love-object. Seen in relation to the Oedipus complex, whence the castration anxiety of the transvestite is derived, there are two different aspects in this representation. On one level the love-object represents the mother, but on a deeper level it represents also the father, and is thus homosexual in nature.

The feminine identification of the male transvestite is typically accompanied by masochistic features which usually manifest themselves through fantasy content. In some cases, however, they may involve self-infliction of severe pain on the part of individuals who not only put on female clothes but also tie themselves with ropes. There are known cases of such transvestitic acts (in adolescents) resulting in death.[166] Schechter[166] suggests that the transvestitic suicidal act in adolescent boys symbolically represents "the first submission to the all-powerful father figure." One of my homosexual patients used to tie himself to a chair or to a bedpost while wearing his mother's or sister's clothes, and always attained orgasm by struggling to get out of both clothes and ties.

The foregoing comments evidently require

* This study of fetishism in a child is important also from another point of view. Since domination of the sexual organization by a partial instinct is one of the characteristics of perversion, and since in this respect the pervert shows a similarity to the child, the question arises whether it is indeed appropriate to speak of "perversion" in childhood. Undoubtedly, this concept in its application to children has a valid meaning, although perhaps not one entirely equivalent to its meaning as applied to adults.

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some modification in the case of the female transvestite. Since masculine attire cannot provide a woman with the illusion of having a penis, female transvestitism has more of a "make-believe" character. As already noted, some homosexual women wearing masculine clothing do it probably rather out of bravado and defiance than from a genuine transvestitic impulse.

There is a definite point of similarity, at least on the descriptive level, between transvestitism and fetishism. The fact that both utilize articles of clothing of the opposite sex has already been stated, but a corollary of this observation still remains to be pointed out. In a recent paper, Balint[14] emphasized that a fetish, in contrast to a living sexual partner, has no demands of its own, that no effort is required to "win" or "hold" the fetishistic object. The same holds true for transvestitism, which similarly employs an inanimate object as a means of sexual stimulation.

But this point of similarity between the two perversions should not be overdrawn, since the inanimate object plays a different role in each. In the case of fetishism, the inanimate object acquires importance in itself as a result of symbolic displacement; in the case of transvestitism, it acquires significance primarily when brought into direct contact with the subject's body. Unlike the fetishist, the transvestite is not "in love" with a specific article, as such, but utilizes articles of apparel of the opposite sex as a means of attaining orgasm and of facilitating identification with the other sex.

Exhibitionism

This perversion involves exhibition of the genital organs for the purpose of obtaining sexual gratification.

Exhibitionism was introduced into psychiatry as a clinical entity in 1877 by the French neurologist Lasègue.[133] As its striking characteristics, he described that the act was "instantaneous and compulsive"; the subject was spellbound, unable to control his impulses to exhibit his genitalia, finding himself always in a state of heightened anxiety. Garnier,[83] in 1900, completed the symptomatological outline by emphasizing that the compulsion refers not only to the exhibitionistic act itself but also to the time and place of its performance.

In its pure form, exhibitionism is rarely found in women. Descriptively, one may say that the male genital exhibitionist very frequently suffers from potency disturbances and has little interest in normal sexual relations. He performs the exhibitionistic act only in the presence of strangers, and often his own family is quite unaware of his abnormality. In fact, it sometimes happens that there are several male exhibitionists in one family and that they do not know of each other's perversion.

While the exhibitionistic act often has an aggressive aspect, in the sense that the woman is shown the penis against her will, in other cases—for example, of pedophiles—it may take place without such an aggressive connotation. Exhibitionism also plays a role in male homosexual relationships.

Exhibitionism as a clinical syndrome differs from the exhibitionism that forms a part of the normal developmental process in young children. This normal exhibitionism of childhood is practiced by mutual consent; often, as in the "doctor" game, it is closely tied up with voyeuristic elements. The adult exhibitionist's susceptibility to visual stimulation, however, usually is weak; thus he is typically not stimulated by the sight of the female breast.

Viewed from the dynamic aspect, the defensive function of the exhibitionistic act is almost self-evident, inasmuch as the exhibitionist demonstrates to the woman and simultaneously to himself that he is still in possession of a penis. Christoffel,[36]* who made a thorough study of the problem, aptly observed that male genital exhibitionism has some characteristics of an unconscious phobia—more specifically, of a claustrophobia. The exhibitionist's behavior is characterized by anxiety, and the claustrophobic quality of this anxiety is evidenced by his feeling of insecurity in his own home and his own bed. The typical exhibitionist does not exhibit in his home, and only

* Christoffel's paper includes interesting historical and cultural material on male genital exhibitionism.

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very rarely will he display his genitalia from his window.

The compulsion of the exhibitionist to return to the scene of his crime is the manifest symptom of his deep sense of guilt and need to be punished. Also significant is the tendency, noted by Christoffel, to report other exhibitionists to the police or (more often) at least to frighten them.

The magical thinking inherent in exhibitionism is as prominent as in its counterpart, voyeurism. The exhibitionistic act implies the magical wish for the woman to exhibit her own phallus: "I wish you would do the same."

An impressive amount of material on the subject of the magical overvaluation of the penis, as it is encountered universally in folklore and myth, was collected by Ellis.[50] It is of interest to remember that in medieval times the exhibition of the phallus or phallic symbols was used in order to frighten or to delude demons.

Voyeurism

In this perversion the primary means of sexual gratification consists in looking at the sexual organs or sexual activities of others. Voyeuristic practices range all the way from "peeping," which is carried out without the cooperation of the person being observed, to spectatorship at elaborate performances, for example, in houses of prostitution. The sex acts staged on these occasions are usually a combination of various forms of perversion, preponderantly sadistic in nature and often including intercourse with animals.

Underlying voyeurism we find similar infantile fixations, relating to primal scenes, as in exhibitionism; and, like almost every perversion, voyeurism can be interpreted as an attempt at reassurance against castration anxiety. But because such reassurance cannot be obtained, the voyeuristic tendencies usually become insatiable, sadistic, and displaced to areas other than the genitals.[52]

In voyeurism the original sadistic impulse to destroy is transformed into a milder one, to look: "I didn't do it, I only watched the other fellow do it." According to Fenichel,[52] this tendency to replace sadistic action by the more ego-syntonic form of looking or watching can be studied particularly in women: "Curiosity in women sometimes is more or less openly aimed at witnessing catastrophes, accidents, war scenes, operations, hospital scenes, and the like; such curiosity represents active sadistic castration tendencies, reduced from action to observation."

To examine the universal validity of this statement would lead too far afield, but I should like to remind the reader of a fascinating illustration of precisely this type of camouflaged sadistic voyeurism in a work of literary art, Ibsen's famous play *The Master Builder*. I refer, of course, to the dramatic scene where Hilde Wangel, the heroine, witnesses the builder's fall from the top of his last creation, to which he has mounted at her instigation. It is a powerful example of the great naturalistic dramatist's acute—one can almost say, clinical—observation of human behavior. For, as Reik[161] rightly remarks, the sexual symbolism of this climbing and falling, which seems so obvious to us today, certainly was quite unknown to Ibsen, the puritanical Norwegian, in 1891.

That the act of seeing, which in voyeurism and some other deviant sexual tendencies is the tool of perversion, plays a focal part as well in our normal sexual and cultural development, no one will deny. As Freud[78] put it:

> Visual impressions remain the most frequent pathway along which libidinal excitation is aroused; indeed, natural selection counts upon the accessibility of this pathway—if such a teleological form of statement is permissible—when it encourages the development of beauty in the sexual object. The progressive concealment of the body which goes along with civilization keeps sexual curiosity awake. This curiosity seeks to complete the sexual object by revealing its hidden parts. It can, however, be diverted ("sublimated") in the direction of art, if its interest can be shifted away from the genitals on to the shape of the body as a whole.

Obscenity, Pornography, and Coprophilia

These are all closely related to the exhibitionistic and scopophilic perversions.

That the verbalization of obscenity has a

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special, unconscious significance was first discerned by Freud[81] and further described by Ferenczi,[55] Bergler,[19] Jones,[112] and others. Words are often the tools of

mild exhibitionists and voyeurs, who instead of actual exposure content themselves with an act that has been weakened into the form of speech, and who in doing so select those words that (through their being forbidden, as through their motor and plastic attributes) are especially calculated to evoke the reaction of shame. This perversion might be called "coprophemia."[55]

Ferenczi[55] differentiated between "coprophemia" and "coprolalia," defining the latter as "the involuntary obsessive expelling of obscene words, as may happen, for instance, in severe cases of *tic convulsif*."

But some individuals, usually males, use obscene words and also pornographic or erotic literature as a means of stimulation to the point of orgasm. Typically, but not invariably, this is done in conjunction with masturbation. In some cases, men who are relatively isolated from opportunities for heterosexual contact utilize such material to achieve sexual arousal. Women appear to be less responsive than men to this type of stimulation.

As Fenichel[52] points out, in one respect the use of pornographic literature in conjunction with masturbation is nearer to normal sexuality than is masturbation by itself, "the book being a medium between sexual fantasy and sexual reality." But whether the use of erotic literature actually comes closer to normal sexuality depends, of course, on the type of material involved.

In coprophilia, excretory functions (defecation) serve as the primary means of obtaining orgasm. This perversion sometimes takes on a voyeuristic character, for example, when a man derives gratification from watching women defecate.

Coprophilia, too, can be described as a defense against castration anxiety. By emphasizing the anal zone as a source of sexual pleasure, the difference between the sexes is circumvented, and hence the conflict about castration is removed. The symbolic equation feces = penis is thus confirmed. In some cases a fetishistic fixation was detected as a factor in this perversion.[52]

Fenichel[52] stresses the combination of coprophilic, exhibitionistic, and sadistic elements involved in coprolalia, "in the joy of uttering obscenities."

*Sadomasochism**

In sadomasochistic perversion the infliction of pain is a prerequisite for sexual gratification. The sadist is the one who inflicts the pain upon the sexual object; the masochist endures it in a passive way.

Detailed descriptions of sadomasochistic practices are contained in the older literature on sex, particularly in the works of Krafft-Ebing,[127] Ellis,[50] Bloch,[27] Moll,[150] etc.

Freud[78] considered sadomasochism to be the most significant of all perversions, inasmuch as "the history of human civilization shows beyond any doubt that there is an intimate connection between cruelty and the sexual instinct." "Sadism and masochism," he wrote, "occupy a special position among the perversions, since the contrast between activity and passivity which lies behind them is among the universal characteristics of sexual life." Schilder,[167] emphasizing the close relationship between sadism and masochism and the integral part they play in sexual life, believed that they represent only an accentuation of a general human tendency to distribute the roles of activity and passivity, aggression and submission.

According to Freud's early formulation in the *Three Contributions*,[78] the

connotation of sadism oscillates between, on the one hand, cases merely characterized by an active or violent attitude to the sexual object, and, on

* The term, a modern contraction of "sadism" and "masochism," illustrates the inextricable alliance of the two concepts. "Sadism" is derived from the name of Donatien Alphonse François de Sade (1740–1814), more generally known as the Marquis de Sade, a French writer whose novels depict many incidents involving torture and cruelty. The term "masochism" is similarly derived from the name of an Austrian novelist, Leopold von Sacher-Masoch (1836–1895), who often dealt in his books with the theme of subjugation of men by women, and who in his own life displayed masochistic traits, for example, a desire that his wife should be unfaithful to him.

Schrenck-Notzing[170] preferred the term "algolagnia," which means "pleasure in pain," designating sadism as "active algolagnia" and masochism as "passive algolagnia."

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the other hand, cases in which satisfaction is entirely conditional on the humiliation and maltreatment of the object. Strictly speaking, it is only this last extreme instance which deserves to be described as a perversion. Similarly, the term masochism comprises any passive attitude towards sexual life and the sexual object, the extreme instance of which appears to be that in which satisfaction is conditional upon suffering or mental pain at the hands of the sexual object. Masochism, in the form of a perversion, seems to be further removed from the normal sexual aim than its counterpart; it may be doubted at first whether it can ever occur as a primary phenomenon or whether, on the contrary, it may not invariably arise from a transformation of sadism.

There is no sharp demarcation line dividing the roles in a sadomasochistic relationship. Neither of these roles is specifically tied to one of the sexes. In some sadomasochistic pairs the sadistic role is taken by the man, in others by the woman. Sadomasochistic relationships likewise occur among homosexuals. Case histories of sadists and of masochists constantly reveal "traces of both groups of phenomena in the same individuals" and that the two are so closely related that they can be regarded as representing the same perversion.[59]* (In the *Three Contributions* Freud made reference to these findings.)

A patient with strong homosexual tendencies,† whose masturbatory activities were invariably accompanied by masochistic fantasies, frequently dreamed of witnessing sadistic acts inflicted upon others. These dreams would usually cause nocturnal emissions. A typical, recurrent dream is the following:

He is in a sort of stone cell, the type of cell one would find in a medieval castle. A man in brightly colored pajamas is chained by the wrists, facing the wall. A woman dressed in a rather loose, flowing robe is beating him. The man struggles and finally breaks loose. Somewhere the man has found an ice pick. He throws it at the woman, and the pick sticks in her face. He pulls it out, throws it again. This, as the woman slowly backs away, is repeated three or four times.

It is not possible in the frame of this chapter to attempt a detailed account of Freud's ideas on sadomasochism and the sequence of their development. The problem of masochism presented greater difficulties than that of sadism, owing to its apparent contradiction of the pleasure principle. According to his original conception, the component instincts of sadism and of masochism formed a complementary pair (very much in the same sense as those of exhibitionism and scopophilia). We have seen that in his earlier work[78] he assumed that masochism, which involves the turning of aggression upon the self, is derived from sadism (that is, from aggression against the object). Later on, Freud[64, 66, 67] elaborated a different view; namely, that both sadism and masochism are derived from the death-instinct. In this new formulation, masochism was the primary and sadism the secondary phenomenon. However, Freud proceeded from it to the further assumption that masochism, which thus had turned into sadism, could once more be turned back against the self, and this form he termed "secondary masochism." In a footnote added in 1924 to the *Three Contributions*,[78] Freud summarized his new conception thus succinctly:

> I have been led to distinguish a primary or erotogenic masochism, out of which two later forms, feminine and moral masochism, have developed. Sadism which cannot find employment in actual life is turned around upon the subject's own self and so produces a secondary masochism which is superadded to the primary kind.

Moral masochism can be defined as a form of masochism which has "loosened its connection with what we recognize to be sexuality," and in which "it is the suffering itself that matters."[67] The moral masochism is expressed in unconscious feelings of guilt derived from the Oedipus complex.

Freud's ideas on masochism, especially the conception relating it to the death-instinct as well as his concepts of feminine and of moral masochism, have aroused considerable con-

* In this connection Ellis also argued that de Sade himself could really be considered a masochist rather than a sadist.

† This is the same patient I mentioned in my illustration of certain transvestite practices (see page 598).

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troversy.* On the other hand, there is considerable agreement on the view that a turning of originally object-directed sadism upon the self plays a role in the masochistic perversion.

To summarize, we may say that, in the psychoanalytic conception, sadism and masochism represent means of defense against castration anxiety. By performing symbolic castration on others, the sadist gains the reassurance that he is the castrator and not the one castrated; especially where the symbolic castration is mild in character, it means that the effect on the victim is not so serious. (Of course, this does not hold true for extreme sadistic acts, such as lust murder.) As for the masochist, his guilt feelings stemming from the oedipal conflict are allayed by the pain and suffering which become the "price" for genital orgasm. Thus, by submitting to symbolic castration, he obtains the proof that his organ still is intact.

Zoophilia

Zoophilia erotica, a term coined by Krafft-Ebing,[127] denotes a love for animals. Zoophilic perversion may take any one (or a combination) of at least three possible forms: (1) sexual arousal through observation of sexual activities of animals (voyeurism); (2) a form of fetishism whereby animal objects, such as furs, acquire special sexual significance; and (3) actual intercourse with animals (zooerasty). This is an excellent example illustrating how many different aspects a perversion can present.

Observation of sexual activities of animals is a frequent occurrence in young children, but there are some cases on record of adult persons, male as well as female, deriving gratification from the observation of horses being bred.

Sexual intercourse with animals has in some periods and cultures had religious sanction, but in others has been severely condemned. Mosaic law prescribes the death penalty for the offending person as well as the animal. In medieval Europe the punishments inflicted for such contact included death by burning for both.

Zoocrasty appears to have been most frequent among peasants living in close contact with animals and among persons of low educational level. The animals most commonly used for this purpose include the goat, the dog, and the sow, but even geese are known to have been used occasionally. Animal intercourse is said to be particularly frequent among shepherds, and approximately 9 per cent of the males from farm areas sampled by Kinsey *et al.*[123] had experienced it at some time in their early teens. In my clinical practice I have found that most persons who had sexual contact with animals were either psychotic or of extremely low intelligence.

According to Ellis,[50] there are some cases on record of women attempting coitus with large dogs and suffering major genital injury as a result. He states that while actual coitus between a woman and a dog seems to be quite rare, apparently dogs are used by women much more frequently for purposes of cunnilingus and are able to perform it without special training.

A case of a man who had practiced animal intercourse was psychoanalytically studied by Lorand.[146]

Lust Murder

This is the most extremely sadistic perversion. It involves killing and the mutilation of corpses for the purpose of sexual gratification. According to Krafft-Ebing,[127] the lust murderer does not attempt coitus with his victim, because it is the act of murder itself that provides him with genital gratification; he thus differs from the rape murderer, who resorts to killing in order to prevent discovery. Lorand,[146] on the other hand, maintains that the lust murderer's sexual aim is to have intercourse with the corpse, since he cannot face the possibility of rejection by a living woman. The same view was held by Ferenczi (as mentioned by Lorand without citing source). This inter-

* Of the numerous psychoanalytic contributions to the problem of masochism, unfortunately but a few can be cited. The reader is especially referred to (besides Freud's own writings) the works by Reik,[160] Nunberg,[158] Deutsch,[40] W. Reich,[159] Fenichel,[52] Horney,[110] Lampl-de Groot,[131] Eidelberg,[45] Bergler,[17] Berliner,[22, 23, 24] Nacht,[153] and Loewenstein,[144] whose recent paper contains an extensive bibliography on the subject.

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pretation would make lust murder closely akin to necrophilia.

Intermediate in character between lust murder and the sadomasochistic perversion are those perverse practices which involve injury to the victim or the sight of the victim's blood as a condition of genital discharge. Thus, Krafft-Ebing[127] reported the case of a man who periodically visited a prostitute in order to see her kill an animal in his presence, a sight which apparently provided him with genital gratification.

Necrophilia

Necrophilia (literally, "love of corpses") is a very rare perversion and one that involves a very deep-lying disturbance. It consists in having intercourse with corpses, followed, in some instances, by mutilation of the latter. Some of the individuals known to have practiced this perversion had no interest in normal coitus.

As was already noted by Bloch,[27] necrophilic fantasies are more frequent than actual necrophilic acts. Such fantasies have been reported in the psychoanalytic literature; among others, in the case of a patient with an actual history of animal intercourse.[146]

A motivating factor in necrophilia—and even more strongly marked here than it is in pedophilia—seems to be the need to eliminate the risk of rejection by choosing an object that can offer no resistance or opposition of any kind. Indeed, this is the explanation suggested by Krafft-Ebing,[127] who reported cases of necrophilic perversion in some detail. However, even though it may be partly correct, his interpretation cannot fully account for the facts in these cases. It fails to account for the mutilation of the corpses, for the considerable risk taken by the necrophiles in removing the bodies from graves, or for the fact that some of them showed no interest at all in intercourse with living women.

Group Perversion

This term is applied to any sort of sexual activity involving the participation of more than two persons.* One type of group perversion is the orgy.[50] Originally, the orgy had a religious function, permitting sexual excesses on special ritual occasions, somewhat analogous to the totemic feast as described by Freud in *Totem and Taboo*.[79] As Ellis[50] points out, some of the medieval church festivals (for example, All Fools' Day) were characterized by permitted relaxation from certain customary constraints. The medieval flagellation orgies, though different in their manifest intent, sometimes had the character of a group activity leading to sexual excitement.

Other activities that come under the heading of group perversions include group rape (a group of men raping one woman) as well as voyeuristic practices in which sexual excitement is reached by one individual or a group of individuals while watching sexual activity of others. (However, such activities are classified as group perversion only if three or more of the participants are involved in its perverse aspects. If a voyeur watches normal coitus between a man and a woman who do not know that they are being observed, we do not speak of a group perversion, even though three persons are involved and voyeuristic activity is perverse.)

As Sperling[173] has suggested, in a group perversion there is usually a leader who is a genuine pervert; the "followers," according to this view, participate in the perversion under conditions which are ego-alien to them, but the fact that they do so indicates the presence of a super-ego that permits substitution by a leader.† Sperling refers to this condition as "induced" perversion.‡

* In a certain sense, the triangular sex situation (*ménage à trois*) resembles a group perversion. Almost without exception, a strong homosexual element is present under the guise of heterosexual interest. The perverse aspect of such relationships becomes more clearly apparent when exhibitionistic and voyeuristic manifestations are involved as well.

† Sperling further suggests that culturally sanctioned perversions in primitive societies have the same character, that is, were introduced by a genuine pervert.

‡ That there is always a biological compliance and a readiness for sexual seduction seems beyond doubt. "He only can be seduced who is capable of being seduced."[150]

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¶ Community Attitudes and Preventive Aspects

In our society the attitude of the community to sexual deviations is still one of contempt and moral condemnation, strongly determined by unconscious as well as conscious fears.

Not surprisingly, there is a particular virulence in the public's reaction of fear and indignation to criminal acts involving rape, pedophilia, lust murder, etc. Not only do such cases of "sex fiends" arouse severe panic in the neighborhood where the act was committed; they tend to receive such intense and wide publicity that they may remain a source of horrifying fascination for a long time. (The tale of "Jack the Ripper" continues to agitate the imagination of anxious mothers to this very day.) This peculiar fascination, perennially exploited by the popular press, is indicative of a specific ambivalence in relation to sex and cruelty. Such accounts, like the "penny dreadfuls," exert an insidious appeal to unconscious sadomasochistic strivings in the reader; hence the objection of many community leaders to the sensational reporting of "sex crimes," on the ground that such newspaper stories might stimulate potential criminals to commit similar offenses. The actual extent of this danger is difficult to assay, especially in view of the enormous amount of comparably arousing material disseminated by other mass media.

With regard to homosexuality, the community reactions are much more variable. Although a great deal of opprobrium still attaches to it, some of the opposition takes the form of ridicule rather than of violent indignation, and, at least in some segments of society, an increasing tolerance for the homosexual can be observed.

No doubt the community must protect itself against certain dangers inherent in some forms of sexual perversion. From this standpoint, as well as from the medicolegal aspect, it is necessary to distinguish two different categories of perversions: (1) extreme and violent forms of sadism which actually present a danger to society, and (2) pervert practices constituting rather a nuisance, such as exhibitionism and "indecent assault."

Exhibitionistic acts, it is true, can occasionally have traumatic consequences if the victim is young and impressionable, but such a case would not necessarily be typical. In this connection it should be pointed out that there is sufficient evidence to indicate that the choice of a vicim by the sexual pervert is not always an accidental matter.[101] In pedophilia, for instance, the juvenile object is sometimes a fully willing participant in the sexual activity, although, in terms of the law, the responsibility for the acts rests on the adult partner. In some perversions (for example, nonviolent homosexuality) the roles of the participants are more or less voluntary, so that no clear demarcation exists between offender and victim. The effect on the victim may vary a great deal, depending on the person's psychological make-up. This likewise applies to the victim of "indecent assault."*

The fact that sexual perversions are punishable by law is meeting with increasing opposition based upon the view that sexual morality is a private matter and should be subject to public regulation only if (1) the acts are carried out in public places, (2) one of the partners is a minor, or (3) violence or coercion is involved. Particularly the opinion that homosexual practices should not be subject to legal sanction receives support from contemporary psychiatry.† From the psychodynamic standpoint, homosexuality is a manifestation of an underlying disturbance which is primarily a psychological problem.

As far as really dangerous perverts are concerned, it appears necessary to isolate them for the protection of society, but the fact that imprisonment has no deterrent effect is amply

* This is a legal rather than a psychiatric term, used differentially from "rape" to denote sexual attacks involving no attempt at genital intercourse. The attack usually serves as a means of providing sexual gratification, and its form may range from exhibitionism to attempted contact with genital zones. An attempt to coerce the victim is usually an essential feature of indecent assault.

† The reader is referred to the Wolfenden Report[187] for extensive clarification of this question.

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evidenced by the number of individuals repeatedly apprehended and convicted of the same offense; this is especially striking in the case of exhibitionists, for example.

Under the present system, whether an offender is sent to prison or to a mental hospital depends upon the judge's application of the M'Naghten rule in deciding whether the defendant is legally insane. This formula, which dates back to 1843, is completely at variance with current psychiatric opinion.

At any event, the mere isolation of sexual offenders by society cannot suffice for the prevention of dangerous perverse acts. As we know, sexual deviations have their origin in childhood and may be fostered by unconscious or conscious parental attitudes and influences. Either by prohibiting genital sexuality or by directly encouraging tendencies to pregenital manipulations, the parents may actually foster the development of perverse sexual strivings, thus giving them super-ego sanction. Sometimes the very manner in which the child is admonished for a perverse act is designed to encourage the perversion. Concurrent therapies of parents and children indicate that similar perverse tendencies are often present in both. Public enlightenment thus may contribute eventually to the prevention of sexual offenses.

Therapy

In discussing methods used in the treatment of sexual inversion, Ellis[50] noted the ineffectiveness of castration or vasectomy. Hypnosis, as used by Krafft-Ebing,[127] Schrenck-Notzing,[171] and others, achieved only very limited and short-lived success. The association technique developed by Moll[151] consisted essentially in attempts to shift or recondition the patient's inclination from homosexual to heterosexual object-choice by utilizing similarities between the two, for example, using an attraction to boys as a basis for developing an attraction to boyish-looking girls.

In contrast to these various methods, which aimed at a cure of the inversion as such, Hirschfeld's[104, 105] "adaptation therapy" sought primarily to adjust the patient to his inversion; it was advocated and employed particularly by those who stressed the congenital character of inversion. Some authors, notably Ellis,[50] expressed the view that treatment of the congenital invert should aim at what today would be called sublimation of the inverted impulse. Adaptation in this sense undoubtedly represents a legitimate therapeutic objective in a large number of cases.

One of the central difficulties in the treatment of perversion lies in the fact that the pervert, unlike the neurotic, derives conscious gratification from his symptoms. Hence very few perverts seek treatment on account of their perversion, unless they are forced to do so because of external pressures. More frequently, they consult the psychiatrist on account of concurrent neurotic symptoms.

However, even when a patient initially has no desire to be cured of his perversion, some progress can often be made by showing him some of its genetic sources. Such insight opens the path to further analytic work. Where guilt feelings (as distinguished from mere social fears) can be made conscious to the patient, the therapeutic outlook is more favorable.[124] In the treatment of perversion, as in the treatment of phobias, direct intervention is often necessary. A completely neutral attitude in the therapist is apt to be interpreted by the patient as parental sanction. Thus in many instances it is advisable to impose the rule of abstinence as soon as the transference situation provides a suitable basis for the successful use of such intervention.

There is no doubt that, in those cases which are amenable to treatment at all, psychoanalysis is the method of choice, but there are many instances in which it is difficult to obtain a cure. Even when the removal of a person's perverse symptom proves impossible, psychotherapy still can help him to reach a better social adjustment.

In 1935 Freud[111] wrote to an American woman who appealed to him for advice about her homosexual son:

Dear Mrs. . . .

I gather from your letter that your son is a homosexual. I am most impressed by the fact that you do not mention this term yourself in your information about him. May I question you, why

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you avoid it? Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual function produced by a certain arrest of sexual development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michelangelo, Leonardo da Vinci, etc.). It is a great injustice to persecute homosexuality as a crime, and cruelty too. If you do not believe me, read the books of Havelock Ellis.

By asking me if I can help, you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way, we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies which are present in every homosexual, in the majority of cases it is no more possible. It is a question of the quality and the age of the individual. The result of treatment cannot be predicted.

What analysis can do for your son runs in a different line. If he is unhappy, neurotic, torn by conflicts, inhibited in his social life, analysis may bring him harmony, peace of mind, full efficiency whether he remains a homosexual or gets changed. If you make up your mind he should have analysis with me!! I don't expect you will!!! he has to come over to Vienna. I have no intention of leaving here. However, don't neglect to give me your answer.

Sincerely yours with kind wishes,
Freud.

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CHAPTER 30

DRUG ADDICTIONS

Marie Nyswander

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As viewed by the medical practitioner, drug addiction today has three distinct aspects—psychological, pharmacological, and sociological. Of these, only the pharmacological aspects appear to remain constant. Regardless of time and place, pharmacological manifestations of the use of narcotics and the predictability of their effects have not changed.

¶ History of Narcotic Drugs

We find that man has used opium (from the opium poppy, *Papaver somniferum*) as far back as we have recorded data. Findings indicate that the Europeans have been cultivating opium for at least four thousand years, and the earlier records of the Sumerian civilization indicate that not only was the drug in use then but was given a name which it still holds today, "the plant of joy." Ancient writings show that opium was used throughout the rise and fall of the Babylonian, Egyptian, Grecian, and Roman empires. Homer refers to the poppy and its properties of "lethal slumber."

Hemp (*Cannabis indica, Cannabis americana*) has an equally long history of use as a narcotic and medicine, dating before 500 B.C. In India this drug was used orally in connection with certain religious rites. Its use did not remain restricted to India but, along with opium, was well known to the Europeans.

Records of the use of the leaves from the erythroxylon coca tree date it as a later discovery of man, occurring in the eleventh century in South America. This tree was utilized by the Incas in their religious rites. It seems entirely probable that the chewing of coca leaves has been a custom there as long as men have inhabited the region. Its introduction to Europe, however, was not until the middle of the eighteenth century and is credited to Joseph de Jussieu, a botanist.

Prior to 1903 opium and cocaine were used in their crude forms. Opium was smoked or the tincture, known as laudanum, was taken orally. At the beginning of the nineteenth century, Sertürner[15] isolated an active constituent from opium, which is known as morphine. Within the following thirty years, codeine, narcotine, papaverine, and other alkaloids derived from opium were discovered.

The invention of the hypodermic needle by Woods of Edinburgh in 1853 was to play an

important role in the story of modern addiction. At the time of the hypodermic's discovery, the claim was made that addiction was not possible if hypodermic administrations were used. The explanation for this claim was that if the narcotics did not reach the stomach, the person would not develop a "hunger" for them.

In 1898 heroin was isolated from opium and was widely heralded as a nonaddicting substitute for morphine. Its use became widespread, and fully fifteen years elapsed before physicians acknowledged its great addicting propensities.[16] Since that time, chemists have created a number of analgesics, hoping for one with the effect of morphine but without its addicting qualities.

Narcotics consist of two groups: (1) opium and its derivatives, and (2) their synthetic equivalents.

Opium is available for medical use in its pure powdered form. When opium is mixed with ipecac, its proprietary name is Dover's powder. Laudanum is a tincture of opium, and when this tincture is camphorated it is known as paregoric. Pantapon is a refined opium which is available for oral as well as hypodermic use.

The derivatives of opium include morphine, heroin (not manufactured in the United States), Dionin, Dilaudid, Metopon, Dromoran, and codeine. Codeine, too, has derivatives, namely eucodal and Dicodid (Hycodan). The two last-mentioned drugs are used more frequently in Europe than in the United States. The synthetic equivalents of the opiates consist of Demerol (meperidine, Dolantin) and methadon (Amidon, Dolophine, and Adanon).

Each of these drugs was originally felt to be nonaddicting, but in a short time after they became available, primary addictions to them were occurring.[19] The addictive potentiality of these drugs has been graded from the greatest to the least, in the following order: morphine, heroin, Dilaudid, Metopon, Demerol, methadon, and, lastly codeine.

Since 1915 the addict's drug of choice in the United States has been heroin. This has undoubtedly been due to the fact that it has a greater potency than the other narcotics and is also more easily obtained. Juvenile addicts use it almost exclusively. Its presence here is, of course, illegal. It is made from opium or morphine, probably in this country. Second in preference to heroin is morphine. However, addicts will use any narcotic if their drug of choice is not available.

Cocaine addiction is comparatively rare owing in part to its scarcity and to the fact that its effects of visual and auditory hallucinations are feared by most addicts. There is no evidence that tolerance is built up by repeated use of cocaine, nor that withdrawal symptoms occur at its cessation.

There has been a marked rise in the use of marijuana (Indian hemp) in both the American and European continents. In India it is either chewed or mixed with liquid drinks, but here it is smoked in the form of cigarettes. Its use is primarily confined to juveniles and jazz musicians. Its chief harm may be that it brings the user in contact with dispensers of heroin. There is no evidence that marijuana inflicts serious harm on the smoker. Although transient psychoses have been reported, these are few. Like cocaine, there is no tolerance developed, and there is no evidence of withdrawal symptoms upon its discontinuance. Marijuana creates for the smoker a euphoric state in which time passes seemingly very slowly. The pharmacological actions are not known but are probably cerebral in origin. Intellectual and muscular performance are impaired, and electroencephalograms show an increase in the muscular activity of the scalp.[20]

¶ Incidence of Drug Addiction

The nineteenth century marked the advent in this country of large-scale addiction. In 1885 addiction in the United States was estimated at from 1 to 4 per cent of the population. The exact incidence is still unknown, but a decrease in addiction occurred with the passage of revenue acts throughout the world, thus bringing drugs under government supervision (Harrison Narcotic Act, 1914, United States, and The Dangerous Drug Act, 1916, England).

Estimates of the incidence of addiction currently range from 60,000[2] to triple that number. England estimates only 400 addicts!

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Since 1914 the United States laws governing addict, peddler, and the physician-addict relationship have been the most stringent in the world, but it cannot yet be said that these measures have succeeded.

Addiction is common to the large cities and occurs most in New York, Chicago, San Francisco, etc. In the southern part of the United States, addicts are to be found primarily in the smaller towns.

The sexual ratio of addicts has reversed itself with the advent of the Harrison Narcotic Act. Prior to its passage, there were approximately 3 females to 1 male addict. At present, the ratio is 4 males to 1 female.

Except for physicians and nurses who comprise the largest single professional group, addicts are, on the whole, unskilled workers. This fact is explained by their early association with drugs, which interrupts all schooling.[17]

Studies of the religious background of addicts fail to reveal any predominant sect. Although recent surveys point to a rise in the incidence of addiction among Jews and Catholics, the evidence is not as yet conclusive.

It is, of course, an arduous task to estimate the family background of an addict. However, preliminary studies showed that 54 per cent came from homes that were intact and relatively normal.[11] More recent studies reveal varying psychological disturbances taking very specific directions.[1] In almost half the families investigated, the father of a juvenile addict either worked out of town, lived apart from the family, or was indifferent if not hostile to the addict. The mother appeared to dominate the household. Furthermore, these families were shown to have an undemanding attitude toward the addict. They did not encourage him to follow a vocation or schooling. As an example of this, one mother said to me, "Steve was never very good in school, but neither was I, so I didn't worry. I just wanted him to get by and be happy." This boy had an I.Q. of 124.

¶ Addiction Defined

British physicians have a simple operational definition of the addict—a person who feels normal on drugs.

In the United States Wikler defines addiction as the compulsive use of chemical agents which are harmful to the individual, to society, or to both.[21]

Tolerance

Inherent in the definition of addiction are the phenomena of tolerance, dependence, and relapse.

Tolerance is the condition in which a diminution in the effectiveness of a drug occurs with repeated use. It is illustrated in addicts in whom tolerance reach has been built to as high as 75 gr. of morphine a day with no untoward effect.

Tremendous tolerance can be built up in a matter of months. Experimentally, it has been demonstrated that a tolerance of 1,200 mg. a day can be established in four months' time.[23]

With the development of tolerance to narcotics, some of the effects of a single dose of the drug cease. Thus, in the case of morphine addiction, there is no longer a depressant effect on respiration. With the growth of tolerance, the characteristic constipation may leave or may turn to diarrhea. The characteristic constriction of the pupils often disappears.

The physical reasons why addicts can tolerate such high doses of the drug are not yet understood. Tolerance is known to develop most easily under the regular administration of the drug. Recent reports indicate that a high degree of tolerance may occur with as few as eight doses of morphine administered in a two-day period.[22]

At present there is some indication that the early theories concerning the metabolic rate at which an addict destroys morphine in the body have some basis in fact. Another explanation was offered by the cellular-tolerance theory which postulated that the cells of the central nervous system become hyperirritable with repeated use of morphine and hence require more and more of the drug to reduce them to a state of equilibrium.

Dependency and the Abstinence Syndrome

Physical dependency on the drugs is dramatically demonstrated when, after addiction

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is present, the drugs are withheld. The abstinence syndrome, thus provoked, consists of dilation of the pupils, twitching of the muscles, goose flesh, lacrimation, rhinorrhea, yawning, and sneezing. If allowed to continue, the symptoms may become alarmingly severe, with profuse sweating, elevation of temperature and blood pressure, vomiting, and dehydration. Although few deaths occur under even abrupt withdrawal, it is generally considered to be inhuman to give such treatment.

Withdrawal symptoms are physiologically determined and have been produced in dogs, cats, and monkeys, as well as in spinal and decerebrate preparations.[24]

Through the use of drugs, a new biological dependency such as thirst or hunger has been created.

A chemically induced abstinence syndrome may be effected with administration of the drug Nalline (n-allyl-normophine) to a person who is addicted. Nalline is antagonistic to the effects of morphine, despite the fact that it is also an opium derivative. Discovered in 1912,[18] it is in chief use by obstetricians who employ it to rid the newborn of possible lethargic effects from the narcotics given previously to the mother.

It is interesting to note that when Nalline is given in combination with morphine, it does not diminish that drug's analgesic effect.

Relapse

Relapse is generally considered to be psychological and social in origin. However, there may be a pharmacogenic factor in relapse. It is quite common to observe addicts, during a long prison confinement, undergoing withdrawal signs. They subjectively report a deep craving for drugs and simultaneously experience mild lacrimation, sweating, etc. Whether they are psychologically reproducing the signs of physical dependency or whether there is a chemical stimulus involving the central nervous system has not been clearly determined as yet.

¶ Clinical Course of Addiction

Despite popular belief, addiction does not seriously impair either the mind or body, as do barbiturates and alcohol. There is no evidence of mental deterioration caused by drugs even after an addiction as long as fifty years.[12] Although addicts neglect their bodies and, as a result, may appear emaciated or have rotting teeth, they are a surprisingly healthy lot.

The course of addiction varies with the laws of the country as well as with the economic status of the addict. In England there is little association of criminality with addiction. In the United States those addicts who have been medically addicted and continue to receive drugs from physicians retain their economic status, working and living normally with their neighbors. The wealthy addict is rarely hailed into the courts.

The larger majority of addicts in this country, are, however, forced into social deterioration. Because of the exorbitant cost of illegal narcotics, addicts must rob, steal, prostitute, pimp, or peddle drugs. Social, not pharmacological, factors produce this type of criminality.

The years spent as a social outcast take their toll. For the ordinary addict, any dream of living within the law must be discarded. A marked diminution in libido may lead to marital difficulties. Gradually, the addict's main goal of existence becomes the satisfaction of his need for drugs.

¶ Psychodynamics of Addiction

Personality theories of the addict advanced twenty to thirty years ago have generally been discarded with the accumulation of data from institutions such as the United States Public Health Hospital at Lexington, Kentucky. In addition, these years have also seen a change in the type of addict himself.

Whereas dynamics of addiction formerly grouped narcotic addiction with alcoholism, pharmacological and psychological data now available warrant a clear line of demarcation between the two.

Drug addiction cannot be said to follow one specific neurotic pattern. Studies show that psychotic disturbances do not occur any more frequently among addicts than are found elsewhere.[12] Using our current nosology, addicts would fall into three main categories of personality disturbances: (1) inadequate person-

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alities, (2) character disorders, and (3) all varieties of neuroses.

Psychiatric diagnoses have not appeared to be helpful in predicting the course of treatment for an addict. Borderline psychotics often surmount addiction and remain drug-free, and mild character disorders often remain in transient addictives. We must conclude that addiction may exist in individuals with almost any psychic organization, and that they may overcome the illness without necessarily undergoing any obvious change in the personality.

There is undoubtedly a psychological factor which determines an individual's reaction to drugs and, more specifically, why he chooses the drug he does. Work with placebos indicates that the person who will get consistent relief of pain from placebos is also apt to favor opiates over other drugs.[3]

Work by Chein[1] on the premorbid personality shows specific psychiatric disturbances which predispose such a person to addiction. Gerard[4] holds that all juvenile addicts are very disturbed individuals and would probably have required help in meeting their life problems whether or not they took to drugs.

Omnipotence, grandiosity, and magical thinking are revealed by conscious daydreams. Mistrust bordering on paranoid projections is frequently encountered. An inability to relate other than in a narcissistic fashion is best illustrated by the addict's frequent belief that he is so uniquely interesting that he should be paid by the treating psychiatrist.

Characteristic of the addict's psychology is his ambivalence regarding drugs. This is reflected in his statements and in his jargon, in which he refers to drugs as "junk" or "crap."

One observes a flattened effect in some addicts. This state is desired by the addict and is given the word "cool." In his innermost self, his idealized image is to be a person who is quiet, untroubled, and contemplative. Narcotics facilitate just such a state by virtue of their action on reducing aggression. So strong is the action of narcotics on aggression that vicious criminal tendencies have been known to have been reduced or eliminated after addiction.[6]

The continued use of drugs solidifies behavior, which includes a passive withdrawal from the main stream of life. His symptom becomes like a religion to the addict, and he moves in a circle inhabited by other devotees. They not only accept, in each other, the antisocial behavior into which they are forced but develop their own language for interchange. Although they, in part, feel rejected by the nonaddict world, they, in turn, exclude nonaddicts. Though these concomitants to addiction may prove decisive in the treatment of addicts, they are not necessarily representative of the basic dynamics behind addiction.

Wikler Theory

I think it can be readily seen that a discussion of the psychodynamics of addiction in terms solely of unconscious impulses and psychic organization is to avoid the specific role which the continued use of drugs plays on an individual's reality and unconscious.

The theoretical formulations of Wikler are based on animal and human subjects and are the most comprehensive and inclusive that we have to date.[23] His postulated psychodynamics take into account the specific actions of narcotics.

Wikler has demonstrated that the specific actions of narcotics are based on the primary needs of man: hunger, sexual urges, aggression, and removal of anxiety and pain. Thus when the addict says he feels "normal" on drugs, he does. He feels sexually satisfied, full of food, and free from anxiety and pain; nor is he beset with aggressive strivings. (This is in marked contrast to the alcoholic who chooses a drug which releases inhibitions and becomes belligerent, exhibitionistic, grandiose, etc.)

Wikler concludes that "regardless of conventional personality classifications which may be applied to them, addicts are individuals in whom the chief sources of anxiety are related to pain, sexuality and the expression of aggression."

In summary, then, we may say that the complicated psychodynamic picture of the addict must include: (1) a possible premorbid personality problem, (2) normal strivings on

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a sexual and aggressive level, (3) overwhelming anxiety when it comes to satisfying these strivings by life's ordinary methods, (4) the knowledge of a drug which is pharmacologically specific for satisfying these strivings, (5) the creation in him of a new need by the use of narcotics, and (6) the all-important secondary reactions and gains from the continued use of them.

¶ Diagnosis

The diagnosis of drug addiction may be made quite simple for the physician by the manner in which the patient states his problem. The addict who is seeking drugs rather than treatment will probably attempt to simulate painful illnesses. He may put blood in his urine and complain of kidney stones. He may clutch his abdomen, heart, or back and complain of ulcers or a heart or gallbladder attack. Needless to say, the mention of a complete work-up before any medication is prescribed will generally speed his departure.

In cases involving former addicts who are attempting to reinstate themselves with a licensing bureau or an employer, Nalline has proved an effective gauge. Administration of 5 mg. of this drug to an actively addicted person will produce withdrawal symptoms within twenty minutes. Some patients offer to take such a test monthly, in order to reassure their families or employers. A cautionary note: Before Nalline is given, the patient should be forewarned that if he is on drugs, the injection may precipitate serious withdrawal effects which will be refractory to morphine for a period of about two hours.

¶ Treatment

Psychiatric Treatment

Perhaps in no other field of medicine have so many strongly held beliefs been held by so few and developed on the basis of so little experience. The present recommended official treatment procedures stem from, and are limited by, recommendations made by the American Medical Association in 1924, which resulted in the Treasury Department issuing regulations which prevent physicians from administering opiates for the maintenance of addiction. This action seems to have been based on the widely held assumptions that addiction was evil, caused physical deterioration, and forced people into vicious crimes, and that physicians would be forced into criminal collusion if allowed to prescribe narcotics for them.

Although professional groups and individuals, surveying the current treatment status, suggest some modification of these early regulations, the basic premise for most treatment still is based on a moral attitude toward addiction. It follows, then, that acceptable treatment at the present time includes (1) enforced institutional treatment for approximately four months, (2) regulations against ambulatory treatment until the subject is drug-free, and (3) prohibition of self-administration of drugs even if regulated by a physician.

Estimates of cures based upon thirty-five years of these procedures range from 1 to 15 per cent.[13] It would appear that the old saw is true of the drug addict: "He who is forced against his will is of his own opinion still." Modern psychiatric knowledge insists that we take into account the motivation of a patient. It would therefore appear that supportive, reeducative, and rehabilitative methods are of little use to the addict when they are forced on him or when he has not expressed any wish for such help.

Successful treatment of addicts who wish help can be effected and is being effected despite limitations placed upon the physician. It is impossible to ascertain how large a group these addicts comprise. There are several papers available describing the successful psychoanalytic treatment of addicts on an ambulatory basis.[10, 14]

Psychiatric treatment of addicts does not differ from the treatment of any disorder which has symptoms of a behavioral nature. The presence of addiction may be treated as may any other symptom. A recent study[10] showed that, during the course of ambulatory psychiatric treatment, all the patients who con-

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tinued therapy requested help for withdrawal, on their own initiative, within three months. Withdrawal, under conditions where the patient requests it, becomes a relatively minor procedure and may be accomplished at home or in a local hospital. One such patient, addicted for ten years to 4 oz. of paregoric daily, conducted her practice of law during withdrawal. She was gradually withdrawn (administering drugs to herself) and finally hospitalized over a week end to complete total discontinuance.

Withdrawal Treatment

Withdrawal treatment of all narcotics (except primary addictions to codeine and Demerol) consists of giving the addict either morphine or methadon and slowly reducing the dosage until he is entirely off drugs. The maximum initial dose for any addict is either ¼ gr. morphine or 10 mg. methadon four times daily. In morphine withdrawal, dosages are reduced to ⅛ gr. morphine, and then 1 gr. codeine is substituted. This amount is eventually reduced to the vanishing point. In methadon withdrawal, the patient is kept on 5 to 10 mg. of methadon four times daily for several days. The shots are progressively reduced during the next few days and then stopped altogether. The major difference between withdrawal results of the two drugs is that morphine produces severe withdrawal symptoms within twenty-four to seventy-two hours, whereas methadon produces milder symptoms which occur from four to seven days after the drug has been discontinued entirely. A description of the detailed management of the patient during withdrawal can be found in the paper of Nyswander.[9]

To sum up, it can be said, in general, that addicts who consult the physician in order to be withdrawn from drugs, or for psychiatric treatment, can be helped, and that, as far as the majority of addicts are concerned, the physician can do nothing until they—for reasons of their own—seek such help.

¶ Barbiturate Addiction

Although hospital records show admissions for barbiturate addiction which date back twenty-five years or more, it was first reported in the medical literature in 1949 by Isbell.[5] It is still not uncommon to meet or to receive letters from physicians who vehemently deny that such an addiction can occur.

Barbiturate addiction is indeed very common and frequently goes unrecognized. The patient who is taking two, three, or four sleeping pills a night is more than likely addicted. He not only will not stop, he cannot stop. And if he does stop abruptly, he may experience such discomforting symptoms that he will beg to return to the pills or will obtain them without the physician's knowledge.

Tolerance for great amounts of barbiturates can be built up by the body. I have withdrawn patients taking as much as 40 gr. a day.

Barbiturate addiction greatly resembles the picture of alcoholism. In fact, both may occur in the same individual. Alcoholics are very prone to this addiction, and the drug should be used sparingly if at all with them.

Because of the mental status of a barbiturate addict, he usually appears as an unkempt individual whose gross and finer muscular control is poor. His gait may be staggering. His sensorium will be clouded and, like the alcoholic, his judgment will be greatly impaired.

The continued use of barbiturates, unlike opiates, is mentally deteriorating, and organic changes are to be seen on the electroencephalogram.

The abrupt cessation of barbiturates or even too rapid withdrawal of the drug may produce serious consequences. These withdrawal symptoms may range from gross tremors, disorientation, and hallucinations to tonic-clonic convulsions and hemiplegia.

Of prime importance in the treatment of this addiction is the use of the same drug for withdrawal.[8] *There is no substitute drug for withdrawal.* Treatment must be accomplished by a gradual reduction over a period of from

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one month to six weeks. Withdrawal symptoms may occur anywhere from one day to a week after cessation of drugs. Needless to say, hospitalization is preferable for withdrawal. However, I have found it possible, by daily contact, to withdraw people quite satisfactorily on an ambulatory basis. In planning a withdrawal routine, it is necessary to specify the time that medication is to be taken. Midmorning, midafternoon, and bedtime are satisfactory for this. Reduction of the daytime medication by one or two pills every other day is a safe procedure. We have found that if the reduction does not exceed 50 per cent of the total dosage within a four-day period, withdrawal symptoms are not likely to occur.

In the event that the patient begins to show serious mental or physical symptoms of withdrawal, they can be quickly stopped by the administration of intravenous barbiturates.

¶ Amphetamine Sulfate (Benzedrine) Addiction

The occurrence of addiction to the stimulants Benzedrine and Dexedrine seems to have been considerably lessened in the last five years. This is due in part to the wider knowledge of its occurrence as well as to the manufacturers, who have cooperated in making the drug less easily available for abuse. However, primary addictions to these drugs do exist, and tolerance may reach proportions as high as 1,500 mg. daily.

The symptoms of addiction to amphetamine sulfate include the inability to stop its use, increase of dosage, insomnia, restlessness, irritability, and organic psychoses, including visual and auditory hallucinations.[7]

Unlike the other addicting drugs, the withdrawal treatment can be instituted by abrupt cessation of drugs. There are no withdrawal symptoms of great import.

There is no question that the prescribing of this drug should be under strict medical supervision to prevent the patient from using it as a daily "pickup." Its indiscriminate use frequently becomes the excuse for the patient to begin the use of barbiturates to "quiet him down." Thus the stimulants may usher in a more serious addiction to barbiturates.

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CHAPTER 31

ALCOHOLIC ADDICTION AND PERSONALITY

(Nonpsychotic Conditions)*

Israel Zwerling
Milton Rosenbaum

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The use of alcohol to induce a state of altered consciousness extends back into the earliest history of man—Noah (Gen. 9:21) was, perhaps, the first inebriate—and extends, as well, over virtually all of the earth. The varieties of beverages created to provide the alcohol, and of techniques for their preparation, are almost countless. A recent estimate cited by Keller and Efron[19] is that 68,000,000 persons in the United States drink alcoholic beverages, and Lewis[26] has noted that the annual expenditure in this country for alcoholic beverages exceeds the entire national expenditure for education. In itself, and as a reflection of man's ingenuity in inventing sources of pleasure, this is a phenomenon which would merit psychological investigation. Far more compelling of attention, however, is the population of alcoholics:

> . . . those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations and their smooth social and economic functioning; or show the prodromal signs of such developments.[46]

The magnitude of the population of alcoholics clearly establishes this entity as a major mental-health problem, and there is evidence that the prevalence has increased during the decade

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since Jellinek's classic estimate of alcoholism rates.[17] Keller and Efron, after converting total numbers of alcoholics with and without complications into rates for persons over twenty years of age, find a steady increase in the total prevalence rate in the United States from 1920 to 1953. For the latter year they estimate a total rate of 4,390 per 100,000 adults (7,590 per 100,000 men and 1,320 per 100,000 women) and a total of 4,589,000 alcoholics. The impact of this large population upon medical and hospital services, upon the national economy, upon judicial and correctional institutions, and upon family and community life is again of the highest order of significance.

A number of difficulties inherent in the study of alcoholism are pointed up by the very definition of this entity. Although there is no unanimity in support of the World Health Organization definition stated above, most current writers are in accord on the basic elements contained in this definition, perhaps with more specific attention to the compulsive character of the drinking. To begin with, the definition is descriptive and symptomatic, rather than etiologic, in character. It embraces a triad of phenomena at different levels of integration—physiologic, psychologic, and social—which not only characterize alcoholism clinically but also provide crucial data concerning etiology and treatment. Again, there is no possibility of quantification in such a definition, so that only qualitative estimates of the several elements may be made. Finally, the crucial criteria for the condition are social, and this introduces the temporal, ethnic, and class variability of, for example, standards of "good" and "poor" interpersonal relations, or of "good" and "poor" social and economic functioning, into the establishment of a psychiatric "diagnosis." One reflection of these difficulties has been the profusion of qualifying terms—"primary" versus "secondary" alcoholism; "symptomatic" versus "addictive" alcoholism, etc.—which may have some descriptive value but, in the end, add little more than new borderline states. The formal resolution of the Committee on Alcoholism of the Council of Mental Health of the American Medical Association (1956) that it and ". . . the profession in general recognizes this syndrome of alcoholism as illness which justifiably should have the attention of physicians" is a reflection of these difficulties in definition; there are, indeed, few diagnostic entities which were voted into the official nomenclature. Furthermore, the recency of this decision—that alcoholism is a medical rather than a moral problem—merits comment. The basic moral attitude to alcohol has been to characterize it as an evil, and its use as sinful. The Book of Proverbs enjoins, "Look not upon the wine when it is red, when it sparkleth in the cup, when it goeth down smoothly; at the last it biteth like a serpent and stingeth like an adder" (23:31, 32). In the sixteenth century, Sebastian Franck cautioned in his text *On the Horrible Vice of Drunkenness* that "More men are drowned in the glass than in the sea." A very recent pamphlet, which earnestly and intelligently stresses that alcoholics are sick people rather than hardened sinners, is yet entitled *Strong Drink is Raging* and pleads for "reverent understanding" that "Alcoholics are God's children, too—unlovely, perhaps, but God's." Undoubtedly, the persistence of the moralistic attitude toward alcoholism, in both lay and professional persons, and present at both conscious and unconscious levels, has seriously retarded the development of research and treatment programs.

The greatest difficulties in the study of alcoholism derive from the fact that data from physiologic, psychologic, and sociocultural fields are of such immediate relevance as to require that any approach to etiology, pathogenesis, or treatment take cognizance of all three. The observation, for example, that alcoholics may tend to be overly dependent in their adaptation does not readily suggest an application to the finding that a disproportionately larger number of persons of Irish descent, and a disproportionately smaller number of persons of Chinese descent, in the United States, are alcoholics; nor, again, to the finding that 17-hydroxycorticoid excretion is reduced in alcoholic patients. The philosophic problem of dealing simultaneously with entities at different levels of integration is as old as the mind-body problem, and a recent attempt at a resolution in application to be-

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havioral science by Gerard[8] is noteworthy. The plan of the present chapter is to describe the conceptualizations concerning relationships between personality and alcohol addiction, and then to attempt an integration of psychodynamic and sociocultural formulations.

Nonspecificity Formulations

A number of excellent summaries of the psychiatric literature on the etiology and pathogenesis of alcoholism have been published (Lemkau, Gibbins, Lorand, etc.), and an additional review is not justified. However, attention is called to the frequency with which the opinion is offered that there is no single specific personality disorder basic to alcoholism, at the same time that there is virtually no existing study which denies the coexistence of *some* personality disorder with every instance of chronic alcoholism. Diethelm[6] has noted, "There is not sufficient evidence to support the claim that specific personality types predispose to alcoholism." In the same volume Sherfey reviews the variety of psychiatric diagnostic categories found in a population of alcoholics, and concludes ". . . that alcoholism is not a single entity or disease, but a symptom associated with several illnesses or syndromes." A variant of this view is developed by Higgins[11] whose concern is rather with dynamic than with clinical diagnosis. He writes:

> In short then, a revised hypothesis can be briefly expressed in the following way: A predisposed person (*and the predisposition may represent fixations at various levels of personality development*) [emphasis ours] is confronted with a difficult life situation; the difficult situation may or may not be one which has as its primary component an oral threat; an attempt is made, through drinking, to handle the anxiety aroused by this conflict. The drinking may serve as a defense through various channels; it may bring diminished awareness of internal or external stress, or it may facilitate defenses previously inhibited.

It will be noted that two quite separate viewpoints are involved. The first holds that the finding of various clinical psychiatric diagnoses in a population of alcoholics is evidence of the lack of specificity of the psychopathology of alcoholism. This appears to the present writers to be a confusion of process and content: a constellation of traits may well be hypothesized to be basic to the etiology of addictive drinking, and yet be embedded in such a diversity of character structures as to be obscured to eyes focused only upon the most dominant integration of the total personality. A model is suggested by a perceptual test used by one of us in the study of alcoholism, the "Embedded Figures Test." A simple geometric figure (say, a pyramid) may be exposed to a subject, who will then experience difficulty in identifying it when it is re-presented but obscured within a complex geometric design. Patently, this is a mechanical and far more simple situation: the pyramid is not itself altered by the complex form in which it is embedded, and we would not expect a basic character pattern to be similarly impervious to broader integrative patterns of the total personality. But, the observation that a wide range of clinical diagnoses may be found among addictive drinkers does not preclude the role of a specific personality constellation as basic to the etiology of chronic alcoholism. The conclusion of nonspecificity reflects an approach to psychopathology which ignores unconscious processes.

The second viewpoint denying a unitary personality basis for alcoholism derives from the observation that conflicts at various personality levels may elicit drinking as a defense against anxiety—to make instinctual impulses more acceptable, or to make defenses more acceptable, or to narcotize the individual against the pain of the conflict. Again, as with the observation that many clinical diagnoses are to be found among alcoholics, this is readily verified in the course of the psychiatric study of alcoholic patients. The nonalcoholic who must "prime" himself for a sexual, or assertive, or aggressive situation, or who finds that a cocktail or a beer before dinner picks him up after an arduous day's work, is quite familiar, and the alcoholic who traces a binge to a dependency threat, a homosexual threat, a heterosexual threat, the threat of the crup-

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tion of powerful hostile impulses, or whatever, is equally familiar. But the existence of an underlying personality disorder common to alcoholics is not at all precluded by the observation that alcohol may be pressed into the service of the personality at all levels of conflict and in association with all varieties of defense. The question as to why the addictive pattern develops in some of the army of imbibers, and not others, remains quite unsolved by such observations. It is not crucial to the thesis that the addictive *process* develops on a specific personality base, that any specific addictive *practice* must similarly trace to conflicts derived from this same base. It is the view here proposed that alcoholism may be found in the setting of any clinical diagnostic state, and that specific drinking episodes may occur in relationship to conflicts at all personality levels, but that the addictive process does develop in a specific character matrix.

¶ Psychoanalytic Formulations

A number of contributions attempting a description of the psychodynamics of alcohol addiction have been developed out of experiences with the psychoanalysis or psychotherapy of alcoholics; those of Rado,[33] Knight,[22] and Lolli[27] will be briefly summarized.

Rado starts by stressing that ". . . not the toxic agent, but the impulse to use it, makes an addict of a given individual" and further, that ". . . we feel impelled to regard all types of drug cravings as varieties of *one single* disease" which he terms "pharmacothymia." He finds, in the potential addict, ". . . a certain active preparedness for the pleasure-effect of the elatent drug." This derives from their membership in ". . . the group of human beings who respond to frustration in life with a special type of emotional alteration, which might be designated tense depression . . . marked by great painful tension and at the same time by a high degree of intolerance to pain." This condition is remarkably improved by alcohol, which brings about a sharp rise in self-regard and an elated mood. Rado stresses that this magical effect is brought about by the ego itself: "A magical movement of the hand introduces a magical substance, and behold, pain and suffering are exorcised, the sense of misery disappears and the body is suffused with waves of pleasure." This state is, however, inevitably followed by the rapid return of the tense depression, and with it the renewed craving for elation: ". . . the ego is now maintaining its self-regard by means of an artificial technique." The sexual life of the patient is rapidly caught up in the addictive illness—"all elatents poison sexual potency . . . the pharmacogenic attainment of pleasure initiates an artificial sexual organization which is autoerotic and modeled on infantile masturbation . . . the pharmacogenic pleasure-effect discharges the libidinal tension associated with these (oedipal) fantasies. The pharmacogenic pleasure process thus comes to replace the natural sexual executive." The self-destructive aspects of the pattern inevitably are presented to the addict: by illness consequent to the addiction, by pressure from family and friends, and by the increasingly transient nature of the pleasure. The addict characteristically handles the crises which arise by a transient flight into a free interval; alternatively, suicide or psychosis may be seen. This free interval can only be a brief interlude, and the pharmacothymic process reasserts itself. Rado views homosexuality in addiction as a fusion of genital erotism and masochism—as retreat from active heterosexual pursuit, denial of castration, and the pursuit of the passive goals of masochism. In his recent restatement of his views,[32] the essence of the addictive process remains unchanged, but with the substitution of the adaptational concept of hedonic regulation for the classic libido theory, there is less specific concern for the symptomatic manifestations of the replacement of the sexual pleasure apparatus by the pharmacothymic pleasure system.

Knight presents a summary of his observations on the psychodynamics of the alcoholic as follows:

His childhood experiences have given him a personality characterized by excessive demands for indulgence. These demands are doomed to frustration in the world of adults. He reacts to

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the frustration with intolerable disappointment and rage. This reaction impels him to hostile acts and wishes against the thwarting individuals for which he then feels guilty and punishes himself masochistically. As reassurance against guilt feelings and fears of dangerously destructive masochism and reality consequences of his behavior, he feels excessive need for affection and indulgence as proof of affection. Again, the excessive claims, doomed to frustration, arise, and the circle is complete. The use of alcohol as a pacifier for disappointment and rage, as a potent means of carrying out hostile impulses to spite his parents and friends, as a method of securing masochistic debasement, and as a symbolic gratification of the need for affection is now interweaving itself in the neurotic vicious circle.

He observes that the mother of the alcoholic is characteristically overprotective and indulgent, and ". . . by fostering the pattern of soothing the infant through oral pacifying, she builds in a pattern of tremendous strength." It is out of this course that alcoholism develops as an attempt to cure or solve some emotional conflict. Knight denies any specificity as to the type of emotional conflict—"any type of neurotic conflict may be present"—but traces the development of addiction to early experiences which produce the impulsive character structure which cannot tolerate frustration, which responds with rage and, in turn, guilt and masochistic repair, and which sustains itself through proof of affection which is unrealistic and insatiable, and thus continuously feeds frustration back into the addictive cycle.

Lolli has approached alcohol addiction as a manifestation of a diseased food attitude, and has noted the significant parallels between compulsive drinking and obesity. His most recent summary formulation of the psychodynamics of alcoholism may be quoted:

> The alcoholic experiences unconscious and to a certain extent conscious longings for physical warmth, pleasurable skin sensations, maternal coddling, liquid and warm feelings in his stomach which are not differentiated from longings for security, reassurance, self-respect, independence and, at times, omnipotence. In contrast to the infant, the alcoholic is denied in real life the experience of undifferentiated pleasure of body and mind for which he is hopelessly yearning. The revelation that alcohol is able to provide a blended pleasure of body and mind marks the beginning of the addiction. . . . Under its influence (i.e., alcohol) the alcoholic first disregards and finally denies the reality of the world he lives in. . . . The alcoholic is an individual who lives under the tyranny of his past, of his very early childhood. The confusion between pleasures of the body and pleasures of the mind which is normal in the infant hinges around the alcoholic's adult life. Thus, the beverage alcohol is closely linked with the beverage milk which quenches the infant's thirst, satisfies his hunger, and gives him the security and power of mother's love. Alcohol gives the alcoholic adult what milk gives the normal infant. . . . Experience teaches that an inadequacy—real or fantasied but felt as real by the alcoholic—is found in his childhood relation to his own mother. The tyranny of these early events is enormous. Later experiences in life can minimize but never really nullify the meaning of a mother-child relation in which the complete satisfaction of an instinct, hunger, only can occur through and is not distinguished from the perfection of a secure, mutually rewarding association.

Lolli's formulation emerges from his religio-existentialist philosophy and his extensive clinical and research experience with alcoholics, Rado's current approach is from the framework of adaptational psychodynamics, and Knight writes from his experience with and interest in the application of classic psychoanalytic dynamics and of modifications in classic therapeutic technique to borderline states. Yet it is not difficult to detect the consistent thread which runs through the contributions of all three, as well as of Schilder,[35] Bergler,[2] and others: in essence, the alcoholic is seen as having been rendered vulnerable, by early security-threatening experiences of deprivation, to addiction to a magical fluid which dispels tension and depression, relieves the sense of aloneness, places an instantaneously available source of pleasure at his disposal, permits the mastery and simultaneously the expression of unmanageable hostile feelings, and has a virtually built-in and guaranteed array of sufferings and punishments which serve both to

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appease the conscience mechanism and to feed back stress stimuli for continuing the cyclic addictive process. There is a parallel in this formulation to recent views of the pathogenesis of psychosomatic illness, in which disease processes are seen as originating in relation to specific patterns of conflict between personality organization and life situation, but as coming eventually to serve as channels which drain conflicts quite removed from those of specific etiologic significance.

¶ Learning Theory and Conditioned-Reflex Formulations

Concurrent with the growing psychoanalytic interest in ego psychology, there has developed increased attention to learning theory in psychiatry.[12] Although there has been no systematic attempt to develop an approach to the etiology and pathogenesis of alcoholism in terms of the principles of learning and conditioning, this appears to the present writers to be a most likely development. Certainly, a number of clinical observations readily suggest a relationship between the paradigm of Skinnerian conditioning and the development of alcoholism. The pattern, anxiety → alcohol → relief from anxiety, is practiced repetitively and becomes highly overlearned; the reinforcement (that is, relief of anxiety) is immediate, in contrast with the delayed reinforcement of other, alternative, adaptive maneuvers for handling the anxiety; the conditioned reflex (that is, drinking), as is characteristic in conditioning, progressively pre-empts the field of response choices, which narrows rapidly down to virtually this one response for the widest range of stimuli; and finally, the conditioned reflex is essentially nonadaptive, and therefore contributes to the perpetuation of the anxiety to which it has become a response.

Two series of animal studies provide supportive evidence in this general direction. Masserman and Yum[30] observed that alcohol "disintegrated" conditioned responses in cats, and had selectively greater effects on more complex and more recently learned responses. Masserman *et al.*[29] had previously demonstrated that alcohol protected cats from developing "experimental neuroses" when subjected to conflicting fear and hunger motivations. In the 1946 study, the authors report the development of "experimental neuroses" in twenty-one cats, who were rendered incapable of simple goal-directed behavior by the "neurosis." Alcohol "disintegrated" the neurotic patterns, and permitted simple food-getting responses to supervene. While "neurotic," the cats preferred alcohol to alternative fluids equally available; however, as the "neurotic" symptoms receded, the "addiction" disappeared. They conclude that, while alcohol ". . . partially disintegrates . . . all behavior patterns . . . nevertheless, along with these general effects there occurs a particular disorganization of highly complex neurotic patterns themselves, so that, with small doses of alcohol, more nearly elementary and better established reactions . . . remain relatively intact and reappear in overt behavior."

Conger[4] ingeniously advanced the work of Masserman and Yum a significant step further by demonstrating in the albino rat (1) that alcoholized animals resolved a simple approach-avoidance conflict, while control animals continued to hesitate in approaching the feeding box where they had received electric shocks; (2) that the resolution was produced by a diminution in the avoidance (or fear) response rather than by a heightening of the approach response; and (3) that alcohol given only when the animal was shocked impaired the development of a discriminatory conditioned reflex, in contrast to alcohol given only on nonshock trials, although eventually the discriminatory response was established. Conger proposes that the differential reduction of fear is the crucial reinforcement which makes the learning of the drinking response so efficient in the alcoholic. In another paper[5] he and, independently, Shoben (cf. Kruse[23]) have offered some perspectives for a research program in this area. Both writers point out that there is no necessary conflict between reinforcement theory and psychodynamics, but rather that the two approaches may supplement each other. It is the feeling of the present writers that the systematic investigation of the laws

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of conditioning with specific reference to alcohol addiction presents a meaningful line of research. However, it can be anticipated that the crucial obstacle will be the variability of the reinforcement value of alcohol in humans as against the presumably constant reinforcement value of, say, food following a defined starvation period in animal studies. There is an enormous gap between the roles of externalized and reality-borne sources of fear and conflict, and internalized, unconscious, and irrational sources.

¶ Psychological Test Data

The literature on psychological test data bearing upon personality structure and alcoholism is extensive and is rapidly expanding, so that a complete review is not possible within the confines of the present chapter. Sutherland, Schroeder, and Tordella,[88] and Gibbins[9] have critically summarized a number of studies reported through 1952. The issue of character specificity in alcohol addiction is again central in these studies, and again there is a sequence of reports of negative findings as to specificity but positive findings as to pathology. Again, strikingly, these seem to evoke further studies of similar design and, inevitably, similar findings and conclusions. It is abundantly evident that no reliable difference in objectifiable and tabulable performance data from any of the standard projective and nonprojective personality tests uniquely characterizes alcoholic patients and differentiates them from normal controls or from nonalcoholic mentally or emotionally ill patients. Again, the significance of negative evidence of this sort must be seen as subject to several limitations, including the relevance of test items to personality structure and especially to personality in alcoholism, availability of personality disturbances in alcoholism to quantification and tabulation, and variability in the manifestation of underlying disturbances with variations in other personality dimensions. It is the latter problem in particular which the present authors wish to stress.

Similar dependence-independence conflicts, for example, based on similar early life experiences, but integrated (1) into an obsessional character structure with crucial concern with power struggles against authorities, (2) into an hysteric character structure with crucial concern with establishing a sexual identification, and (3) into a schizophrenic character structure with gross disturbances in affective and thought processes, will not reveal themselves as similar if psychological test performances are subjected to quantitative item analyses. The alternative procedure, that is, the clinical analysis and evaluation of the test performance as a whole, is hazardous in research, since it invites the bias of the investigator to select from the productions of the patient those responses which are most consistent with the bias. It seems fair to state that most studies in which the test data have been itemized, quantified, and tabulated have provided negative results, whereas most studies in which the test data have been analyzed and evaluated as a whole have led the investigators to positive conclusions concerning the specificity of psychopathology in alcoholism. Sutherland *et al.* sum up their review by stating that "No satisfactory evidence has been discovered that justifies a conclusion that persons of one type are more likely to become alcoholics than persons of another type." On the other hand, a number of careful clinical studies have led the investigators to strikingly parallel conclusions. Billig and Sullivan[8] studied the Rorschach responses of 29 hospitalized and 11 jailed alcoholics, and found consistently (1) an unrealistically high level of aspiration coupled with limited achievements; (2) poor restraint or control of impulses; (3) tendencies to withdraw from the environment, linked to an inability to effect smooth reality relationships; (4) self-centered thinking patterns, with rich imaginativeness; and (5) wide and poorly controlled mood swings. Halpern[10] contributed a summary of psychological test data obtained from 47 patients whose psychiatric histories were separately reported. She stressed the impulsive, willing-to-take-chances approach, the use of the mechanism of denial, the underlying wish for a passive role, and the need for self-punishment. Her composite picture of the

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alcoholic from his Rorschach performance is illuminating:

He is a maladjusted, immature individual who has developed few techniques for alleviating his feelings of discomfort. Actually, his attitude implies that he will not recognize limitations or inadequacies in his personality, will not admit them. In order to convince himself that he has no need to compromise or inhibit his reactions, he deliberately exposes himself to irritating and challenging stimuli instead of insulating himself against them. There is a certain "grandiosity," a certain omnipotence in such behavior. This refusal to accept his personality problems in a way that would enable him to work with them and build up the more acceptable forms of compensation is one of the most striking characteristics of the alcoholic personality as revealed in the Rorschach Test protocols. If he cannot accept the idea of limitations or inadequacy, the conflict must be outside himself, and he proceeds to externalize it. While there is tremendous aggression of a kind in such an attitude, and it is part and parcel of the general highhandedness found in many of his reactions, the alcoholic does not really strive for activity and aggression. He is satisfied with the passive role in the majority of instances, and it is important to him to find a passive way of handling his difficulties, a way which will put the problem outside himself and make no active demands on him.

Klebanoff,[21] using the Thematic Apperception Test in a study of 17 nonpsychotic chronic alcoholics, reported the predominance of intoxication and rejection themes in the productions of his subjects, along with pervading concern for power or dominance-submission struggles in which the central character generally failed.

There is consistency in these and other studies with regard to the findings of poor reality testing, depressive trends, difficulty in impulse control, and struggle with activity-passivity conflicts. The further consistency between these findings and the psychodynamic formulations of Rado, Knight, and Lolli summarized above is immediately apparent.

Physiologic Data

Studies concerning the possible role of various physiologic factors in the etiology and pathogenesis of alcoholism are as rife with disagreement—at times quite bitter—concerning the nature of the physiologic defect as are the conflicting views of the partisans of a physiopathologic theory with those of a psychodynamic theory. There can be no question of the gross physiologic and neurologic derangements associated with acute intoxication, nor with the gross metabolic and nutritional disturbances associated with chronic alcoholism, nor again with the diffuse organic symptoms associated with the abrupt withdrawal of alcohol from an addict.[14] These are not issues germane to the present chapter, however. Our concern is with the role of physiologic factors in the development and maintenance of the addictive cycle. A number of diverse approaches have recently been offered. Williams[44] has developed a genetotrophic theory on the basis of his demonstration that rats deprived of B vitamins select, with variable readiness among different strains, a dilute solution of alcohol in preference to water. His theory is complex, and a brief summary may not do justice to his views. He holds that genetically determined and partial enzymatic defects render carbohydrates less readily metabolized and consequently inadequate as sources of rapid energy, and alcohol, experienced as a replacement source, is craved for precisely this effect. His theory explains cultural differences in incidence on the same basis—for example, the difference in incidence of alcoholism between people of Jewish and of Irish descent is presumed to be due to hereditary differences in the intactness of the metabolic apparatus for handling carbohydrate dissimilation. Lester and Greenberg,[25] however, demonstrated that under identical experimental conditions, but with an additional fluid choice to the water and alcohol solutions in the form of 11.5 per cent sucrose solution, the rats drank the latter and none took the alcohol; fat and saccharine

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solutions and solid sucrose also diminished alcohol intake, although to lesser degrees.

Smith[36] sees a biochemical and clinical similarity between delirium tremens and Addisonian crises: in both, plasma potassium and nitrogen are elevated, sodium and chloride are decreased, and acidosis, malaise, vomiting, slowed pulse, and low blood pressure are present; in both, terminally, a rapid and thready pulse, high fever, and markedly elevated respiratory rate are noted. He reports findings of similar, though less severe, biochemical changes in acute alcohol intoxication and adrenal cortical insufficiency, and posits in alcoholics (1) a constitutional susceptibility of the adrenal to alcohol, genetically transmitted, and more heavily clustered in Celtic and Scandinavian people, and (2) the development, especially during the period of heightened susceptibility at the time of the male climacteric, of adrenogonadal deficiency which in turn, by implication (this is not directly stated by Smith), creates a craving for alcohol as an adrenocortical stimulant. Wexberg[48] has systematically reviewed Smith's work and convincingly argued for adrenogonadal hypofunction as a complication of, rather than a cause of, prolonged drinking.

Mardones[28] has offered a systematic experimental approach in support of an organic theory of etiology in alcoholism. A series of autoselection experiments with rats led him to postulate a specific dietary factor—"N_1"—a lack of which causes an increase in the voluntary consumption of alcohol; this is aggravated by thiamine deficiency. The defect has been localized in the pyruvate-to-acetyl coenzyme A step in carbohydrate metabolism. Studies with tagged (C^{14}) carbohydrates, however, indicate an absence of alcohol dehydrogenase in brain tissue, which would render the role of alcohol in repairing the defect which Mardones postulates as doubtful. Evidence for this "N_1" factor seems compelling, however, and his own summary may be quoted:

> All the facts . . . induce us to believe that voluntary alcohol intake is increased when a difficulty in the utilization of the energy of carbohydrates or fats is present, and that this difficulty does not interfere with the utilization of the energy of the alcohol. They also induce us to suspect that, in some cases, the excessive ingestion of alcohol is not the cause but the consequence of nutritional or metabolic difficulties.

There have been a number of other organic approaches which merit passing mention. One finds repeatedly in the literature—though no systematic presentation of supporting data has come to the attention of the present writers—reference to the idea that alcoholism is the behavioral consequence of an "allergy" to alcohol. Fleetwood and Diethelm[7] reported evidence for "anxiety," "tension," and "resentment" factors in the blood of all humans; in alcoholics, the resentment factor would characteristically be found to rise over a period of days or weeks, with no conscious awareness by the patient or manifest change observable by an examiner; when it reached an intensity of 25 gamma or higher, the alcoholic would drink, and the titer of resentment factor would disappear within an hour. Various other writers have implicated thyroid deficiency, defects in the hematoencephalic barrier, and toxic products of alcohol metabolism with direct addicting effects upon the cortex.

The variety of physiologic theories reflect the experimental dilemma which faces the investigator: to study objective human behavior or subjective reports of feelings of craving involve the investigator in dependent variables too complex to permit of definitive conclusions from any body of data; alternatively, to study animal behavior under controllable conditions permits of limited conclusions with reference to the nature of the role of alcohol in the behavior of the animals and only highly speculative applications to alcoholism in humans. Furthermore, animal studies are inherently limited to demonstrating that certain physiopathic states produce a *preference* for alcohol and never a *craving* for alcohol. Again, the clinical phenomenology familiarly observed in alcoholism would appear to require rather unfamiliar physiologic mechanisms which would not only be operative during the period of withdrawal but would remain operative after the disappearance of withdrawal symptoms and through years of total abstinence. In the light of the frequent observation of alcoholics in-

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gesting hair tonics, skin and shaving lotions, and various other ill-tasting fluids, it becomes apparent that the craving is not in response to altered taste and smell sensation, as is the case in animal studies in which atypical food preferences are created by either deficient diets or experimental alteration of metabolic processes; rather, it is a craving for the *effect* of the alcohol. In the same vein, such experimental studies have always dealt with the absence of necessary metabolites, and to posit an "alcohol-deficiency state" in consequence of which the subject craves alcohol seems doubtful. Critical reviews of physiopathic theories of the etiology of alcoholism have been contributed by Wexberg[43] and by the Joint Expert Committees on Mental Health and on Alcohol of the World Health Organization (cf. Jellinek[18]). It remains an open question as to the role of a biochemical or physiological predisposition to alcohol, as well as to the role of alcohol itself in establishing a bodily state of greatly enhanced readiness to consume more alcohol.

¶ Sociologic Approaches

Although there is no systematic sociocultural study of prevalence rates of alcoholism, there is substantial indication that there are reliable differences in male-female rates.[19, 20] The World Health Organization estimates the following prevalence rates of alcoholism with and without complications (data approximately for 1953):

RANK ORDER	COUNTRY	RATE PER 100,000 ADULTS
1	United States	4,390
2	France	2,850
3	Sweden	2,580
4	Switzerland	2,385
5	Denmark	1,950
6	Canada	1,630
7	Norway	1,560
8	Chile	1,500
9	Finland	1,430
10	Australia	1,340
11	England	1,100
12	Italy	500

A number of approaches to these data merit review.

Horton[13] analyzed 56 primitive societies for which data were available as to the amount of alcohol consumed, the relative subsistence security, and the accessibility of alcoholic beverages. He was able to demonstrate a convincing relationship between a high degree of subsistence anxiety—inferred from the level of subsistence hazards or inadequacy of subsistence techniques—and "strong degrees of insobriety": the greater the anxiety concerning drought or flood or crop failure, or concerning the potential disruption of food supply by more powerful neighboring societies, the greater the amount of drinking, except as this relationship might be influenced by nonavailability of alcohol. Horton makes special note of the tendency, among members of those societies in which ceremonial drinking would take on a near-compulsive quality and continue to the point of total unconsciousness, for aggressive behavior to emerge during the drinking bout. In essence, Horton proposes that alcohol has the "unequivocally significant" property of reducing anxiety, and that it will be differentially used among different societies, depending upon the level of basic security anxiety, regard being given to its availability.

Bales[1] has proposed a complex and encompassing theory relating social organization and cultural practice to alcoholism. He sees three bases for the relationship: (1) "the degree to which the culture operates to bring about acute needs for adjustment, or inner tensions, in its members"; (2) "the set of attitudes toward drinking which the culture produces in its members"; and (3) "the degree to which the culture provides suitable substitute means of satisfaction." He adds to the Horton data, in connection with the first point, observations by Bunzel on the Chichicastenango Indians in Guatemala, and by Hallowell on the Northeast Woodlands Indians in the United States, and offers a description of Irish social structure in which many stress areas are noted. With reference to his second basis for relating culture and alcoholism, Bales states that "The crucial factor seems to be whether a given attitude towards drinking positively suggests

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drinking to the individual as a means of relieving his inner tensions, or whether such a thought arouses a strong counteranxiety." He describes four cultural attitudes: the abstinent, ritual, convivial, and utilitarian. Complete abstinence, or total prohibition, is well illustrated by the Moslems. Bales notes that "An attitude capable of restraining strong impulses in all members of a group cannot be created by fiat," and that, indeed, "The breaking of this taboo becomes an ideal way of expressing dissent and aggression" and anticipates that this prevailing attitude will be variably associated with high and low alcoholism rates, depending upon the pressure of anxiety. The ritual attitude is illustrated by the drinking patterns of orthodox Jews: the crucial aspect of this attitude is that precisely because drinking is so intimately a prescribed part of a substantial number of religious rituals,

> . . . the wine is sacred and drinking is an act of communion . . . repeated again and again, and the attitudes toward drinking are all bound up with attitudes toward the sacred in the mind and emotions. In my opinion this is the central reason why drunkenness is regarded as so "indecent"—so unthinkable—for a Jew. . . . Drunkenness is a profanity, an abomination, a perversion of the sacred use of wine. Hence the idea of drinking "to become drunk" for some individualistic or selfish reason arouses a counteranxiety so strong that few Jews ever become compulsive drinkers.

Snyder,[37] in a series of articles, has applied Bales's proposal to a more thorough and systematic appraisal of nondrinking among Jews, and similarly concludes, ". . . the orthodox Jew cannot, as it were, split the concrete act of drinking from the controlling elements in his conscience." The "convivial" attitude seems hardly to merit a separate description from the "utilitarian" attitude, in which drinking is "

> . . . calculated to further self-interest or exclusively personal satisfaction."

Here are included drinking as part of economic transactions, or drinking to celebrate all the principal occasions in the life cycle where the drinking is not part of any attendant religious ritual itself but is part of the conviviality, or—perhaps most clearly "utilitarian"— drinking to get over a hangover. In such a setting, the inebriate is likely to be treated with kindly care, or even with envy—and Bales notes that the characteristic Irish mother's attitude to her drunken son is that he is "the poor boy." Bales cites drug addiction (for example, in Jews, Japanese, and Brahmins, who have low alcoholism rates) as prominent among alternative provisions by the culture for dealing with the tensions which it creates. Bales sees his three modes of relating culture and drinking as simultaneously operative. "They all work together, and the rates are complicated end-results." Barnett (cf. Diethelm[6]) has offered an analysis of the strikingly low incidence of chronic alcoholism among the Cantonese living New York City's Chinatown area, which at first glance appears to offer contrary data to Bales's formulation of convivial and utilitarian drinking attitudes as consistent with high rates of alcoholism. He notes that, "Within the home, and at social gatherings, drinking represents an important social function. At meals and banquets heavy eating is accompanied by considerable alcohol consumption." It is clear, however, that in this instance, the role of religious sanctification is taken by the sanctification of the revered parental figure, in whose presence intoxication would be looked upon as an affront. Furthermore, Barnett stresses that the drinking pattern is consistent with the fundamental expectations and obligations of Kwangtung culture, to the extent that, even when intoxicated, the drinker remains quiet and is kept from public view. He sees a role, as does Bales for the Jews, for the factor of minority-group status as forcing upon the Chinese in the United States a need for maintaining control and avoiding scandal and persecution.

A quite different sociologic approach is exemplified by the study of Mowrer and Mowrer.[31] Their specific hypothesis concerning alcoholism as ". . . an escape mechanism by which the individual seeks to reinstate in adult social relationships a preferred superior role achieved in the early family group," is not the concern of the present writers so much as their application of the "ecological approach." Their

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specific ecological hypothesis is that alcoholism is etiologically associated with the

> . . . differentiation of areas of varying rapidity of social change and disorganization, the rates of which are roughly inversely related to the distance from the center of the community. . . . Thus, rates of inebriety . . . present a pattern of bands in the general form of concentric half-circles; the highest rates occur in those communities which form the axes of the arc, and the rates decline progressively to the peripheral band of communities, in which they approach zero.

Their own data show how dubious is the regularity of the relationship they posit, but the desirability of an ecologic approach to the etiology of alcoholism can hardly be doubted. Gordon (cf. Kruse[28]) poses an epidemiological approach to alcoholism as a medical problem in which *any* use of alcohol is subsumed under "alcoholism," and addiction and alcoholic psychoses are seen as merely the end states of the total process: by analogy with diphtheria, abstainers are like those with no diphtheritic infection, the social drinkers are like those with inapparent infection, the symptomatic drinker like the patient with atypical clinical diphtheria, the alcohol addict like the typical diphtheritic, and the deteriorating organic psychotic like the patient with black diphtheria. Such a biologic gradient, coupled with an ecologic approach involving considerations of agent (that is, type of beverage), dosage, host, and environmental factors, offers the basis for a program of prevention and control more promising to Gordon than a program of clinics for the treatment of the alcoholic: "A program based on treatment of the exaggerated illness is temporizing and with no great promise of productive result; it is good clinical medicine but poor public health."

Still another sociologic approach is offered by the methodology of Ullman.[39] He reports significant differences in the memory of the first drink among alcoholic and nonalcoholic subjects: the alcoholic has more frequently a clear and vivid memory of the event; it occurred in places in which it is unusual to drink; it occurred at a later age than in the nonalcoholic; and there is a clear recollection of some remarkable effect—for example, 40 per cent reported getting sick. Those normal drinkers who did recall their first drink had it at home or at a gathering or event at which alcohol is ordinarily consumed as a matter of course, had it at an earlier age, and less frequently recalled any particular effect. If the nonalcoholics are tabulated according to per cent recalling their first drink, the rank order was Irish, English, Scandinavian, Jewish, French, German, and Italian, corresponding fairly closely to the rank order of his populations in incidence of alcoholism.

These and other studies in class and national differences in alcoholism rates permit of no simple summary formulation. There is little room for doubting that, whatever the dynamic social forces and counterforces involved, cultural determinants of alcoholism are of decisive significance. The consistency with which certain national and ethnic groups persist in manifesting significantly high or low prevalence rates, in an era of rather little variability with regard to the availability of alcohol in the culture or to subsistence anxieties, indicates the prepotent influence of cultural attitudes to drinking and inebriety. It would appear that the impact of these forces reaches the individual early in development, and the direction imparted may be detectable by family studies, and especially longitudinal studies, of alcoholic and nonalcoholic subjects. The implications of the sociocultural data concerning alcoholism for a predictive study have never been fully explored.

¶ Interdisciplinary Approach to Alcohol Addiction

Specific methodologic concern with multifactorial etiologic approaches in psychiatry is provided elsewhere in the present text. Data derived from an interdisciplinary study of 46 alcoholic subjects, of whom 23 were currently drinking and 23 had been "dry" for two or more years at the time of study, may be drawn upon for a summary statement on alcohol addiction and personality. Psychiatric histories were obtained in five hours of anamnestic

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interview by one of the present writers, who also served as project director, under the general guidance and supervision of Dr. Howard M. Potter, Professor of Psychiatry at the State University of New York College of Medicine at New York City. A battery of paper and pencil and projective personality tests were administered, scored, and interpreted. Social and family histories were obtained from the subjects and from a family informant. Perceptual tests, and physiologic and metabolic studies were conducted. The study was conducted at the State University Alcohol Clinic, State University of New York College of Medicine at New York City, from 1954 to 1956. Separate initial reports from each discipline are currently in preparation for publication.

Psychiatric Interviews

Life-history data revealed a range of nosologic entities, including virtually all categories of neurosis, functional psychosis, and character disorder. The spectrum of alcoholic phases described by Jellinek[16] could be identified in each subject. The early readiness to respond to alcohol was a prominent finding; one subject put it, "I could hardly wait until I was sixteen and could start drinking." The significant psychiatric finding was the consistent presence of a number of descriptive-dynamic states which suggested a basic character disorder underlying the varied psychopathologic pictures found in these subjects:

1. The subjects are *schizoid*. There is a basic sense of estrangement or isolation from people, associated with a characteristic quality of egocentricity and with the use of autistic, immature modes of thought. Even in subjects with a façade of outgoing, sociable behavior, it becomes quickly apparent that not far beneath is a pervasive emotional detachment from people. Not infrequently, this finds expression in paranoid concern about the motives or roles of those closest to them; frequently it is expressed as a direct awareness of a sense of aloofness and separateness—a feeling of being an outsider or of not belonging—by the subject. The egocentricity has the quality of an absolute conviction of omnipotence and invulnerability, and appears to us to reflect a basic narcissistic core, as well as to represent a reparative function against feelings of dependence and of great vulnerability. The autistic thinking may reflect in a range of distortions, from areas of infantile thought out of keeping with the intellectual capacity of the subject, through moderately severe associative defects, to prelogical primary process productions. One would grow a mustache each time he fought with his wife, and shave it off with each reconciliation. Another is described by his oldest sister as follows: "He had very few friends. Children just didn't like him. He always gave the impression of being different." Repeatedly, the subjects would report, "I prefer to be by myself," or "I guess I must have been born with five times my share of alcoholic luck, or I'd have been dead by now." In addition, fully one-half of the subjects had been diagnosed clinically either as schizophrenic, or as mixed character disorders in which schizoid character features were a component.

2. The subjects are *depressed*. There is a basic sense of hopelessness, sadness, and futility which ranges in its manifestations from sporadic expressions of personal worthlessness to repeated and grim suicide attempts. The facade of joviality and gaiety which many of our subjects wore bore no regular relationship to the depth of the underlying depression, which in any event was never less than moderate in severity. Frequently, the depression is stated in less direct terms than sadness, or the blues, or feeling "down in the dumps," but as overwhelming boredom, or as loneliness, or moodiness. The severity of the familiar "vegetative signs" of depression similarly provided no regular guide to the depth of the depression, because of the frequency of insomnia, anorexia, and a semistuporous psychomotor state as concomitants of the drinking. There was elicited a history of suicide thoughts or attempts in more than one third of the subjects; another quarter gave a history of repeated "accidents" of life-threatening seriousness. Always there were references to intense feelings of loneliness or sadness.

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3. The subjects are *dependent*. There is an irrational reliance upon external agents for security and care. This is manifest in two closely related behavioral trends—an infantile orientation to other persons as the providers of insatiable demands for food, love, acceptance, and comfort, and a pervadingly passive attitude toward the world as essentially beyond his influence and determining his fate without reference to his behavior. Because of the sense of estrangement from and distrust of people, the dependence is far more frequently manifested as a concealed, "taking," relationship rather than a trusting, openly dependent one. The passivity is often concealed behind a great deal of aggressive, vigilant "activity" whose purpose is either the immediate or impulsive gratification ("taking") of a wish, or protection against the felt threat of the loss of the dependency object, or protection against destruction at the hands of some representative of implacable fate. Adaptation through a basic reliance upon the self, in a setting of give-and-take relationships with dependency objects, does not occur. One joined the army "to be certain of a place to eat and sleep." Another married a woman sixteen years his senior who owned the flophouse he had used during binges. Many reported earliest memories about food; one was certain he recalled the difficulties his mother had in arriving at the right formula for his bottle.

4. The subjects are *hostile*. There is reflected in their patterns of adaptation a marked, and sometimes overwhelming, amount of chronic rage which suffuses the personality and enters into all aspects of ego-function. No uniform pattern of dealing with the hostility is found. In some subjects it is overtly expressed as outwardly directed destructive behavior—generally only evidenced in inebriety but sometimes as well in sober states. In some subjects it is outwardly directed but remains concealed and controlled, even in inebriety, and is reflected only in murderous hallucinations during delirium tremens or nightmares. Perhaps in all subjects there is a strong component which is directed inwardly, against the self, and is varyingly expressed in verbalized self-loathing or overtly self-destructive acts. The most frequent fear following blackouts was that the subject had killed somebody. One subject would regularly surrender himself to the homicide division of a police station in order to request hospitalization. Another had the repeated hallucination in each episode of delirium tremens of killing his mother and attending her funeral procession. Several heard voices telling them to kill their wives. One subject, particularly impressive because of his stable life situation seven years after he stopped drinking, had been stopped just in time from pushing his father out of an upper-story hotel window during his last drinking spree.

5. The subjects are *sexually immature*, with a basic and serious failure in masculine identification. This ranges in verbal expression from reaction formations against implied feminine identifications to angry yet wistful observations that, in the end, the woman has the preferred lot. In sexual behavior the manifestations range from markedly reduced heterosexual behavior to active homosexuality. In no instance among the 46 subjects was there the complete abandonment of heterosexual activity and the full acceptance of homosexual activity; indeed, in only one subject was there a greater amount of participation in homosexual than heterosexual behavior. On the other hand, in a striking number of instances there had been episodes of homosexual behavior in adult life, generally but not exclusively during inebriety. One subject was described by his wife as constantly complaining that "women have an easy life. I think secretly he was sorry he was born a male." Another told of the shock he experienced on his wedding night on discovering that his wife had a vagina—"I thought intercourse was through the backside." Still another, who owned seven fishing poles though he never went fishing, who had had extended adolescent homosexual experiences, and who limited intercourse in his marriage to once in two months for reasons of health, told the following story for TAT card No. 13: "He gets layed and he loses his cherry. He goes out and gets drunk—he looks ashamed of himself. She looks like she's well satisfied."

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Psychological Tests

Psychologic test data were derived from a battery which included the Rorschach, 11 cards of the TAT, Machover Figure Drawing, the Blacky Picture Test, Wechsler-Bellevue, Word Association, the M-F Scale of the Minnesota Multiphasic Personality Inventory, the F Scale, the Allport-Vernon Scale of Values, Animal Choice, and the Sims SCI Occupational Rating Scale. Individual detailed clinical interpretive summaries were prepared for each subject. These were then reviewed, and entries found in 60 per cent or more of the summaries were listed as follows: schizoid character deviation; use of withdrawal and maintenance of social distance; generalized defense attitudes; narcissism; excessive mother involvement and dependency; feelings of insufficiency; oral receptivity problems; excessive hostility; high level of tension and anxiety; difficulties in expressing hostility; feelings of frustration; excessive general ambivalence; obsessive patterns; mechanism of denial; castration problems; sex-role ambivalence; female identification; homosexuality; low self-esteem; depression; general guilt feelings. Each of these entries is carefully defined: the following is quoted from the draft report of the psychological testing program as an illustration of the procedure followed:

Schizoid character deviation. Subjects were regarded as significantly schizoid when they showed evidence, on the tests, of excessive social isolation, weak ego-boundaries, excessive self-absorption and fantasy, autism, affective shallowness, excessive distance from objects. As examples of test evidence for schizoid character deviation may be cited the following:

Subject NJ: Rorschach devoid of color percepts, percepts distant and unreal, e.g., flying lobsters, weird animals from another age; figure drawings self-absorbed, fragmented line-quality, general impression of concreteness, flatness or insensitivity.

Subject SC: Word-Association Test, 95th percentile for contrast responses; Rorschach, feeling of diffusion and loss of reality, e.g., on Plate I: "two skaters whirling at high speed toe-to-toe and holding hands," on Plate II: "two persons walking side-by-side, climbing stairs in the dark, holding a torch," Plates IX and X rejected with avowal of fear of going off on flights of imagination; TAT, Plate 13 MF, "he murdered the girl in order to help his condition so that he could continue with his sexual urge."

Subject XB: TAT, distance and symbolism as on Card 2: "the girl in the picture is looking at a picture. In the card she sees fertility and in the man's back she sees vitality." Rorschach, neither people nor animals are seen, only "images" of people and animals.

Subject LP: Rorschach, loss of distance and ideational over-fluidity as on Plate II: "this is the drops of blood, it was dropped on this paper, here are the lungs, and these are the digestive organs or the female privates, either one"; and on Plate VII: "islands, but I don't recognize them, I know the maps of many territories and I've never seen them before"; Figure Drawings have markedly distant, self-absorbed facial expressions and lines weak, unsure, light, scarcely contacting the paper.

Perceptual Tests

The perceptual test program utilized the procedure described by Witkin[45] in which the subject is presented with three sets of tasks: (1) In a completely darkened room, seated before a movable, faintly luminous, but clearly visible rod surrounded by a square frame, the subject is asked to adjust the rod to the true vertical, the frame being fixed at various angles to the true horizontal. (2) Seated in a tilted chair, within an independently tilted room, the subject is asked to adjust himself and his chair to the true vertical, the room being kept at various angles to the true horizontal. (3) A simple geometric figure is presented to the subject, and then the subject is asked to identify this figure from a complex figure within which the simple figure is obscured or "hidden." Previous studies had indicated a range of performances continuously distributed between two broad patterns of perception: the "field-dependent" and the "field-independent" patterns. In the former, subjects are unable to resist the pull of the field, and a typical per-

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formance will consist of (1) adjusting the rod so that it is aligned with the tilted frame, and accepting the rod in this position as "vertical" even though it may actually be at an angle as great as 60 degrees from the true vertical; (2) adjusting the chair so that it is parallel to the walls of the tilted room and using this position as "vertical," even though, again, it may be, in reality, at an extreme angle from the true vertical; (3) losing the embedded figure in the more complex pattern. The field-independent pattern is given by subjects who are able to stand up against the field, resist its pull and achieve a close approximation to the true vertical, or, in the embedded-figure test, resist the distraction of the complex pattern and identify the simple figure promptly. The field-dependent pattern was felt, from earlier studies, to represent a more primitive perceptual pattern, associated with a passive-dependent orientation. Alcoholic subjects produced a striking perceptual pattern on these tests, unique to an astonishingly significant degree from any other group tested, and consistent despite the range of psychiatric diagnostic entities noted. The draft report summarized the performances of the alcoholic subjects as follows:

In the rod-and-frame and embedded-figures tests, where the task is, perceptually, to "hold on" to an external item (a rod, or a simple geometric design) against the influence of the field surrounding it, alcoholics "yield" to the field in an extreme way. In the body-adjustment situation of the tilting-room–tilting-chair test, where the body is surrounded by a tilted field and the task is to adjust the body to the upright, alcoholics are as capable as other groups to perceive the body independently of the surrounding field. Thus, when the body itself is at issue, alcoholics are far better able to escape the "tug" of the field than when an external item is the object of perception.

A pattern score was invented, to permit the expression of this pattern in a single symbol rather than in three separate scores, through a multiple correlational analysis using point biserial correlations with the criterion variable. A cutoff point halfway between the mean score of alcoholic subjects with two or more years of sobriety and the mean score of the control subjects (college students) distinguished between members of the two groups with a diagnostic accuracy of 86 per cent. The alcoholic pattern is interpreted by the experimenters as a manifestation of a pervasive passive dependent attitude, coupled with a primitive, insulating narcissism through which the field is not so much resisted as the preoccupation with the body and its sensations is responded to. The experimenters offer the following conclusion in their draft summary:

We would suggest that the person who gives a straight field-dependent performance has failed to develop beyond the most primitive level, involving a lack of awareness of body as separate from the field and a diffuse, global-dependent mode of perceiving the environment. The person who shows the perceptual pattern encountered among alcoholics, has progressed to the point of developing distinct body boundaries, although not a well-defined body concept, nor has he achieved a level of self-differentiation necessary for a field-independent orientation. Finally, the person who gives a straight field-independent performance has made the greatest progress in development, having achieved a well-integrated body concept and a degree of self-differentiation which makes possible an active, manipulatory, analytic approach to the field. In this conception, the first two levels must be regarded as fairly similar to each other, involving persistence in a global, field-dependent way of perceiving, which, from developmental studies carried out in our laboratory, we know to represent an earlier, more primitive way of perceiving. An alternative conception which needs to be considered is that the pattern type of perceptual performance occurs in basically passive, field-dependent persons who, as a result of early traumatic experiences, have developed compensatory devices involving overinsulation of body boundaries. These defensive techniques are particularly likely to be operative in situations in which the body is directly at issue, as in our body-adjustment test, where such defenses make possible fairly effective separation of body from field. Yet, in other kinds of situations, the basically passive orientation of the person

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expresses itself in an extremely field-dependent mode of perception.

Physiological Tests

Data from the physiologic studies of the subjects suggest three interrelated areas of findings which merit closer study: liver function and protein metabolism, autonomic-nervous-system function, and endocrine activity. Possibly associated with the first are irregularities in glucose-tolerance curves, with an increased rate of decline and an increased incidence of hypoglycemia. Protein studies appear to indicate a significant lowering of total circulating proteins, marked among the alcoholics who were dry for two years or more, as well as among those actively drinking; this finding will require further study. Autonomic activity is, widely in degree but regularly in direction, vagotonic, with the preponderance of parasympathetic over sympathetic tonus manifested by decreased cold pressor responses and increased salivary flow. The endocrine studies reveal reduced 17-ketosteroid excretion, which generally is interpreted as secondary to liver impairment, with consequent reduction in testicular androgens. However, the excretion of 17-hydroxycorticoids was normal or mildly depressed in the alcoholics who were actively drinking, but significantly decreased in the alcoholics who were dry two years or more. Furthermore, when alcohol was given to normals and to actively drinking alcoholics, the excretion of 17-ketosteroids was not significantly affected, but the excretion of 17-hydroxycorticoids was significantly increased. A number of studies have linked the combination of vagotonicity and low 17-hydroxycorticoid excretion with depression and states of debility, and it has been demonstrated that chlorpromazine and reserpine act to increase 17-hydroxycorticoid production. The concept that alcohol acts as a tranquilizer for tense and depressed persons is suggested by the physiologic data. Further, although no reliable clue as to the genesis of the physiologic disequilibrium which is "corrected" by alcohol is afforded by present data, it is extremely significant that the physiologic changes induced by prolonged consumption of alcohol are precisely in the direction of creating and maintaining the very state which is temporarily relieved by more alcohol, but inevitably also worsened so that still further disturbance results, presumably with a still greater discomfort, quite reminiscent of the addictive cycle in which the alcoholic drinks to relieve the symptoms of the previous day's drinking.

Social Histories

The social and family data obtained in connection with the 46 subjects are not of relevance to the etiological issue, since the study was focused upon current social relationships. Descriptive data concerning the subjects are as shown in Table 1.

TABLE 1. **Comparison of Inactive with Active Alcoholics in Matching Criteria**

	GROUP I INACTIVE ALCOHOLICS	GROUP II ACTIVE ALCOHOLICS
Age		
Range	27–55	26–56
Mean	41.96	41.79
S.D.*	7.48	7.97
Highest school grade (years)		
Range	8–20	8–18
Mean	12.17	10.65
S.D.*	2.75	2.82
Ethnic background		
Irish	13	13
Anglo-Saxon	4	2
Scandinavian	2	2
German	2	3
Other	2	3
Years alcohol a problem		
Range	6–29	6–38
Mean	19.27	19.39
S.D.*	6.78	7.32
History of hospitalization	15	21
Arrests or divorce due to alcoholism	14	14
History of delirium tremens	11	11

* S.D. = standard deviation.

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Summary

The parallel findings of the psychiatric, psychological, and perceptual tests in the present study are patent, as are the essential similarities between these data and those reported by other investigators and summarized above. A tentative formulation concerning personality and alcohol addiction may then be offered in summary form.

Disruption of the mother-child relationship in the period of dependency sets into motion a series of developmental trends evolving into sequences of (1) distrustful withdrawal, with attendant experiences of isolation and estrangement in addition to persistence of atypical, magical thinking processes; (2) persistent passive-dependent longings, with resultant distortions in object relationships; (3) inevitable frustration in the insatiable omnipotence and dependency demands, with resultant impulsive grasping behavior and chronic rage; (4) conflicted, ambivalent dependency relationships which must frequently be ruptured, repeatedly establishing the setting for depressive reactions; and (5) conflicted, ambivalent sexual role-playing with immature modes of sexual behavior. The sequences noted are not assumed to develop independently into a series of separate "traits" but are unified in a single pattern of the character structure. The character disorder described is conceived as existing through a range of severity, in terms of the extent to which it dominates the adaptive systems of the individual, at the same time that other forces in the adaptational dynamics variably influence the character of the total integration of the individual. The character disorder described is frequent in our culture and is not unique to alcohol addiction. It is conceived as necessary, but not sufficient, in the etiology of alcoholism. Variations in cultural attitudes to drinking are conceived as the crucial co-variable: where permissive and utilitarian attitudes prevail, then relatively mild adaptive disorders may enter into the formation of an addiction cycle; where cultural attitudes arouse powerful counteranxiety, more severe character disorders will be necessary for the cycle to be initiated. An inference, readily substantiated in the clinical experience of the present writers, is that psychopathology will be more severe in alcoholic patients from cultures in which alcoholism is infrequent than in patients from cultures in which it is frequent.

Physiologic factors may conceivably play a role in the initial readiness to addiction in alcoholic subjects, through a disordered metabolic state which is specifically relieved by alcohol. It seems certain that prolonged and heavy drinking produces distressing physiologic symptoms which are relieved by alcohol, and therefore these physiologic disturbances may significantly enter in the pathology of the addictive cycle.

¶ Therapy

Little can be stated with reliability concerning the factors which enter into the successful treatment of the alcoholic patient (cf. Muench, in Kruse[28]). It is the repeated experience of treatment centers (cf. Zwerling[47]) that between a quarter and a third of unselected volunteer applicants for treatment never return following their first visit, an additional one third will discontinue treatment within the first month, and about 10 to 25 per cent may be expected to remain in treatment at the end of a year. Discouraging as such results must appear, there has nevertheless been a sufficient experience to provide some clues to factors in treatment. It is, additionally, a particularly difficult task to define criteria for success in the treatment of alcoholism. Without entering fully into the issue, the present writers share with many the view that the measure of abstinence alone is a grossly insufficient and even misleading index, and would seek additional indices in terms of family, social, and vocational functioning, as well as in terms of alternative symptoms emerging during a period of abstinence.

A variety of replacement therapies—with vitamins, hormones, sedatives, tranquilizers, and special carbohydrate preparations, depending upon the bias of the therapist as to the

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etiologic deficit in alcoholism—have all had their enthusiastic supporters, but their number speaks for the lack of notable success enjoyed by any one of these. Often such therapeutic regimens are described, with a note concerning the need for "psychotherapy" which remains undefined. The writers know of no adequately controlled study in which any replacement factor has proved to have significant advantages over placebos in the treatment of alcoholism. In those instances in which there is a clinical deficit state, it is patently good medical practice to treat this appropriately. In addition, possibly more than in the treatment of any other psychiatric state, the prescription of a substance representative of the doctor and taken in orally by the patient is of enormous consequence, particularly in the early phases of a therapeutic relationship.

Two special physiologic treatment modes merit specific mention: disulfiram (Antabuse) and aversion or conditioned-reflex-therapy. The former traces to the demonstration by Jacobsen and Martensen-Larsen[15] that tetraethylthiuram disulfide alters the metabolism of alcohol so that a toxic product, generally thought to be acetaldehyde, is formed. As a consequence, within minutes following upon the ingestion of alcohol, a patient taking Antabuse has a reaction which includes flushing, nausea and vomiting, a sharp drop in blood pressure, marked palpitations, and quite regularly a feeling of impending death. A daily dose, generally between 0.25 and 0.5 gm., is prescribed, and all alcoholic beverages are absolutely proscribed; since disulfiram is slowly metabolized, patients are generally told not to drink for three to four days following ingestion of the last dose. Aversion therapy (cf. Voegtlin[41]) employs emetine or apomorphine to produce a sudden and intensely debilitating reaction, including nausea and vomiting, timed to commence immediately following the sight, smell, and taste of the patient's favorite alcoholic beverage. With repetition, the nausea and vomiting become the conditioned responses to the presentation of the alcoholic beverage, and, in successful cases, a strong aversion replaces the previous craving for alcohol. Although the general experience is that a higher improvement rate is associated with these modalities, their use depends upon some initial period of sustained contact with the therapist, and the greater success may be an artifact of the more prolonged initial contact. Furthermore, these are again not without unconscious emotional meaningfulness to the patient, as Usdin[40] and Wallerstein[42] and their collaborators, and others, have stressed. Thus, disulfiram is perceived by many patients as a powerful conscience symbol incorporated from the therapist; others see its use as the substitution of a "good" parentlike regulatory mechanism for a "bad" one, alcohol; still others ritualize its use and bind, in the compulsive taking of the drug, precisely as they previously did with alcohol, the components of the passive-dependent and defiant-independent conflict which may be central in their adaptive systems. Although the initial enthusiasm for the use of both these techniques has waned considerably, they remain significant adjuncts in the management of alcoholic patients.

Psychotherapy remains the most uniformly endorsed therapeutic approach in alcoholism. However, there is little uniformity in the type of psychotherapy prescribed. Indeed, few techniques of psychological treatment have been described which have not been applied to alcoholic patients. There is rather general agreement about a number of principles, which may be stated in summary form:

1. The goals of treament may vary with factors in the patient, the therapist, and the therapeutic situation, with reference to all parameters save one: abstinence must be total and lifelong. The writers know of no authenticated treatment programs in which the capacity to drink in moderation is restored.

2. The massive use of denial by the patient must be dealt with, preferably at the earliest occasion. A number of writers have described the beneficial use of Jellinek's chart of the phases of alcoholism during the first interview.

3. The sensitivity of the alcoholic to a therapist who has moral discomfort about drinking, or who is subjectively concerned with the fate of the family of the alcoholic, or who has omnipotent needs to have his way about preventing drinking, is notorious. The "motiva-

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tion of the patient," classically described as weak because of the pleasure derived from drinking, turns out to be fully as much a problem in the motivation of the therapist. The alcoholic may be expected to react with great promptness to countertransference distortions of this nature, and his reaction is his familiar solution to effect the reduction of anxiety from any threatened source.

4. Classical psychoanalytic techniques rarely succeed—possibly because of the intensity of the transference relationship fostered, possibly because of the absence of immediate supportive-reassuring comfort from the therapist. Severe character disorders present difficulties to analysis at the very best, and these become virtually unsurmountable when the acting-out propensity has the consequences which inhere in protracted alcoholic binges.

5. There is available a most valuable adjunct to therapy in the form of Alcoholics Anonymous. This is a loosely organized, voluntary association of alcoholics which now numbers well over 5,000 groups or clubs throughout the world and has a membership estimated as upwards of 150,000 in the United States alone. The A.A. *Grapevine*, a monthly newsletter published by the organization, describes A.A. on its masthead as follows:

> Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is an honest desire to stop drinking. A.A. has no dues or fees. It is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

A member of A.A. once described it to one of the present writers as a cafeteria from which one could take whatever one felt to be his cup of tea; aside from the rather characteristic oral framework of the analogy, it does communicate the varied psychological needs it serves. In terms of the specific character problems of the alcoholic, offered above, the multiple purposes served by A.A. may be seen in dynamic perspective. It has its greatest strength in the awareness it imparts of comradeship among fellow alcoholics—the individual alcoholic feels "understood" and less isolated. He senses the impossibility of rationalizing his drinking among people who have themselves all used the same devices. He knows that although the group will not condone drinking, it will not be punitive about "slips"; with many patients we have observed, the consequent subsidence of rage is striking. The practice of programing autobiographical accounts of drinking encourages frank introspective reviews by each member. Dependency needs can be gratified through identification with the group or with the new member being cared for, without shame, and with little incitement to rebellion. The active role in helping other alcoholics serves as a powerful social deterrent to relapse, lest the brother being worked on be lost. At the same time, we have often seen it serve as a socially valuable expression of omnipotent and even sadistic needs. One patient considered himself a specialist on "tough pigeons" and would transfer alcoholics to other A.A. brothers as soon as they had recovered beyond the stage of repeated anguished cycles of delirium tremens, recovery, remorseful vows of sobriety, further drinking, further delirium tremens, etc. In many instances we have observed, during the early phases of sobriety, that participation in A.A. work keeps the patient away from home and in the fellowship of men who share his concerns about alcohol fully as much as did his previous drinking and saloon companions, though with an entirely different impact and prognosis: the ritualization of nondrinking is patently more adaptive. Finally, many groups are led by intuitive and skillful group leaders, and the sessions take on the character of good group-therapy programs. Referral to A.A. should be considered as an adjunct to the treatment of any alcohol addict.

6. Finally, the value of a family treatment orientation to the management of the chronic alcoholic may be noted. The alcoholic, along with every other emotionally disturbed adult, may be counted upon to reproduce the interlocking pathological relationships of his own

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early family experiences in his marriage. The problems posed to an individual therapist who attempts to deal with the spouse or with the couple are extremely difficult, and the advantage lies with a clinic or team approach in which separate support can be offered to the spouse in a setting which can adjust with flexibility to the unique needs of the patient, the spouse, and the special relationship they share.

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PART FIVE

Psychosomatic Medicine

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CHAPTER 32

GENERAL CONCEPTS OF PSYCHOSOMATIC MEDICINE

Theodore Lidz

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THE TERM "PSYCHOSOMATIC MEDICINE" currently is in disfavor because it perpetuates a dichotomous orientation and because misuse has blunted its meaning. Its modern usage arose because there was need for a name that would describe the influence of emotions and personality maladjustments in producing physiologic dysfunction and disease. Many of the early studies focused upon illnesses in which emotional disorder seemed to constitute an essential factor in etiology, such as peptic ulcer, essential hypertension, rheumatoid arthritis, ulcerative colitis, bronchial asthma, and hyperthyroidism. Therefore the word "psychosomatic" filled a vacuum and spread rapidly, and it now would be difficult to eradicate and replace. As with any other word, particularly when the area it is supposed to symbolize is diffuse, its usage can become difficult to control.

As medicine turned from the search for single causes of illness to consider multiple factors that could upset the homeostatic defenses of the organism, more room was found for emotional determinants of illness. It became apparent that personality factors can influence the onset and course of virtually any sickness. Even in the acute infectious diseases, emotional disturbances can undermine resistance directly, or indirectly, by fostering unconscious neglect or exposure. The boundaries of psychosomatic medicine grew indefinite. Then, when physicians became systematically involved in patients' problems of living and reacting emotionally, they moved into essential related interests—the effects of illness upon behavior, the therapeutic use of the doctor-patient relationship, the emotional difficulties created by specific therapies, and, in planning treatment, the importance of the patient's personality structure and defenses. When psychosomatic medicine refers to all of these areas, little of its original connotation remains. A term such as "psychotherapeutic medicine" would seem to be more descriptive of a holistic, patient-oriented medicine that utilizes knowledge achieved by dynamic psychiatry in treating patients. "Psychosomatic" could then regain

its use as an adjective to indicate studies of the influence of emotions on physiologic dysfunction and certain illnesses in which emotional maladaptation plays an essential role. Of course, there is no place for the common misuse of "psychosomatic" as a euphemism for "neurosis" because it sounds more stylish or acceptable or as a way of telling the patient that his complaints are imaginary.

The developments in psychosomatic medicine profoundly influenced psychiatry as well as other fields of medicine. Dynamic psychopathology required reorganization to include a type of emotional disorder that left the person vulnerable to severe physiologic dysfunction and tissue damage instead of evoking neurotic defenses or psychotic withdrawal. Psychiatry was firmly related to other medical disciplines through common interest and because it was useful to them in their research and therapy. The possibility of testing psychoanalytic and psychodynamic concepts against observable physiologic responses of patients brought new research interests and theoretic ferment. The provocative hypotheses which related specific developmental dynamics to types of physiologic responsivity helped sharpen and alter some basic psychiatric concepts.

As poetry and folklore testify, there is nothing new in the idea that emotions profoundly influence physiologic activity and can lead to illness or even death. Homer dramatically recounts the impact of fear on the viscera even in his heroes. Hawthorne, for example, reflected the spirit of his day at the dawn of the scientific era of medicine over a hundred years ago when he wrote, "A bodily disease, which we look upon as whole and entire within itself, may, after all, be but a symptom of some ailment in the spiritual part" and "He [the physician] deemed it essential . . . to know the man before attempting to do him good. Whenever there is heart and intellect, the diseases of the physical frame are tinged with the peculiarities of these." Such views recurred in medical literature before the advent of histopathology and microbiology turned medicine toward the laboratory conquest of many diseases. Then psychiatrists, seeking to follow the medical trend in a search for specific physical causes of disease, turned away from considering spiritual, or emotional, causes of insanity. In an effort to gain scientific respectability by basing its hypotheses on the study of the central nervous system, genetics, and biochemistry, psychiatry became increasingly useless to its patients, itself, and medicine as a whole. Paradoxically, psychiatry achieved a significant place in medicine only after psychiatrists began to follow the leads provided by their own patients and developed theories of human functioning that deviated from those held by other medical scientists. The concentration of interest upon psychosomatic disorders had to await the historic developments of the past twenty to thirty years in both medicine and psychiatry, as well as for the emergence of leaders.

The good physician has always been interested in the emotional problems of his patients, but it was necessity that finally forced a scientific interest in psychophysiologic problems. As the conquest of infectious diseases neared, attention turned increasingly to the unsolved problems presented by metabolic and chronic illnesses. The alert internist recognized that emotional difficulties played a significant role in producing peptic ulcer, ulcerative colitis, hypertension, etc. His customary investigative techniques and his reliance upon laboratory animals did not provide approaches to such problems. Some psychiatrists had become interested in related problems, for they had recognized that the physiologic abnormalities which had been painstakingly examined as possible causes of emotional disturbance were, rather, concomitants of the emotional turmoil. Owing to the influence of Freud, psychiatrists had become increasingly interested in the neuroses and then found that the problems of the neurotic patient were but exaggerations and distortions of normal behavior. Basic principles that were clinically useful in understanding human behavior began to guide psychiatric treatment. Studies of unconscious motivations, the phases of libidinal development, the mechanisms of defense, etc., brought insights just as useful in work with medical as with psychiatric patients. Interviewing methods and scientific utilization of the doctor-patient

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relationship developed from the technique of free association. Methods for study and therapy awaited application in psychosomatic disorders. In addition, psychiatrists had come to think of overdetermination of a symptom or about multiple factors leading to illness and had, through necessity, learned to think in meliorative rather than curative terms; both of these attributes fitted into the changing needs of contemporary medicine.

Psychiatry's most significant contribution to medicine as a whole has not been stated explicitly, because it involves a philosophy of medicine rather than a tangible technique or discovery. Medicine, by and large, had sought to understand man and his ills by focusing upon the unfolding of his genetic biologic endowment through interaction with his physical environment while protected by his epidermis and his highly developed homeostatic systems. This frame of reference left little room for consideration of emotional problems except as manifestations of physiologic disorder or impairment of the brain. It could not encompass the interrelationship between mind and body, or between the stresses of interpersonal relations and physiologic activities. Psychiatry, however, focused increasingly upon man's development as a social being, reluctantly abandoning animal models to concentrate on man's uniqueness among animals. It became apparent that the infant must not only mature physically but also assimilate the mores and instrumentalities of his social environment in order to become a person. These two heritages, the cultural and genic, are inextricably intertwined, affecting physiologic functioning as well as emotional and interpersonal behavior. The infant's helplessness at birth and his long period of dependency upon parental figures while he grows by introjection, identification, and learning ways of living, as well as through physical maturation, make interpersonal or object relationships assume central importance in man's total functioning. Such relationships are no less real than his physical environment, even though they are intangible. As part of the role of the symbolic processes in human integration which accounts for man's inordinate adaptability, the meaning of an event can be more important than the actual occurrence, and the distant past and remote future, whether perceived consciously or unconsciously, can influence behavior and physiologic reactivity as intensely as does the immediate present; indeed, the repressed and dissociated experiences often influence more profoundly because they are outside of conscious control. The body-mind dichotomy may continue to present a metaphysical dilemma, but for practical medical purposes it has been resolved. The problems that remain and will continue to challenge us concern the precise mechanisms by which thoughts and emotions influence given organ systems.

The current status of theory and investigations concerning the structural mechanisms through which emotions and conflictual life situations produce physiologic dysfunction and structural change constitutes an enormous topic beyond the scope of this chapter and of this author. There has been general agreement, often taken for granted, that the changes leading to psychosomatic illnesses are mediated through the autonomic nervous and the neuroendocrine systems. Cannon's[10,11] studies of the defensive functions of the adrenal medulla and the sympathetic nervous system provided the foundation and framework. The work of Wolff and his co-workers,[60] particularly Stewart Wolf, has greatly advanced knowledge of the effects of autonomic defenses upon the various organ systems. Although several theories exist concerning the role of the autonomic nervous system in producing physiologic dysfunction, a general formulation of the problem can be presented briefly. The autonomic nervous system serves two general functions: It prepares the body to respond defensively to danger, and it plays a major part in maintaining homeostasis through its role in respiration, digestion, excretion, and vasomotor control. These two functions can be antagonistic and can lead to diminution of adaptive ability in one or both spheres. Thus, for example, the stomach, while responding to fear or anger, will not meet digestive needs properly. The operation of an organ system can become dissociated or improperly reinforced, causing dysfunction. This statement describes an orientation and does

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not enter into the complex interrelationship between the central nervous system and autonomic and endocrine mechanisms involved in the translation of the stresses and conflicts of living into visceral reactions and tissue damage.

Recent physiologic and anatomical developments have greatly altered and increased the understanding of the intricate interrelationships and balances involved in the regulation of visceral activities. Although the complexity of the neural and endocrine interconnections can bewilder to the verge of provoking despair, some new and tangible approaches to the pathophysiology of psychosomatic disorders have already emerged. Thus, French *et al.*,[23] through the production of peptic ulcers in monkeys by hypothalamic stimulation with implanted electrodes, have clarified the interrelated influences of the anterior pituitary, the adrenal corticoids, the vagal stimulation, and the reticulospinal pathways on gastric motility and secretion; and the work of von Euler[20] and others on the differentiation of noradrenalin from epinephrine has direct pertinence to the study of essential hypertension.

A few areas of physiologic progress that appear to have particular importance to the understanding of psychosomatic research will be mentioned, and the reader is referred elsewhere for more adequate surveys.[15, 27, 34] The hypothalamus, long recognized as a center of endocrine and autonomic-nervous-system control, is now understood to form a critical juncture in a circular feedback system that mediates and regulates neural impulses concerned with emotions and neuro-endocrine activity.[12] The control that the hypothalamic nuclei exerts over the anterior pituitary secretions appears to be mediated through the vascular portal system between these structures, perhaps by adrenergic secretions.[24, 57] The hypothalamus influences and is influenced by the neocortex, the limbic system, and the reticular activating system as well as various endocrine secretions. The limbic system has been found to perform major regulatory functions, and has been termed the "visceral brain" by MacLean, who considers that it mediates visceral needs rather than ideational functions, being concerned with feelings in contrast to the symbolic activities of the neocortex.[39, 40, 48] The frontotemporal limbic activities may be concerned with primitive self-preservative activities and may exercise a controlling influence upon ACTH secretion, the more posterior regions, the cingulate gyrus and hippocampus, affecting sexual behavior and the sexual hormones. Both the hippocampus and the amygdala are implicated in diffuse emotional states.[26, 49] The connections of these neural complexes with the central gray and the reticulum of the brain stem indicate that they can exert regulatory influences on the neocortex as well as on visceral activities. The explorations of the reticular activating system by Magoun[42] and his associates have, in turn, altered neurophysiologic thinking, particularly concerning the plasticity of the central nervous system in responding to stimuli by filtering out and alerting the flow of neural impulses and by activating various portions of the central nervous system.[37]

Among the many developments in neuro-endocrine research, the role of the adrenals in the defenses against trauma have particular pertinence to psychosomatic concepts. The extent of the changes provoked by adrenergic secretions in response to danger or trauma has become clearer through understanding of their influence on the hypothalamus and the reticular activating system. The differentiation of noradrenalin and epinephrine has required revision of the concepts of the diffuse nature of the defensive fight-flight reactions proposed by Cannon, for these hormones can be secreted independently with different physiologic effects;[21] noradrenalin seems to be concerned with hostile states and epinephrine with fear and anxiety.[13, 25] Then, too, the medullary and cortical secretions of the adrenal no longer appear to have such disparate functions. The adrenal corticoids play a very major role in defense of the tissues against trauma, and the adrenergic hormones probably help mobilize their secretion.[38] The importance of the corticoids in the defense against both physical and emotional traumata have been highlighted by the extensive researches of Selye[53, 54] on the general adaptation syndrome, opening new approaches to the understanding of psychosomatic

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disorders. He considers that derailment of these defenses can lead to profound tissue damage and may be involved in the etiology of "diseases of adaptation" such as hypertension, peptic ulcer, arthritis, etc., as well as in the production of certain central-nervous-system damage. The therapeutic use of cortisone in arthritis, asthma, ulcerative colitis, and various collagen diseases has also stimulated much research by others in this general area.

This sketchy and fragmentary review of various neurophysiologic and neuro-endocrine considerations related to the impact of emotional reactions on visceral dysfunction can only serve to remind the reader of the complicated systems of controls that must be taken into account, and of the present state of flux when understanding of these mechanisms is undergoing rapid and drastic revision. It should be noted that relatively little research has been carried out concerning the influence of the various sexual hormones upon mood and mental activity, considering the critical position of libido theory in psychoanalysis. The work of Benedek and Rubenstein[8] upon the influence of the changing hormonal balance, during the menstrual cycle, upon mood and dreams has long awaited confirmation and extension.

Psychiatrically oriented studies have naturally approached the relationship between conflicts in living and physiologic dysfunction from a totally different frame of reference—one concerned with the types of ego-weakness and emotional conflict that dispose to psychosomatic ailments. The relationship between psychosomatic conditions and other personality disorders raises critical questions that have elicited a multiplicity of hypotheses. Most persons suffering from neuroses, including the transitory neurotic symptoms that occur in most lives, also suffer from some physiologic dysfunction that gives rise to somatic complaints. The early psychoanalytic studies of psychosomatic conditions by Ferenczi,[22] Jelliffe,[32, 33] Deutsch,[16] and others conceived of the physiologic disturbances as displaced unconscious symbolic expressions of repressed instinctual drives, very much as they considered conversion symptoms. Ruesch's[52] later theory, suggesting that these patients utilize a regressive body-language to communicate because of their defective ability to communicate by verbal symbols, bears a relationship to those early theories. Alkan[7] initiated a more comprehensive approach, but perhaps psychosomatic medicine became a differentiated field of study when both Flanders Dunbar[18] and Franz Alexander[1, 3] emphasized that the physiologic expressions of emotion need not have any symbolic meaning. The vegetative systems are not under voluntary control, and their activities are concomitants of emotional reactions rather than defenses against them. Alexander[1] wisely suggested that conversion reactions be limited to symptoms that can be produced through cortical discharge or inhibition. Ruesch[51] was among the first to stress the infantile residues in the personality organization of psychosomatic patients as a group. Alternation between psychosomatic illness and psychosis occurs frequently, and the frangibility of at least some of these patients during psychotherapy indicates serious ego-weakness. Such deficiencies in ego-structure have impressed most investigators, and various theories have sought to relate the primitive quality of the emotions experienced to the intensity of the physiologic response. While some psychiatrists simply consider that ego-regression reawakens intense emotions, others, starting with Michaels,[46] have postulated a physiologic regression to explain the damage caused by the physiologic reactivity as well as the choice of the organ system involved. Margolin[43] considers that the range of physiologic fluctuation decreases with age, and that physiologic regression subjects an organ to fluctuations beyond its capacities and leads to tissue damage. Grinker and Robbins[29] have postulated a loss of the differentiated responses acquired through conditioning when the organism is under extreme stress, leading to diffuse infantile reactivity. Szasz[55] has emphasized parasympathetic overactivity as a source of malfunction and considers such parasympathetic responses to be a regressive means of withdrawal from stress. Such theories are difficult to confirm or refute, and Mendelson *et al.*,[45] in a timely review, question whether they are necessary or contribute to an experimental approach.

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The following hypothesis, which helps differentiate psychosomatic illnesses from neurotic and psychotic reactions, may serve to clarify the vulnerability of some persons to physiologic dysfunction in response to emotional traumata. The mechanisms of defense of the ego are varieties of symbolic self-deceptions that ward off recognition of situations which provoke anxiety and other disturbing emotions. Their elaboration leads to organized neuroses. Regression differs, for it is a withdrawal from current conflicts and insecurities by seeking to return to a period of dependent security. It may evoke the price of leaving the individual prey to the fears of the infantile or childhood period. Psychotic regression and withdrawal provide escape from the untenable through abandonment of reality testing. The person who is prey to psychosomatic illness has suffered serious insecurity early in life but has not erected adequate mechanisms of defense to protect against the danger. Rather, he avoids recurrence of the insecurity or trauma by patterning his life so that he will never be exposed again. The critical area of weakness is encapsulated, but the patient neither becomes desensitized to the insecurity nor develops mechanisms of defense to blunt its impact. Superficially, the patient may seem a reasonably stable person, capable of relating well to others. When the defensive pattern of living collapses, he is subject to the emotion as it had been experienced in early life, with intense physiologic reactivity. The very nature of the defensive pattern may make recurrence almost inevitable. The patient with peptic ulcer, who has defended himself against loss of dependency by insistent self-sufficiency, may be overwhelmed by any business setback even though he is already wealthy. The hyperthyroid patient, who, by becoming the good child whom mother will eventually appreciate, avoids repetion of feelings of abandonment by the mother, has not built other object-relationships and will still be vulnerable in adult life when mother dies.[35] In such persons the impact in adult life remains as overwhelming as in childhood, and the illness seems to start when the defensive pattern crumbles.

The problem of why a given organ system is affected in an individual has occupied a central place in psychosomatic theory and research. There are many potential reasons why emotional turmoil provokes dysfunction in a specific organ system. Genetic or constitutional factors may make the organ the weakest link, or predispose toward malfunction through placing the individual at the extreme limits of the normal range of some biologic activity. The apparent hereditary occurrence of hypertension, diabetes, and other illnesses requires such considerations. Prior illness may have conditioned an organ to pathologic response; it has been suggested, for example, that whooping cough may dispose to asthma. A coexistent condition may create a confluence of factors to which one organ system is vulnerable. The emotional disorder need not be the only factor involved but may only be a contributant of greater or lesser significance in different persons and different diseases. Some asthmatics are severely allergic to ragweed and only suffer from asthma during ragweed season; others suffer only when emotionally upset during ragweed season; and some have no allergies and become asthmatic only when emotionally disturbed.

Many investigators, however, have been convinced that a fairly definite relationship exists between specific illnesses and some aspect of the patient's personality structure and functioning. Flanders Dunbar,[18] following her systematic studies of groups of patients by means of analytically oriented interviews, maintained that persons suffering from the same psychosomatic ailment had certain personality traits in common, in a configuration which she termed the personality profile. Although these profiles were highly useful in helping to focus early studies of personality factors, they were not sufficiently dynamic and failed adequately to differentiate patients.

Franz Alexander arrived at a different concept of specificity which many members of the Chicago Psychoanalytic Institute have followed in an important series of clinical studies (Alexander and French[5]). Alexander emphasizes the adaptative reactions of the vegetative organs to "the total situation in which the organism finds itself." He recognizes the im-

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portance of organ vulnerability but also postulates a "specific correlation between the emotional state and its physiological concomitants or sequelae" (Alexander and Szasz[6]). The nature of the conflict confronting the person and the dynamic configuration of the persons responding to the conflict are important in determining the involvement of a specific organ system. Alexander[4] thus does not stress personality profiles, as Dunbar has, but believes that the unconscious emotional configurations which may be present in differing types of personalities make these persons sensitive to similar conflicts. Dependency needs and the strivings for reactive self-sufficiency are placed in a central position in the dynamics of patients suffering from psychosomatic disorders. In a general way, the parasympathetic overactivity when the patient regressively seeks a position of dependency is considered important in the production of peptic ulcer, colitis, asthma, etc. The sympathetic overactivity when patients seek an active overcompensatory position may lead to migraine, hypertension, arthritis, etc. A recent study of Engel's[19] concerning the alternation between ulcerative colitis and headaches with the shift in the patient's basic position to dependency points in the same direction.

Harold Wolff[59] and many of his co-workers, with primary interests in neurology and medicine, have viewed the problem from a different perspective. Emphasizing the defensive adaptive nature of physiologic responses to stress, Wolff believes that the choice of an organ depends upon how the organ is implicated in a biologic pattern of defense or offense in a given individual. An individual may react to different types of stress with a similar physiologic reaction as determined by his constitutional make-up. Of course, differing emotional states can also provoke different physiologic responses in the same individual.

Interest in the mother-child interaction, with emphasis upon the mother's characteristics as a determinant of the patient's reactivity, can fit into any dynamic theory. Bruch and Touraine's[9] study of obese children was an early classic in such research. Similar interest in the mother-child relationship has been an expressed or implicit part of many studies of hyperthyroidism, asthma, eczema, ulcerative colitis, and other conditions.

Specific repressed emotions have been related to symptoms and illnesses. Thus weeping has been related to urticaria, the suppressed cry for help to asthmatic attacks, and hungering for love to peptic ulcer, etc. Such observations are usually placed in a broader theoretic context.[5]

Moving away from the individual, but by no means opposing psychodynamic or physiologically oriented hypotheses, Ruesch[52] has drawn attention to the importance of social change and mobility in the genesis of specific conditions, and Halliday[31] has emphasized the role of social issues, such as working conditions and morale, in the production of miner's nystagmus.

Some of the divergencies result from interest in different segments of the total field or from different systems of reference rather than from opposing observations. As the entire area of study started but a few decades ago, observations concerning specificity must be considered as opening hypotheses for further explorations rather than as established facts. Still, because of dissatisfaction with some hypotheses, because of inability to validate findings stated in the literature, or through misunderstanding of inadequate formulations, many workers have tended to turn away from specificity concepts and the attempt to relate conflict situations or personality factors to the type of illness. Although such scepticism may be healthy and may lead to new and more useful approaches, no clear substitutes have appeared as yet. There is some danger of prematurely discarding concepts that have served as useful guides in both practice and research. Some of these difficulties may have arisen because relatively few psychiatrists have worked intensively both with many patients with one illness and with many patients with a wide variety of diseases. Critical differences can be overlooked because similarities are found in the external and internal situations of some patients with different ailments. Many of the experienced people in the field continue to find definite differences, even though precise description may present difficulties. Basic differences be-

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tween patients suffering from ulcerative colitis and peptic ulcer are almost taken for granted. It is, for example, unlikely that Margolin[44] would have selected patients with peptic ulcer for the same type of anaclitic therapy which he attempted with patients with ulcerative colitis. Dependency problems are important in both hyperthyroidism and peptic ulcer, but the patients have, by and large, striven to cope with these problems in very different ways. (Further comments on specificity concepts and their utility will appear in subsequent chapters.)

Fortunately, effective therapeutic work with patients does not depend upon knowledge of how emotional conflicts are translated into physiologic malfunctioning or upon resolution of problems concerning specificity. The physician who orients treatment to the patient rather than simply to the disease and who can utilize the doctor-patient relationship therapeutically can often alleviate emotional problems and ameliorate the physical illness. The general principles which guide psychotherapeutic efforts with patients suffering from psychosomatic disorders are similar to those used in other psychiatric conditions.[36, 50] Some of the general problems frequently encountered in medical and surgical patients, though differing in setting and context, are basically similar to those of psychiatric patients. Unconscious forces often make the patient's motivation ambivalent, and failures to adhere to a therapeutic regimen must be accepted as part of the therapeutic problem, as in general psychiatry. Understanding of the regressive tendencies provoked by any illness can help both physician and patient cope with trends toward undue passivity and invalidism. The benefits of secondary gains resulting from illness to a person confronted by seemingly unsolvable problems tempt the unconscious of all types of patients. The psychiatrist, accustomed to treating for improvement rather than cure, is often better prepared than are other specialists to practice the melioristic medicine that the treatment of chronic illness has made essential. Opportunity for ventilation and emotional catharsis can by itself sometimes produce striking changes in the course of an illness. Skillful psychotherapy with medical and surgical patients need not differ from any other psychotherapy when patients are selected carefully.

Nevertheless, when a psychiatrist works with patients with psychosomatic ailments or serves as a consultant to a medical or surgical service, specialistic knowledge not acquired through experience in general psychiatry or in psychoanalysis becomes essential. Some of the special problems arise because of the differences between patients who become ill through physiologic expression of emotional disturbance and those who suffer neuroses and psychoses or act out antisocially. Other problems originate from the need to consider medical and surgical exigencies in planning and carrying out treatment.

Initiating a useful psychotherapeutic relationship often presents disheartening difficulties. The patient has sought help for his physical condition, but, not only may he fail to grasp the need for help with emotional problems, he may strongly resist it. The psychiatrist finds the patient poorly motivated, and, rebuffed, turns from that patient to be of use to the many others seeking his services. But this problem must be faced, for the manifestation of serious physiologic disturbance may be related to the patient's need not to recognize, or to admit to, emotional difficulties because of his inadequate defenses against the expression of intense emotions of an infantile quality. The achievement of a working relationship often depends upon the psychiatrist's ability to interview skillfully, with the objective of having a patient talk about himself until he inadvertently tells about his difficulties or hopelessness over life situations. When he realizes that he would be very unhappy, even if well, help can be offered for these problems without insisting that psychiatric treatment is required because of the medical ailment. The psychiatrist need not seek to have the patient gain insight into the relationship between his ulcer or asthma and his personality problems. Here, as elsewhere, insight refers to gaining understanding of the sources of emotional turmoil and unhappiness. Psychiatric treatment is directed toward these

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emotional difficulties, with the hope that amelioration of the interpersonal and intrapsychic disturbances will be accompanied by improvement in the medical condition.

Often, the illness provides secondary gain through fostering the acceptable passivity that forms a necessary defense for the threatened or crumbling ego-structure. The illness thus helps maintain repression and permits a façade of normality because responsibilities need not be faced. Premature or poorly timed uncovering techniques can either increase the physiologic disorder and endanger life or provoke psychotic withdrawal. Therapy with such patients, therefore, approximates that used with borderline schizophrenics. A firm transference relationship must be established before entering upon the patient's role in producing the untenable situations. Increasing feelings of guilt or worthlessness in a patient struggling to maintain some semblance of self-esteem can force the use of pathologic projection.

Although many patients have been amenable to intensive analytically oriented therapy and even to psychoanalysis, the treatment of most patients with psychosomatic disorders requires plasticity of approach from the therapist. These patients cannot be fitted into a single technique. Therapy involves weighing a multiplicity of factors—the type and severity of the illness, the danger of acute exacerbation, the emergency measures available in case of exacerbations, the extent of the risk worth taking, etc., as well as the factors usually considered in carrying on psychotherapy. Rarely can all of these potential influences be evaluated properly at the start of treatment. In some conditions, such as ulcerative colitis, therapy that requires resolution of the transference neurosis is unlikely to succeed without skirting or entering into psychotic episodes. With most patients, therapy is not directed toward fundamental changes in personality structure, but lesser measures should not be derogated and may require great skill on the part of the therapist. The patient may be helped in many differing ways. Often, one hopes to modify a basic attitude that seems critical in perpetuating a destructive emotional reaction. However, the support afforded by the therapeutic relationship may, of itself, turn the patient from preoccupation with death or help him carry through a critical phase of an illness. The experience of being heard and understood can be a unique one to some patients, and it may alter their perspective. Providing firm support or opportunity to talk and weigh a significant decision concerning treatment can change the entire course of an illness. In brief, the therapist often concerns himself with critical problems and with finding ways of helping the patient meet them.

The effects of the psychiatrically oriented intervention may be difficult to predict, at times bringing results that seem disproportionate to the effort expended: A woman with advanced myasthenia gravis, who is seen because of her depression and obsessive fears of killing her daughter, spends several hours venting her bitterness toward her husband, traces the effects of her introjected rage upon her illness, considers her impotence to change her life situations, and experiences almost complete remission of her myasthenia. A girl with a disfiguring atopic dermatitis cries through a two-hour interview as she tells of her shame at having married a pervert, a story which she could not confide to her punitive mother. The vascularity of the skin changes perceptibly during the session, and the course of her illness alters abruptly. Such responses are unusual and unexpected, but others are more predictable. Attacks of status asthmaticus can cease abruptly when the patient can be provoked into sobbing while telling of feelings of hopeless desertion. Patients with ulcerative colitis may respond to ventilation of pent-up mourning reactions and also to firm decisiveness on the part of the physician. This may happen frequently enough to guide the therapist's efforts and his attitude toward the patient.

The psychiatrist must be able to collaborate closely with other medical specialists, which demands reasonable familiarity with the medical problems involved rather than just exchange of opinion. Knowledge of the potential courses an illness might take and the therapeutic methods available permits the psychiatrist greater security and latitude. The choice of a therapeutic regimen sometimes depends

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upon the personality problems of the patient as much as it does upon the medical exigencies, and it may, in turn, influence the psychiatric problems. An obsessive diabetic patient may become unbearably insecure if told that weighing food and testing urine three times a day are unnecessary, whereas other patients who cannot tolerate dietary restriction without becoming depressed can be treated quite adequately and more accurately if placed on a relatively "free" diet. Certain illnesses as well as certain treatments are apt to provoke rather similar problems in many patients. The psychiatrist who is aware of these problems has a head start in treatment and can communicate with the patient more meaningfully. The use of a respirator in polio patients, the strict bed rest imposed following coronary occlusion, the informing of a patient that he suffers from tuberculosis, the creation of artificial stomata, and many other situations are apt to provoke hidden turmoil that can be prevented or aborted only if they are anticipated.

The psychotherapist who is not thoroughly familiar with the potential vicissitudes of an illness can precipitate a critical exacerbation through improper timing of an interpretation or by altering the transference relationship. On the other hand, he may be unwilling to assume risks lest an emotional upheaval result, even when they seem necessary to save a life or to prevent serious suffering.

Here, as elsewhere, experience and knowledge of the literature can furnish direction. The value of specificity hypotheses is not simply theoretic but highly practical. The nature of the illness has often served to alert the therapist to the importance of situations that might otherwise seem of casual interest. The failure of a salesman to achieve an annual bonus greater than the preceding year could be easily rationalized, but to an ulcer patient this fact was a threat to his reactive strivings sufficient to produce a recrudescence. Marriage of the particularly favored child may not always be a cause for rejoicing to the mother, but in a woman who develops hyperthyroidism it could shatter her lifelong defensive maneuvers against abandonment. A young woman's recognition that she failed to stem her husband's alcoholism even more abysmally than her mother had failed with her father could undermine an entire self-concept and constitute a significant factor in her mounting hypertension.

Psychotherapeutic medicine constitutes an enormous field of endeavor that has received systematic attention for only a relatively short time. The internist and psychiatrist have much to offer one another and their patients. Although often an alluring field to the psychiatrist, the difficulties that arise in working with other physicians who speak a different language and with patients who often resist and resent psychotherapeutic efforts can be disheartening. The expectation that a firm grounding in psychiatry suffices to permit successful work with medical patients can also lead to discouragement, for more than casual success is unlikely unless the therapist becomes steeped in the special problems involved. Yet when experience finally provides familiarity and orientation, those who have moved into the field are stimulated by the new discoveries and unanticipated successes that reward those who venture into newly opened territories.

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CHAPTER 33

PSYCHOLOGY OF CARDIOVASCULAR DISORDERS

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THE PSYCHOPHYSIOLOGY of the circulation constitutes an important issue in the theory and practice of psychiatry, since the circulatory apparatus is so intimately involved in phenomena of central importance in psychological life, namely, in the motor expressions of anxiety and other affects. By virtue of this fact, that is, that emotions mobilize, or are associated with, changes in the circulation, physicians dealing with patients who have cardiovascular disorders find that psychological problems are extensively involved in their work, and the clinical psychiatrist is frequently called upon for help in the diagnostic and therapeutic problems encountered. This is so not only because of the role of emotional forces in contributing to clinical disorders of the circulation but also because circulatory disorders, in themselves, frequently constitute sources of psychologic stress for patients and create problems in this sphere. Particularly in patients with heart disease (and to almost as great an extent in patients with hypertension), these psychological problems in reaction to the physical disorder are frequently more intense, and hence more serious, than the generally encountered reactions to the "threat of illness" in a nonspecific sense. Not only may they be more intense, but they may in themselves mobilize further affect which then imposes more burden upon the diseased system, and, in this way, self-reinforcing cyclic reactions may arise. These will be described in detail later in the chapter.

Clearly, the interrelationships between psychological and physiological phenomena may become highly complex in problems of this nature, and in any single patient there may be an admixture of reactions that follow psychosomatic, somatopsychic, and somato-psycho-

somatic sequences. To begin with, two things should be made clear: The first is the fact that psychologically determined motor changes in the circulation will inevitably exert some effect upon *any* pathological condition involving the circulatory apparatus, since these motor effects will constitute demands for function upon tissues compromised by underlying disease. The second is the fact that any disorder of the cardiovascular system, by virtue of the symptoms and functional limitations it produces or merely because it exists, may present a serious problem in psychological adjustment to the patient. In this sense the cardiovascular problems that are affected by emotion or that exert effects upon the psychological condition of the patient constitute a broad spectrum of disorders, starting with structural heart disease and its attendant problems of congestive failure at one end, and ending with neurocirculatory asthenia at the other. Indeed, there is now a vast literature on the "psychosomatic" aspects of congestive failure, coronary artery disease, essential hypertension, peripheral vascular disorders, migraine, cerebral vascular accidents, syncope, and neurocirculatory asthenia. A comprehensive and systematic review of such a spectrum would be beyond the scope of a single chapter, but there is an additional and more cogent reason for limiting the field to be surveyed here. This is simply stated as follows: "psychosomatic medicine" is better regarded as a way of approaching medical problems than as a new or special field.[91, 127, 128] It seems, then, more appropriate to illustrate the approach by focusing mainly and in some detail on the psychodynamic and psychophysiologic issues encountered in one major cardiovascular problem area. The problem chosen for review is that of the patient with structural heart disease leading to diminished functional cardiac reserve and the associated clinical problem of congestive failure. The principles so illustrated apply to the wider range of problems and can be extrapolated to them. Observations about emotions and disease have accumulated in the literature at a very rapid rate, and this may well be expected to continue. Compilations or reviews of these new observations are available elsewhere.[34, 122, 128] It will be our aim here to select data relevant primarily to the problem of congestive heart failure and to make an attempt at integrating them into a broader understanding of the clinical psychosomatic issues encountered.

¶ Psychophysiologic and Psychodynamic Problems of the Patient with Structural Heart Disease

Physiologic Considerations

The basic physiologic problem involved in structural heart disease that leads to congestive failure can be understood as one of supply and demand. With the progressive decrease in cardiac reserve that results from the heart lesion, there ensues progressive difficulty in maintaining circulatory equilibrium, namely, in maintaining adequate cardiac output in response to varying functional demands.

Congestive heart failure will develop whenever myocardial capacity is inadequate to meet the metabolic demands of the body. Certain events then occur which lead to the classical picture of congestive failure, and chief among them is the impairment of normal renal mechanisms with resultant retention of salt and water.[75] The ultimate responsibility for this fluid and electrolyte imbalance must be assigned to the circulatory inadequacy, but the immediate and crucial mechanism is altered renal function.[77] Any consideration of congestive failure must therefore be concerned not only with disordered circulatory dynamics but with the physiologic factors controlling the disposition of sodium chloride and water by the kidney.[59]

The balance between tissue needs and the ability of the heart muscle to meet them may be disrupted by increasing the demand or by reducing the functional cardiac reserve. Infection, exertion, increase in blood volume, certain paroxysmal arrhythmias, and emotional stress are all factors which may lead to a relatively abrupt increase in the demand for cardiac work. Diminution in coronary blood supply, inflammation (myocarditis, myocardosis), arrhythmias which reduce efficiency of cardiac

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function, and emotional stress are all factors which may lead to relatively rapid decrease in the heart's capacity to perform work. Furthermore, increased demand and decreased capacity may occur in combination, and as reserve decreases with time and advancing disease, progressively smaller loads determine the limits of compensation.

There is a direct relationship between cardiac output and effective renal plasma flow; diminished cardiac output lowers the glomerular filtration rate, thereby producing a decrease in salt and water excretion.[54, 68] This is not the sole regulating mechanism however, and it has been established conclusively that the renal tubule may operate independently of the glomerulus in this respect. Indeed, the renal tubule is the second discrete regulator of sodium chloride and water balance. For purposes of simplification, the glomerulus may be considered to be affected primarily by hemodynamic changes. Tubular function, on the other hand, is modified chiefly by humoral agents.[59]

The humoral agents which affect tubular function include the antidiuretic hormone of the neurohypophysis (ADH), which promotes water reabsorption, and the adrenal corticosteroids, which promote sodium retention. Of the latter, the most potent is aldosterone, but other steroids (hydrocortisone, corticosterone) also exert an appreciable effect.[59] Furthermore, norepinephrine can cause marked change in sodium excretion. On the basis of available data, one can state that both adrenal activity and altered circulatory dynamics are necessary for the development of edema, the prime feature of congestive failure. There are many factors which evoke increased aldosterone activity in congestive failure, including dietary restriction of sodium, impaired hormone degradation due to hepatic congestion, and elevated serum potassium levels. In addition, those adrenal steroids which are under ACTH control all have sodium-retaining activity and can, at times, tip the balance in the direction of failure. The role of emotional stress in increasing adrenal cortical activity is well known and will be referred to more fully in the following section when the emotional factors in congestive failure are discussed.

In attempting to clarify the mechanisms underlying the clinical phenomena which concern us, it is pertinent to consider the ways in which psychological stress may affect circulatory equilibrium either by increasing current demand or by decreasing available supply, and/or by altering renal function.

Physiologic Concomitants of Psychologic Stress Which Add to Demand for Cardiac Work (Psychosomatic Sequences)

It has been repeatedly demonstrated that "emotional stress" may be accompanied by measurable changes in arterial blood pressure, heart rate, stroke volume, cardiac output, and peripheral resistance.[5, 8, 38, 45, 50, 57, 58, 86, 88, 98, 108, 112, 113, 118, 129, 131] Perhaps the most carefully and extensively documented study, to cite as representative from a physiologic point of view, is that of Hickam and co-workers[50] who utilized a spontaneous, nonspecific stress situation—an important academic examination—in order to demonstrate differences in measurements reflecting circulatory dynamics obtained during "tension" from measurements obtained during relative relaxation. Twenty-three healthy medical students served as subjects. Each student was studied just before the critical examination and then again a day or two later, after having been informed that he had passed. The average cardiac index (volume output of the heart [in liters] per minute per square meter body surface area) before the examination was 2 liters per minute per square meter greater than that measured during relative relaxation. When this figure was converted to "work load," it corresponded to a load which would be demanded by increasing oxygen consumption by an amount equal to the basal metabolism.

In Hickam's work as well as that of the many other authors cited above, the meaning of the psychologic stress and the nature of the reaction to it were not specifically studied in the individual subjects. Hickam noted that the pattern of mobilization varied in his subjects, and described three patterns. For the largest part of the group, anxiety was accompanied by an increase in cardiac index, decrease in peripheral resistance, and relatively small rise in mean

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arterial pressure. In a smaller second group, the "anxious state" was associated with a slight to moderate rise in peripheral resistance, with a rise in mean blood pressure and no change or a slight decrease in the cardiac index. In three subjects there were rises in cardiac index but large moment-to-moment fluctuations in stroke volume and heart rate.

A great deal of research has been done in an effort to determine whether specific differences in pattern of circulatory response may be related to specific differences in the concomitant emotion involved. The investigative group headed by H. Wolff at Cornell, through the use of structured stimuli (introduction of conflictual topics during interview), have described relationships between different directly observed (and subjectively reported) affects and different patterns of circulatory mobilization.[129, 130, 131, 132] Funkenstein *et al.*,[36] working with groups of healthy subjects subjected to a specified stressful task, have described three patterns of emotional response which they designate: "anger-in," "anger-out," and "anxiety." On the basis of ballistocardiographic, heart-rate, and blood-pressure recordings taken simultaneously, they reported that subjects showing the "anger-out" pattern developed circulatory changes similar to changes produced by administration of noradrenalin. (This resembles the second pattern described by Hickam.) Subjects showing "anxiety" and "anger-in" reactions demonstrated changes similar to those that would be produced by injection of adrenalin (similar to the first pattern described by Hickam). Ax[8] and Schachter,[98] working on subjects who were exposed to laboratory situations deliberately staged to evoke either anxiety or hostility, reported differences in pattern of circulatory changes similar to those described by Funkenstein.

The general implication of all this is that outwardly displayed anger is accompanied by a release of norepinephrine, whereas anxiety and anger directed inward are accompanied by release of epinephrine. It should be noted, however, that these implications have been drawn by indirect inference from measurement of circulatory functions, and the studies did not include assays of the hormone levels in the blood. The inferences drawn are also open to criticism, since they were based upon quantitative amplitude measurements of ballistocardiographic tracings obtained by the use of direct body pickup instruments which cannot be satisfactorily calibrated. The issue may be far more complicated than this, since Lacey and co-workers have advanced a great deal of evidence to show that individual differences in pattern of response may be, in large part, reflections of constitutional differences, and may only partly reflect specific connections between specific affects and particular patterns of response.[57, 58] Reiser, Weiner, and Thaler,[88, 89] in recording circulatory functions during projective psychological testing, observed both of the first two patterns reported by Hickam, as well as an intermediate group which, like Hickam's, seemed too variable from moment to moment for adequate qualitative classification. In all subjects, brisk responses (of the same magnitude as those reported by Hickam and others) occurred in association with surprisingly little directly observable or subjectively reportable evidence of affect. The amount of affect which could be identified in this way was not sufficient for classification. Differential patterning of the circulatory responses appeared to be related more to differential attitudes toward the examiner, but the experiment did not allow for adequate exploration of the unconscious aspects of this relationship, and much more data are needed about this issue. Although the question of specific relationships between affects and physiologic patterns of circulatory response must still be left open, there is no question that these studies singly and collectively demonstrate that emotion is accompanied by circulatory changes which may greatly increase the amount of work required of the heart. Stevenson *et al.*, in another significant datum, have demonstrated that the circulation recovers from the effects of exercise slowly and inefficiently during states of emotional tension, thus prolonging the strain upon the heart.[113]

Most of the studies referred to thus far deal primarily with changes in healthy subjects whose circulatory systems were presumably normal. The studies of Hickam and H. Wolff,

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among others, were also extended to patients with valvular disease and limited cardiac reserve, with similar results. Particularly striking is Hickam's demonstration in a patient with severely limited cardiac reserve that the effects of exercise and anxiety were similar and were in the direction of developing congestive failure. Cardiac index and pulmonary arterial pressure were determined by cardiac catheterization. With anxiety as well as with exercise, there was a failure of the cardiac index to rise, accompanied by an increase in pulmonary arterial pressure.[50]

Physiologic Changes in Association with Emotional Tension That Lead to Decreased Myocardial Capacity (Psychosomatic Sequences)

Diminution in functional cardiac reserve during tension may occur as a result of interference with intrinsic cardiac mechanisms governing heart rate and rhythm. Changes in the electrocardiogram reflecting such interference with cardiac mechanisms have been repeatedly demonstrated by numerous workers, including Katz *et al.*,[55] Mainzer and Krause,[65] Wendkos,[123, 124] and Crede *et al.*[21] This literature has recently been reviewed by B. Weiss.[119]

Physiologic Changes in Association with Emotional Tension That Alter Renal Function (Psychosomatic Sequence)

There have been few studies which bear directly on the role of emotional factors as they affect renal function. Diuresis has been reported in both animals and man following emotional stress, and in recent years investigations have been conducted on the effect of specific emotions on fluid and electrolyte balance. Schottstaedt and his co-workers have recently reported a series of such studies, and indicated a direct correlation of certain emotional response patterns with specific types of alteration of water and sodium excretion. For example, they found that feelings of anger, uneasiness, and apprehension produced increased rates of water and sodium excretion, whereas feelings of depression were associated with decreased rates.[10, 100] Confirmation of these findings by other investigators has not been reported as yet, and further research on these psychophysiologic relationships is needed.

There is more evidence, however, which bears directly on the relationship between emotions and adrenal cortical activity[32, 33, 102] and between adrenal cortical activity and renal tubular function.[59, 77] By inferential reasoning, one step removed, one may hypothesize a sequential psycho-adreno-renal pathway as an important factor in the clinical manifestations of congestive failure.

Clinical Observations—Association Between Psychological Problems and Clinical Course (Psychosomatic Sequences)

In view of the pertinent psychophysiologic findings summarized above, it should in no way be surprising to find that stressful life events often precede the development of episodes of congestive failure in patients with established cardiac disease and limited reserve. Indeed, this expectation can be affirmed readily on the medical wards of any hospital. Chambers and Reiser interviewed twenty-five consecutive patients who were admitted to the wards of the Cincinnati General Hospital because of congestive heart failure.[18] An acute emotionally stressful experience had immediately preceded the development of congestive failure in 76 per cent. In each instance these events seemed to have highly specific meaning for the patient in relation to his previous life experiences and conflicts, and in most they were superimposed upon a chronic state of sustained emotional tension.* An important aspect of these findings lies in the fact that most of these patients had been through similar conflictual crises previously without having developed congestive heart failure, that is,

* It should be noted here that a similar study of personality and life situations in patients with acute coronary occlusion has been carried out by Weiss *et al.* They found evidence of gradually mounting emotional tension prior to the onset of occlusion in 49 per cent of the forty-three patients studied. In addition 37 per cent of them had shown acute emotional stress which in 9 per cent of the instances was added to the tension just before the onset of the coronary occlusion.[122]

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similarly stressful experiences occurring before critical limitation of cardiac reserve had developed had not resulted in clinical disturbance of the patients' circulatory equilibrium. It was only after the underlying progressive heart disease had resulted in serious loss of cardiac reserve that the stressful life events assumed clinical importance in respect to circulation. All of the patients in this series were seriously ill and exhibited advanced forms of heart disease and serious degrees of cardiac decompensation. In other words, they were the type of patient in whom the extent of underlying cardiac pathology might so impress the physician that he might well not feel it necessary to search for a specific precipitating factor. Still it is of utmost importance to recognize that the extent of the underlying heart damage does not ordinarily account for the nature of the forces immediately responsible for the abrupt onset or worsening of congestive failure. In the same study it was noted that marked improvement in clinical status coincided with providing the patient an opportunity to share and discuss his difficult life situation with the physician. It was further observed that a continuing supportive relationship with the physician aided in avoiding further unresolved emotional crises and stabilized the clinical course to a great extent (without, of course, effecting any change in the extent of underlying heart damage).

In summary, the tenuous balance between work load and cardiac reserve in patients with structural heart disease and diminished cardiac reserve may be seriously disturbed by the various circulatory responses that accompany psychological stress. In this fashion, serious episodes of congestive heart failure may be precipitated and sustained by emotionally stressful life situations.

Somatopsychic Problems in Patients with Structural Heart Disease

In the interest of logical sequence it seemed appropriate for a summary of psychosomatic mechanisms and sequences to precede this section. This was mainly because the psychological sequelae may, and usually do, include a large component of unresolved anxiety which then may channel back through the psychosomatic pathways and lead to worsening of the patient's condition. The cyclic reaction thus set in motion may develop to critical proportions, and for a long time such reactions preempted the major attention and energies of workers interested in psychologic aspects of cardiac disease.

While the importance of these cyclic phenomena (which will be discussed in more detail below) has in no way diminished, in recent years our attention has, in addition, been called dramatically to a much broader field of somatopsychic reactions which manifest themselves mainly in the field of behavior. The importance and frequency of the latter reactions could not be fully appreciated until brought into sharp relief by experiences with patients who reacted in "paradoxical" fashion to corrective cardiac surgery. Although the exact incidence of such reactions is not accurately known, the phenomenon constitutes a major challenge to physicians in selecting patients for surgery. Perhaps even more important is the fact that these extreme instances have greatly broadened and deepened our understanding of the somatopsychic sequences which are present to some degree in all patients with major cardiac difficulties.

In a discussion of these problems, it is useful to identify those factors intrinsic to cardiac disease which may operate as stressful agents in the psychologic sphere and thus demand attempts at adjustment on the part of the patient. In the last analysis the ultimate clinical effects of each of them stem from the fact that they act as sources of anxiety. The end results may come about in two ways—either as the result of untoward effects of free anxiety and other affects, upon the tenuous circulatory balance, or as the result of indirect consequences of anxiety, namely behavior which stems from maladaptive use of ego defenses against anxiety. These maladaptive behavioral phenomena, in turn, may complicate or aggravate the circulatory problem. Thus they may lead to behavior which interferes with the patient's ability to utilize a prescribed medical regime, for example, refusal to take digitalis. They may also be reflected in more general aspects of the patient's personality adjustment and lead to psy-

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chiatric problems (e.g., depression) which do not immediately affect circulation but nonetheless may require therapeutic attention in their own right. The complexity of these direct and indirect consequences, and the manner in which they may in themselves lead to mobilization of additional anxiety (thus completing feedback cycles), is schematically illustrated in Fig. 1.

The psychological burden imposed by the onset and/or diagnosis of heart disease may stem from any or all of three general sources. The first source is constituted by the symptoms themselves. The abrupt onset of sensations, such as breathlessness, severe precordial pain, palpitation, dizziness, etc., is in itself understandably terrifying. The initial anxiety so generated at the onset of an acute episode may in itself impose considerable additional burden upon the already compromised circulation.

The second source is the threat inherent in the diagnosis of heart disease. Any illness may generate anxiety by virtue of actual or threatened damage to bodily integrity, but in the case of the heart these issues usually are exquisitely exaggerated. The reasons for this are general and universal. The central indispensable role of the heart in maintaining life provides an appropriate background for the use of its mental representation as a symbolic object of the deepest and most awesome unconscious fantasy fears of all types. Added to this is ample reinforcement from folklore, symbolic language conventions, and a vast popular literature, some of which is quite fearsome —whether intended to be or not. It is probable that the diagnosis of heart disease universally activates, to some degree, fantasies of sudden, unexpected, and catastrophic death. The real danger implied by the diagnosis is not to be minimized here, but it should be pointed out that fantasy fears may exaggerate and amplify it to proportions far beyond the realities. For example, the unconscious threat may be no less intense in the patient who is informed of the discovery of a functional cardiac murmur than it is in a patient confronted by a diagnosis of serious advanced rheumatic heart disease. Beyond these generally present potentials for threat inherent in the diagnosis, there may,

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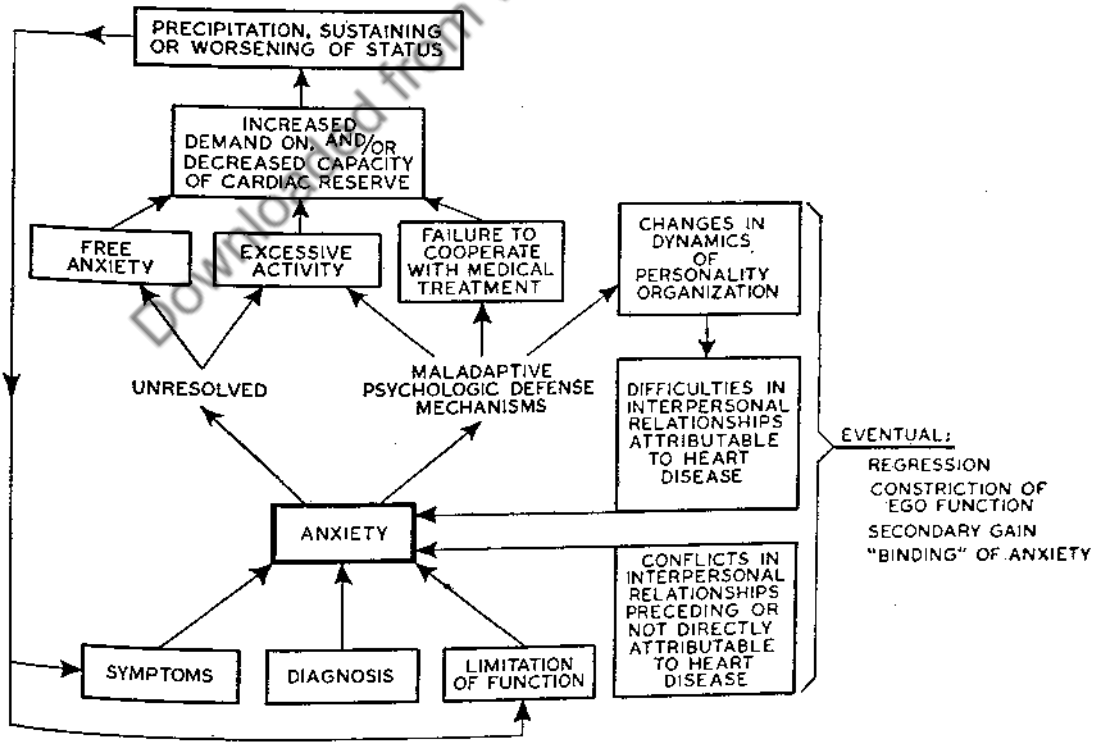

FIG. 1. *Feedback cycles in cardiac disease.*

in individual cases, be specific additional potentials for conflict and turmoil. For example, consider the case of a patient who has had a highly charged ambivalent relationship to a relative or close friend who died of heart disease. Here problems of identification and guilt may add considerable fuel to the fire.

The third source of anxiety stems from the fact that the patient experiences (or can anticipate) a real limitation of his physical capacity, and knows that this will be progressive and result in increasing loss of power in his most vital organ. The adaptive task imposed upon the patient cannot and should not be underestimated. Successful or ideal adjustment necessitates realistic acceptance of the loss and the attendant limitations which it imposes, and also necessitates rearrangement of living patterns which take these limitations into account and at the same time make maximal utilization of residual capacities. Many factors influence the degree to which the patient succeeds in meeting this challenge. Among them, most important are: the severity of the specific emotional impact of heart disease upon him; the strength of his personality make-up; the specific reactions and attitudes of medical personnel, particularly his doctor; and the reactions of important people in his personal environment. Naturally, the psychologic trauma inherent in the development of a cardiac disorder may severely aggravate a pre-existent psychiatric problem, and in some instances it serves as a precipitant for development of major psychiatric difficulties in a previously satisfactorily integrated personality.

There are a number of ways in which things can go wrong. Inadequately resolved anxiety (free affect) may worsen the medical condition, as described above. In addition, psychologic mechanisms which ordinarily have the function of defending against anxiety may be inappropriately and maladaptively mobilized in the patient's attempt to defend against the threat. For example, specific ego defenses such as denial (for example, of illness) and reaction-formation (for example, against dependent wishes) may lead to open, unrealistic, and rebellious unwillingness to adhere to a prescribed medical regime. This is a problem frequently encountered in middle-aged men with coronary disease, and such behavior may be seriously, though unwittingly, self-destructive. In so far as it contributes to progression and aggravation of symptoms and further actual constriction of the patient's physical capacity, it creates new anxiety, and in this indirect way another type of vicious cycle is established.

Disturbances in the sphere of behavior may not be restricted to issues centering about the physical disorder and its care. Rather profound changes may develop in the basic functional organization of the personality. Extensive reliance upon defenses such as projection and displacement may lead to drastic changes in the patient's view of the world and his reactions to specific people in it. Unconsciously determined changes in significant and important relationships may result—for example, dissolution of business associations, divorce, etc. These too may represent fresh sources of tension and conflict which lead to still another type of feedback cycle. Even without this, symptomatic behavior of this magnitude represents major psychopathological development and demands therapeutic attention in its own right.

As the situation progresses, more far-reaching long-term changes may become evident. As in any major illness, strong regressive tendencies develop, and when these are added to and combined with the kinds of developments described above, a process is instituted which may eventuate in serious constriction of all aspects of ego-function in general, and, in particular, in restriction of the defensive operations of the ego to relatively few mechanisms that are for the most part maladaptively utilized. The cardiac status becomes part of the self-image, and the personality becomes constricted, rigid, brittle, and fragile. The cardiac status may become a nuclear part of the patient's style of conducting interpersonal relationships, and this is most often manifested by behavior which exploits the physical condition in the service of secondary gains which may acquire considerable value.

One additional mechanism should be mentioned, which can be described as a form of "binding of anxiety." Whenever serious physical disease (or a physical condition which can be treated as "serious") develops during a

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period when the patient is grappling with a serious unconscious psychological conflict, the physical disease may be seized upon as a way of resolving the conflict. For example, the illness may provide a way of avoiding the issue by precluding the conflictual activity and may thus reduce the importance of the conflict to a state where it is of academic interest only. Two typical and frequently seen examples of this mechanism can be cited. The first is the example of the patient in early adolescence who has not yet reached a satisfactory resolution of problems centering on issues of sexuality and independence; chronic invalidism for such a patient may provide a very convenient way out. The second example is that of the overtly aggressive and ambitious man who harbors unresolved problems about success. Here again, even early manifestations of cardiac disease may offer a face-saving occasion for retrenchment and retreat from vocational growth. In other words, the status of illness may acquire powerful psychic value by virtue of the fact that it offers opportunity for "acceptable" avoidance of serious conflicts that would be activated in a fuller life sphere. All of these mechanisms and phenomena are particularly well illustrated by experiences gained in subjecting patients with long-standing cardiac disabilities to surgical procedures which literally restore the circulatory capacity to levels of competence that permit a wider sphere of activity.

Emotional Aspects of Cardiac Surgery

In the past fifteen years, tens of thousands of people with heart disease have undergone cardiac surgery. From this accumulated experience there has evolved a growing awareness of the major role of emotional factors in all phases of this therapy. In the selection of suitable candidates, in the preparation for operation, in the management of immediate postoperative recovery, in the assessment of postoperative results, and in the patient's adjustment and adaptation to a new life situation, psychological factors heavily weight the course at each step.

In the last few years, reports from various centers have drawn attention to the high incidence of major psychiatric complications following heart operations and to some of the mechanisms involved. In 1954, Little and Pearson reported on a patient who developed an acute schizophrenic psychosis following cardiac surgery. The psychosis was characterized by catatonia, with an admixture of delusional patterns. Treatment consisted of combined insulin coma and ECT. The patient survived this therapy, and responded satisfactorily. They suggested that "with the rapid increase in cardiac surgery and the resultant new way of living, other psychotic reactions may develop which will require shock therapies."[64] This prediction was confirmed in subsequent reports from other observers. In the same year Fox, Rizzo, and Gifford, who had been impressed by the large number of psychiatric consultations requested by the cardiac surgical service and had therefore undertaken a study of psychological mechanisms and reactions before and after valvulotomy, reported a high incidence of major psychiatric complications in their series.[34] In 1955, Bliss, Rumel, and Branch, having encountered two patients who developed severe schizophrenic psychoses after mitral commissurotomy, carried out a retrospective survey of thirty-seven cases and reported that eleven of them had developed major psychiatric complications.[13] Kaplan studied eighteen patients who had experienced mitral commissurotomy and stressed the importance of the individual personality structure and life situation as determinants of the ways in which these people responded to improved cardiac function.[53] In 1957, Priest and his coworkers, confronted with a higher incidence of psychoses after cardiac surgery than after general major surgery, studied a large group of patients undergoing heart operations. They emphasized the uniform high degree of anxiety in cardiac patients approaching surgery, particularly in those with rheumatic heart disease, and related this to the disproportionately high incidence of psychiatric complications. They drew attention to the difficulty in evaluating surgical results because of the postoperative persistence of psychogenic subjective symptoms of disability, particularly dyspnea and fatigue.[79] This problem of the interference of psychological factors in achieving accurate appraisal

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of surgical results had already been discussed in a Cornell therapy conference and had been remarked upon by other observers.[11, 20, 53] On the Psychosomatic Service at Montefiore Hospital, a limited retrospective review of patients who had undergone mitral commissurotomy revealed the anticipated high incidence of postoperative psychoses, suicide attempts, and prolonged depressions.

The specific emotional reactions to cardiac surgery can best be viewed through the frame of reference of the long chain of relevant circumstances beginning with the diagnosis of heart disease and ending with the readaptation following "surgical rescue." The anxiety-laden somatopsychic sequences have already been discussed, and they hold for this group of patients with one significant difference, namely, that there is now the opportunity of halting or reversing the deteriorating course of the disease. With the widely popularized information about heart operations, "hope" has been engendered for many people whose only outlook had been progressive disability and death. A noted cardiac surgeon has commented on the striking difference in overt attitude between patients referred for cardiac surgery and those referred for other major surgical conditions. The latter hope they will be told that surgery is unnecessary; the cardiac patient hopes that he will be accepted for surgery.* However, it is well to remember that all surgery carries with it unconscious fear and dread of mutilation and death, and additional anxiety is evoked when a highly emotionally charged organ, such as the heart, is involved.[23] Herein, then, lies the conflict which confronts all prospective candidates for a cardiac operation and which only serves to heighten the already anxious state. Once such a patient embarks upon the process of evaluation of suitability for surgery, the realistic and unconscious stresses multiply with mounting intensity. The routine procedures which are carried out, including angiocardiography, cardiac catheterization, and repeated examinations by members of the cardiovascular surgical team, are tedious, usually frightening, and carry some risk. Tension is further heightened by the necessity to wait for "the verdict" from the panel of experts.

Depending upon the nature of the long-term defenses, patients may look forward to the operation in different ways. Those who have realistically accepted the burdens of heart disease but continued to be truly dissatisfied with the restrictions it imposes may view the operation as a chance to revert to previous healthy living. Those in whom the heart disease has led to increased dependency, ego constriction, and avoidance of mature responsibilities may then be loathe to give up the illness and face a normal life with its implied independence. Those who have become chronically depressed by a life of increasing invalidism may see the operation as a "sanctioned suicide" in which the real rescue is death.

Once the patient is accepted, and the prospect of surgery is a reality, the original conflict between the desire for and the dread of surgery is intensified, and the patient must supplement his existing and sometimes limited repertoire of long-term defenses with emergency psychological mechanisms. These emergency defenses are seen quite clearly as the time for operation approaches, and they include immobilization (to avoid the fear of disintegration), belligerence (last attempt to deny weakness), excitement or elation (to cover depression and fear), desperate denial (last-minute maneuvers to delay the operation), or total failure to mobilize emergency defenses, in which case overwhelming panic may ensue, with the patient being convinced that his heart will stop during the operation and that he will die. In other cases, where defenses are inadequate, major hysterical mechanisms such as amnesia may appear, or an acute psychotic episode may develop. Hallucinatory states, depersonalization, and even well-developed paranoid or depressive states may be seen. As an example of the last possibility, a patient with mitral stenosis, whom we recently observed, developed an acute schizophrenic type of psychosis following cardiac catheterization.

More commonly, however, the major psychiatric complications occur following rather than before surgery. The surgical experience itself carries with it great somatopsychic impact,

* Hurwitt, Elliott, personal communication.

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involving as it does the physiological shock of a major thoracic operation and the serious disruption of homeostasis that results from prolonged anesthesia, direct tissue injury, hypothermia, and other procedures. Often there are unavoidable periods of cerebral hypoxia, which contribute to subsequent postoperative organic confusional states. Another source of shock is the threat to integrity of body-image which confronts the patient when he awakens in the recovery room. He finds himself attached to a variety of tubes, such as nasal oxygen, thoracic drains, intravenous infusions, and sometimes with tracheotomy and suction. With the return of consciousness, the patient once more reacts to his immediate situation in terms of his original aspirations. The emotional tone may vary all the way from elation that he has survived the operation and will be well again, to deep depression and despair at being alive and having to face the future. If the unconscious conflict has involved a reluctance to give up the illness and its secondary gains, successful operation will represent a danger, and emergency ego defenses may once more be required.

Of great importance in the long-range convalescence and surgical success are the postoperative depressive reactions. These are often disguised as physical symptoms, such as intractable pain, excessive weakness, and disturbances of appetite and sleep. Not uncommonly, the full psychopathological response is delayed until the patient's return home, where he is expected to behave as though he no longer has heart disease. This may involve the assumption of economic responsibilities; marriage, which had hitherto been deferred or avoided; and, similarly, pregnancy. It is in this period of adaptation to a new way of life that the frustrations of dependent drives are experienced most keenly and may become intolerable. The psychodynamic pattern seen in such instances is that of a separation reaction, that is, unconsciously the patient reacts as if he had lost an important ambivalent love object. This sequence of events underlies the delayed psychoses and suicides that have been reported after apparently successful surgical results.

The cardiac surgeon looks to other hospital services to deliver the patient to him in the optimal state of preparedness, and much progress has been made in refining the methods of selection of suitable candidates and in the preoperative physiological preparation. The effects of psychological unpreparedness are beginning to be understood and appreciated. Psychiatric evaluation is now being carried out in some centers as part of the selection of cases, and patients whose personality structures presage serious emotional difficulty are being rejected or the operation is postponed to allow for further psychological preparation. In this way, many so-called surgical failures can be avoided, and patients who cannot benefit from the operation may be spared needless suffering and risk. Better and more exact criteria and methods for preoperative selection and preparation are sorely needed, and this constitutes an urgent challenge for further serious study of these problems.

Comments on Psychological Issues Related to Essential Hypertension and Other Cardiovascular Disorders

As stated earlier, most of the interrelationships between mind and body that are encountered in cardiovascular disorders find apt illustration when the problems surrounding structural heart disease are examined in a comprehensive way. For the most part, the principles involved can be extrapolated as other cardiovascular disorders come up for consideration. There are, however, certain additional issues that arise in connection with diseases in which emotional stress may directly activate the pathophysiological mechanisms underlying the disease process. These can be best illustrated by proceeding to a consideration of the additions necessary to complete the picture of psychosomatic interrelationships as they are encountered in essential hypertension. In this instance the main additional fact that must be taken into account is this—in the cardiac patient, emotional stress is a factor which adds to the burden of the already diseased system, but it does not contribute to the basic lesion in any way. On the other hand, in the patient

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with hypertension, psychologic factors may also contribute to the disorder, since in this disease emotional stress may be discharged through the very same autonomic and endocrine mechanisms which are responsible for the diffuse arteriolar constriction and increased peripheral resistance which characterize its basic pathological physiology.[31, 40, 73, 76, 85, 118, 121, 130, 131, 132] Although the precise nature of these mechanisms is not fully understood, it has been repeatedly and convincingly demonstrated that they may be activated in conjunction with psychological conflict, and in this way stressful life situations may contribute to onset of the disease itself and may precipitate symptoms, complications, and acceleration.[1, 4, 5, 82, 87, 120, 121, 130, 131, 132] It should be emphasized that while linkage between emotional and pathophysiological phenomena of this order is more immediate than in the case of structural heart disease, it still does not constitute a pathogenic connection in the ultimate etiologic sense. In other words, available data indicate mainly that emotional stress may and does drive or activate what might be termed "available hypertensive mechanism(s)," regardless of the nature of the still-unknown factors that may in the first place be responsible for the existence of such mechanism(s) in some individuals.

While the literature is replete with observations which tend to implicate psychologic problems as contributors along with other factors in the genesis of the basic hypertensive mechanism(s), such a role has not been finally demonstrated. Reviews of this literature are available elsewhere.[6, 24, 85, 122, 130]

The important points to be extracted from it are the following:

Regardless of the ultimate etiology, there can be little doubt that emotionally charged life situations may play a major role in affecting the time of onset and the clinical course of the disease process once it has been established in susceptible individuals.

Study of the life situations associated with precipitation of the disease, or its aggravation, demonstrate that these situations have specific emotional meaning for the individual patient by virtue of their relation to previous life experiences and unresolved conflicts and are conflictual for the patient because of these connections.

Most investigators now agree that there is no specific "personality profile" associated with the disease. In general, the data from various authors are in agreement in respect to the observation that the psychologic problems encountered in patients with hypertension frequently stem from extremely early psychological trauma (predominantly pregenital). This observation is in no way unique for patients with hypertension but rather seems to characterize patients with all of the so-called "classical psychosomatic diseases."

Some authors, including Alexander, *et al.*,[6] Binger, *et al.*,[12] and Reiser, *et al.*,[85, 87, 117] place particular emphasis on strongly ambivalent conflict in dependency relationships with extreme difficulties in handling aggressive impulses in such object-relationships. Binger and Reiser emphasize that patients with hypertension are particularly fearful of the persons from whom they seek dependent gratification.

Reiser, Weiner, and Thaler[86, 117] have recently presented evidence that these patients tend to "insulate" themselves emotionally in interpersonal relationships, and they suggest that this type of defensive operation may be a reflection of an inborn vascular hyperreactivity rather than a direct pathogenic mechanism by virtue of its restraining effect on the expression of "hostility." These issues, however, should properly be relegated to the realm of theory and should not influence the clinician's appraisal of the individual psychodynamic problems in each individual patient.

One additional point which carries considerable clinical importance remains to be discussed. It has to do with the genesis of symptoms in the patient with essential hypertension. In this condition a unique kind of feedback cycle may be seen with some frequency, as illustrated in Fig. 2. Emotionally determined symptoms may arise in any of three ways, only one of which reflects activity of the basic disease process. However, symptoms occurring on the basis of purely psychologic mechanisms (for example, conversion) and

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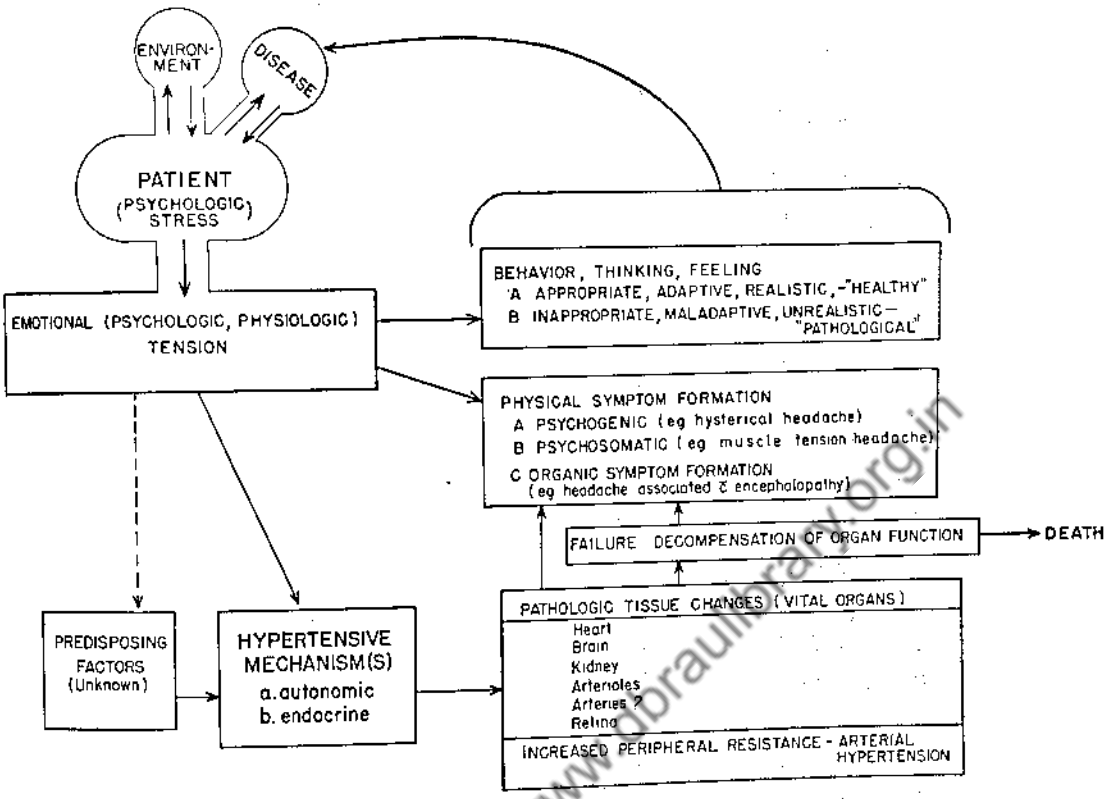

FIG. 2. *Feedback cycles in hypertension.*

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symptoms arising on the basis of purely psychosomatic mechanisms involving other body systems (for example, muscle-tension headache) may be regarded by the patient as evidence of progression or worsening of the basic hypertensive disorder. The anxiety evoked in the patient in response to symptoms so interpreted may then channel back through the basic hypertensive mechanism(s) and, indeed, lead to the very thing the patient originally feared, namely, elevation of pressure and an aggravation of the disease process itself. The implications of this phenomenon for management are obvious. Careful formulation of symptom mechanisms and direct reassurance in instances where symptoms are actually unrelated to the underlying hypertensive process may yield distinct therapeutic gains by interrupting this cycle which otherwise could lead to progression of the hypertensive process.

In summary, there are a number of ways in which psychologic issues may be intimately involved in essential hypertension. Emotionally charged situations, by virtue of their capacity to activate vascular mechanism(s) underlying diffuse arteriolar constriction, may contribute to onset of the disease, to the occurrence of symptoms arising from organic lesions of the disease, and even to acceleration of the hypertensive disorder. Symptoms may also arise on the basis of unrelated psychologic and psychosomatic mechanism(s), and anxiety in response to these symptoms, along with those related to the hypertensive process, may also activate the underlying pathophysiologic mechanism and lead to progression of the disease. Long-term psychologic problems of adjustment to the disease may include all of the mechanisms and consequences described for patients with structural heart disease. Personality disturbances antedating the onset of the disease are frequently found in patients with hypertension, and these can be related to severe difficulties that occurred very early in development; whether or not these are significant factors in the genesis of hypertension is still unknown.

Among the other cardiovascular diseases, there are several in which it appears likely that basic disordered vascular mechanism(s) may be triggered or activated by emotional factors. These include Raynaud's disease,[2,72] migraine,[28,35,134] various forms of syncope,[27,122] and neurocirculatory asthenia.[19,71,122] Ordinarily, the effects of emotional stress upon problems of coronary circulation have been best formulated in a similar fashion to the effects of psychologic tension in valvular heart disease, that is, through disturbances in the balance between demand (for coronary blood flow) and supply (that is, capacity of the coronary bed to deliver). There is, however, some interesting current work in progress[44,46,110] which may eventually implicate emotional factors as contributors in the pathogenesis of atherosclerosis, through elevation of serum cholesterol. Occurrence of cerebral vascular accidents and aggravation of various other peripheral vascular disorders are probably also best considered, on the basis of available evidence, in the same category with structural heart disease and coronary problems. While there has been much speculation in this regard concerning the role of arterial spasm, the actual role of such mechanisms in conjunction with clinical disorders has not been clearly demonstrated. However, there is at least one suggestive set of observations, namely, those of Seidenberg and Ecker.[101] Stasis and disturbances of clotting have been discussed as factors in cerebral, coronary, and peripheral vascular accidents. Some data suggest that clotting time may accelerate during periods of emotional tension, but their ultimate significance remains to be determined.[99]

¶ Role of the Psychiatrist and Treatment Implications

It should be clear from the foregoing that the psychodynamic and psychophysiologic problems that may be encountered are multiple and complex. It follows from this that treatment must be based upon careful and meticulous diagnostic evaluation and formulation of each patient's individual problems. The first and most critical task for the psychiatrist is that of formulating as clearly as possible the nature of the relationships and the sequential connections between the patient's psychological problems on the one hand and the clinical manifestations of the underlying cardiovascular disorder on the other. Careful and comprehensive psychiatric diagnosis (which includes clinical diagnosis, identification of current sources of conflict, underlying genetic conflicts, major ego-defense mechanisms, appraisal of ego-strength, and appraisal of environmental problems and supports) constitutes only a preliminary but indispensable step. Until these have been brought into perspective, vis-à-vis the cardiovascular problem it is not possible to formulate realistic treatment goals and techniques.

Determination of goals for therapy rests upon both psychological and medical issues and is the next step in planning therapy. The principles involved in this step and in carrying out treatment plans have been discussed in detail elsewhere,[62,81,91,106,122,132] and cannot be elaborated here. Clearly, psychotherapeutic considerations and activities are to be integrated into a sound medical-treatment regime and should be added to a program of standard medical measures rather than in any way replacing them. The psychiatrist's role may be mainly that of consultant and adviser to the internist or may develop into that of conducting intensive psychotherapy in close teamwork with the medical specialist. Psychotherapy may be indicated for specific short-term purposes such as preparing the patient for and supporting him through surgery, or it may be undertaken with more far-reaching goals, for example, with the aim of extensive analysis and reintegration of the personality. These issues will vary with the individual clinical problem and with the personnel and facilities available. This area is both challenging and important. Work in it requires the utmost skill, understanding, and effort on the part of the physician—sometimes with only meager therapeutic returns but frequently with major and satisfying gains for doctor and patient alike.

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CHAPTER 34

PSYCHOLOGY OF GASTROINTESTINAL DISORDERS

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DESIRES AND GRATIFICATIONS and the experiencing of pleasure and unpleasure during the first years of life are largely centered in the gastrointestinal tract. The infant relates to the world through sucking, mouthing, and biting, and first experiences emotional security in being nursed and emotional deprivation in being hungry. Feelings of trust and of being loved are initially experienced in being fed, hostility is first manifested in biting, and erotic excitation is experienced with the pleasurable sensations which accompany sucking. The site of tensions and gratifications gradually shifts to the other end of the alimentary canal and the feces, and the processes of their retention and expulsion become central in the experiencing of pleasure, mastery, and unpleasure. Feelings of autonomy, of accomplishment, of possessiveness, of shame and doubt, and of rebellion are experienced with the sensations which accompany the retention and expulsion of feces and with the process of attaining bowel control in compliance with parental demands. The gastrointestinal tract thus is fundamentally involved in the early molding and expression of individual behavior patterns, attitudes, feelings, and of the character of relationships with others.

The gastrointestinal system is a common site for the expression of a wide range of emotional disturbances. Behavioral problems of childhood often involve difficulties in feeding and bowel training. Characterological problems may be reflected in overindulgence, restriction, or idiosyncracies in eating, as well as in constipation or colonic overactivity. Vomiting,

excessive eructation, and globus can be hysterical. Delusional ideas may involve the stomach and bowel in schizophrenia and the depressive psychoses. Periodic intestinal pain is a symptom accompanying the psychoses of porphyria. Dysphagia, cardiospasm, dyspepsia, pylorospasm, and mucous and spastic colitis are physiologic dysfunctions that can be primarily psychologic. Peptic ulcer, regional ileitis, and ulcerative colitis are conditions involving tissue breakdown that are, at least in part, determined by emotional problems. Surgeons as well as psychiatrists have become interested in emotional factors in the symptoms of cholecystitis and pancreatitis. The list may be extended to the consideration of such dental problems as caries and bruxism, and to the relationship between hemorrhoids and chronic constipation. Disorders of appetite may be serious complications in other illnesses, as when obesity is present along with heart disease, diabetes, or hypertension, and when the patient with tuberculosis suffers from anorexia. Disturbances of function involving each unit of the gastrointestinal system, including disorders of appetite and eating, of swallowing, of digestion, and of elimination, may thus reflect psychological difficulties.

Emotional problems clearly require consideration in many of these complaints and may be of primary significance to the understanding and treatment of some. In psychotherapeutic work with patients with these disorders, the relationships between the psychological phenomenology of gastrointestinal functioning and the early phases of psychosexual development are frequently confirmed. During treatment the interplay between emotional disturbances and exacerbations of symptoms or physiologic dysfunction can often be documented in convincing detail, but, in many gastrointestinal disorders involving psychophysiologic dysfunction, relatively little of a definitive nature is known beyond the existence of such a relationship. Peptic ulcer and ulcerative colitis, however, are among the most carefully studied psychosomatic disorders, and the clarification of the psychological and physiological conditions necessary to their appearance is more advanced than in other gastrointestinal problems. They are among the most serious illnesses encountered by the physician, and the importance of psychological factors in their development and course has long been recognized. We shall therefore devote this discussion to the consideration of peptic ulcer and ulcerative colitis as illustrative of the psychosomatic approach to diseases of the gastrointestinal system.

¶ Peptic Ulcer

Correlations between the physiology of the stomach and the emotional life of the person were first demonstrated by Beaumont[6] in his observations of his patient, Alexis St. Martin, who was left with an opening from his stomach through the abdominal wall to the exterior as the result of a gunshot wound. Beaumont followed the course of digestion with different foods, under varying conditions of health, and with alternations in his patient's emotional reactions. More recent observations include those of Wolf and Wolff[79] on the gastric functions of a man with a gastric fistula. They correlated his feelings with his gastric secretions, motility, and vascularity, finding these functions depressed when he was sad or frightened, and increased when he felt angry, resentful, or anxious.

Mirsky, *et al.*[53, 54, 55] have sought to correlate pepsinogen levels in urine and blood with the emotional experiences of persons as reported and observed during psychoanalysis, psychotherapy, and by other means over relatively long periods of time. Pepsinogen excretion was found to be much higher in patients with peptic ulcers. It has been suggested that the level of blood pepsin is determined early in life, perhaps genetically, and tends to remain relatively constant. The pepsinogen level in urine, however, appears to fluctuate. Marked increases in excretion levels were observed, in persons both with and without ulcers, in response to particular life situations, such as reaching a decision to have a child, a patient's wife becoming pregnant, and the arousal of rivalrous feeling toward a sibling. Such experiences often failed to evoke any reactions of

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which he was aware in the person. Thus unconscious responses, largely concerning dependency problems, were accompanied by increased activity of the peptic cells of the gastric mucosa as measured by pepsinogen-excretion levels.

Margolin[51] undertook the psychoanalytic study of a twenty-two-year-old unmarried college girl with a gastrostomy created two years earlier following a suicide attempt with caustic lye. Independently of this psychotherapeutic work, physiological observation and experimentation were conducted regularly, including studies of gastric motility, vascularity, and secretion under varying conditions, with quantitative determinations of hydrochloric acid and pepsin concentration. Regularly recurring gross patterns of gastric functioning were observed and reported to be repetitively and predictably associated with specific unconscious constellations. An important aspect of this work was its demonstration of the effects on gastric functioning of the unconscious meaning to the patient of the experimental procedure, of the extent to which she became aware of these responses, and of the adequacy of the mechanisms of defense which she utilized in dealing with them. These responses included the erotization of the gastrostomy and experiencing the physiological experiments as an intolerable and frightening sexual violation. Crider and Walker[13] had worked with this patient earlier and had observed a decrease in gastric secretion with anger and resentment, in contrast to the report by Wolf and Wolff[79] of an increase in gastric secretion associated with these emotions in their male subject. Margolin's work suggested that the difference in response resulted from the different unconscious meaning of the experimental procedure to a woman.

The effects of emotions on gastric functioning have thus been grossly demonstrated by Beaumont, related to the arousal of specific emotions by Wolf and Wolff, and correlated with unconscious responses by Mirsky and by Margolin. There are difficult problems involved in the further clarification of these psychophysiological correlations. The observational and experimental procedures themselves affect gastric functioning. The study of experimental subjects with gastrostomies and gastric fistulas permits the direct observation of gastric functioning, but they constitute special subjects because their functioning is affected by these bodily alterations. Other problems include the temptation to oversimplify in the effort to unify extremely complex psychotherapeutic and physiological data; the complexity of physiological processes which hinders the identification, isolation, and measurement of single functions; and the difficulty of obtaining psychophysiological data of a sophisticated order on an adequate population.

Recent work promises a further elucidation of the neural pathways involved in peptic ulcer. French, Porter, Cavanaugh, and Longmire[28] have described the experimental production of gastroduodenal lesions in monkeys following the application of electrical stimulation to the low midline axis in the hypothalamus for periods of thirty to eighty-six days. All of the animals who had been chronically stimulated in this central hypothalamic region developed gastroduodenal lesions, including diffuse changes in the stomach, "ulcers" in the duodenum, and focal lesions in the pyloric antrum.

William Brinton[9] wrote of anxiety as a cause of peptic ulcer. Cushing[14] observed that all clinicians know that high-strung persons are particularly susceptible to peptic ulcer, that ulcers become symptomatically quiescent or heal when the patient is physically and mentally put to rest, and that symptoms tend to recur with the patient's return to his former activities and responsibilities. Alvarez,[5] Hartman,[35] Draper and Touraine,[22] and others have tried to describe the personality and character traits of the ulcer patient. The psychoanalytic studies of Alexander and his co-workers (Alexander,[1,2] Szasz *et al.*,[75] Szasz,[71] and Van der Heide[76]) have shifted the emphasis from the delineation of the personality type of the ulcer patient to the elucidation of a typical conflict situation which characteristically precedes the ulcer formation or recrudescence, even when the patients' overt personality characteristics are quite divergent. This represented a shift from the description of personality on an overt

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level to an emphasis upon dynamics, including the consideration of the unconscious determinants of behavior. They observed that the wish to remain in a dependent infantile situation, to be loved and cared for, was in conflict with the adult ego's pride and aspiration for independence, accomplishment, and self-sufficiency. In their overt behavior patients react to their unconscious dependence by being exaggeratedly self-sufficient and ambitious. The repressed wish for a dependent relationship is reinforced by the struggle involved in this overcompensatory behavior, constituting the unconscious psychological stimulus for those physiological processes which lead to ulcer formation. Other ulcer patients are overtly expressive of their oral desires, being outwardly dependent, demanding, and disgruntled. Their dependent tendencies are frustrated by external circumstances rather than by internal repudiation. It was postulated that the frustration of these oral-receptive longings would lead to a regression from the wish to be loved to the wish to be fed. The repressed longing to receive love and help mobilizes the innervations of the stomach, associated since birth with the process of receiving food. With this persistent stimulation, the stomach responds as if food were being taken in or about to be taken in, with a resultant chronic hypersecretion and hypermotility.

The work of Kapp, Rosenbaum, and Romano[38] has confirmed the importance of this dependency conflict and of the varying defensive personality façades which Alexander and his co-workers described. In addition to the hard-driving, exaggeratedly self-sufficient, and the overtly dependent, demanding groups of patients described by Alexander, they encountered a third group who reacted to their dependent desires by giving in to them partially. They were passive and shy, had had close relationships with mother figures, tended toward feminine identifications, and had strong unconscious homosexual trends.

Mahl[46, 47, 48, 49] has questioned the specificity of the dependency conflict in ulcer formation. His work indicates that hydrochloric acid secretion increases with anxiety regardless of its origin, whether it is associated with sexual, hostile, or passive-dependent wishes, ideation, or motives. This conclusion was derived from the experimental induction of "chronic fear" in dogs and monkeys with a resultant increase in hydrochloric acid secretion, as well as from a study of hydrochloric acid secretion during psychotherapy in two patients. Garma[29] and Pickford[60, 61] have conceptualized the peptic ulcer as "a self-inflicted digestive bite"; their findings are also in disagreement with those of Alexander.

The nature of the relationship between mother and child may be influenced by factors related to the child having a constitutionally high pepsin secretion. Its effects upon feeding patterns, the maternal response, and the character of the interaction with the mother forms an important area for study in the elucidation of specificity in peptic ulcer.

Our present knowledge of physiological and psychological correlations permits only a tentative statement regarding the conditions necessary to the occurrence of peptic ulcer. However, the use of such hypotheses has enabled Weiner, Thaler, Reiser, and Mirsky[77] to predict the appearance of peptic ulcer. They postulated that an ulcer should develop in an individual under the following conditions: (1) a sustained rate of gastric hypersecretion, as indicated by serum pepsinogen concentration; (2) the presence of a conflict related to the persistence of strong infantile wishes to be loved and cared for, and the repudiation of these wishes by the adult ego or the external world, as inferred from projective and psychological techniques; and (3) exposure to an environmental situation which mobilizes conflict and induces psychic tension. After determining serum pepsinogen for each of 2,073 army inductees, 63 with values in the upper 15 per cent and 57 with values in the lower 9 per cent were given psychological tests and a complete upper gastrointestinal roentgenological examination. They were then sent to basic training which constituted the potentially noxious environmental situation in this study. Of these subjects, 107 were re-examined in the last weeks of basic training. From the psychological tests alone, 10 men were selected as most likely to develop an ulcer. The predictions

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proved accurate for 7, and 2 of the remaining 3 subjects were found to be hypersecretors. Of the entire experimental group, 9 men had a proved ulcer before the end of basic training, 8 were in the upper 5 per cent of the serum pepsinogen distribution, and the remaining man was in the upper 15 per cent. Their presence among the hypersecretors was correctly predicted from the psychological tests. Although neither a high rate of gastric secretion nor a specific psychodynamic constellation could be regarded as responsible for the development of peptic ulcer, the authors felt that their study indicated that these two parameters constitute the essential determinants in the precipitation of peptic ulcer on exposure to social situations noxious to the specific individual. Similarly, Pilot *et al.*,[62] in a study of the development of peptic ulcer in one of two identical twins, both of whom had high blood pepsin levels, related it to the exposure of the one twin to the acute and chronic stresses associated with the deterioration of his marriage. However, the hypothesis that peptic ulcer occurs only in the group of hypersecretors requires further study. Current research should clarify whether serum pepsinogen levels are congenitally determined and relatively constant, or whether they rise appreciably when the person is in circumstances likely to be stressful to him. In the important study by Weiner *et al.*, the determination of the hyper- and hyposecretor groups was made at the time of army induction—a period of separation and anxiety—and this factor may have led to their selecting as hypersecretors those who react in this way specifically to separation.

It has been observed that, among ulcer patients, women often appear emotionally sicker than men (Kezur *et al.*[40]). It seems unlikely that this is due to some difference in physiologic reactivity between men and women, for, prior to 1900, peptic ulcer was reported more frequently in women. There has since occurred a progressive rise in the male incidence of ulcers, a ratio of 12 to 1 having been reported by Mittelmann and Wolff[56] between 1931 and 1939. The over-all incidence of peptic ulcer has remained roughly the same during the period of this change in sex ratio. It has been suggested that changes in the social roles of men and women may have influenced this shift.

The internist, in his medical management of the ulcer patient, and the surgeon, in his treatment of patients in whom complications have occurred where medical management has failed, are becoming increasingly cognizant of the importance of social and psychological problems in this illness. Their approach to the ulcer patient is enriched by this awareness, and psychotherapeutic considerations contribute to the planning of treatment. Information about the patient's family and work, gathered by physician or social worker, can help clarify the role of social and interpersonal aggravations and can help the physician to provide the emotional support needed by the patient by modifying his environment. The group of chronic alcoholic, occupationally unstable, and delinquent ulcer patients are largely seen in community hospitals and in public outpatient medical facilities. The provision there of a continuing relationship with a physician or social worker may supply sufficient gratification of their wish to be taken care of to diminish maladaptive and self-destructive responses to the frustration of their dependency needs.

The psychiatrist may act as a consultant, contributing to the psychological and social assessment of the patient, and making recommendations for his management and the modification of his environment. The psychiatrist may also be called upon to conduct psychotherapy with the patient. Although patients with psychosomatic illness often have profound ego defects and are frequently diagnostically related to the borderline or psychotic groups, this characterization is not as applicable to ulcer patients. They are often responsible people, relatively stable emotionally, in whom the potentiality for psychotic behavior is not a prominent problem. However, psychoses have occurred in the course of their treatment, sometimes after vagotomy.

The psychiatrist does not usually assume responsibility for the management of the ulcer regimen and must, of course, be able to work closely with the physicians who do. Psychotherapy cannot take precedence over certain medical and surgical procedures essential to the

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patient's well-being. Thus, for example, surgical intervention for otherwise uncontrollable hemorrhage, perforation, or pyloric stenosis must be accepted as necessary. The psychiatrist then directs his attention to helping prepare the patient for surgery and for its possible consequences.

Psychotherapy with ulcer patients is concerned with the resolution of emotional conflicts and the repetitive maladaptive patterns of living and reacting that lead into anxiety-provoking situations, with the expectation that the physiologic functioning of the stomach will then become more harmonious and adaptive to the digestive processes. In thus working with the broad range of life problems which confront the person, rather than limiting the therapy to difficulties directly related to his having an ulcer, psychotherapeutic procedure with these patients does not differ specifically from any other psychotherapy. However, the knowledge that certain basic personality patterns are often encountered in ulcer patients, and that certain rather specific situations frequently precipitate exacerbations of symptoms, may be helpful to the therapist. Attention often focuses upon the intense dependency needs of the patient and his reactive strivings for self-sufficiency to ward off the intense anxiety experienced when he is bereft of a protecting, "feeding" figure. Collapse or the threat of collapse of the defensive pattern may provoke even more intense strivings, accompanied by digestive difficulties. Such efforts may be displaced, as when a businessman seeks to offset insecurities in his dependency on his wife by trying to increase his sales. Resentment and anger as well as dependency problems require attention, for ulcer patients are prone to feel unappreciated and to hide the resentment they experience when demands to assume responsibilities are made of them. Awareness of situations frequently critical in the ulcer patient's life, including the increased responsibilities of marriage, the responsibilities and feared deprivations associated with the birth of a child, and the need to have a secure work position, can sharpen the therapeutic interaction. For example, the ulcer patient often marries an older, "motherly" woman, and becomes anxious and resentful when he finds that she expects him to assume responsibilities, or when the birth of a child both adds to his financial burdens and produces a rival for his wife's attention. In his work the patient may be unable to make demands upon others, but he may then resent others using his compulsive need to avoid insecurity, or he may become silently hostile when his work does not seem to gain him attention and praise. When he considers leaving his job, he becomes anxious because his security is threatened, and an exacerbation of symptoms may ensue.

It is important to help the patient recognize the potential chronicity of his illness and to be prepared for recurrences during stressful periods in therapy and in living. Helping the patient to work on his emotional and life problems rather than focusing primarily upon his ulcer may present a difficult technical problem. A sounder therapeutic relationship is established when the patient is prepared for a reappearance of symptoms and can begin to use them as a means of alerting himself to his emotional conflicts rather than simply becoming discouraged by them. In delineating those situations which are particularly stressful for the patient, he must be helped to recognize their unconscious meanings to him, and to distinguish these from reality. At times, it is necessary to help him avoid certain situations, recognizing with him that he is just not able to handle them emotionally. At other times, when the illness occurs as part of a flight from responsibility, it is necessary to help the patient work out ways of facing and meeting the demands made upon him.

¶ Ulcerative Colitis

Ulcerative colitis remains one of the most difficult and challenging problems in medicine. The nature of the somatic process is not well understood, and although there is a widespread consensus that psychological processes are important in this illness, their delineation remains incomplete.

Nurses, internists, surgeons, and others who have worked with ulcerative colitis patients

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have been impressed with their infantile character, frequent petulance, jealousy of other patients, and extraordinary demandingness. There is considerable agreement among psychiatrists who have had the opportunity to study these patients intensively concerning their psychological characteristics. The relationship between the anal period of psychosexual development and the character traits, the behavioral modes, and the major conflicts which characterize ulcerative colitis patients has been repeatedly demonstrated, but their dependency and the importance of incorporative modes of behavior associated with orality have also been emphasized.

Murray[58] commented upon the infantile character and the emotional immaturity of ulcerative colitis patients, emphasizing the intensity of their ties with their mothers, and conceptualizing diarrhea in the illness as an infantile response to fear. Alexander[1] has regarded the illness as a regression to the anal phase of psychosexual development, occurring in response to a life situation which the patient experiences as requiring the fulfillment of an obligation, or an accomplishment from him, for which he feels unprepared. However, Szasz[72] and Mary Cushing,[15] although acknowledging the association of the character structure of these patients with the anal period of development, have emphasized the orality of the disease. Szasz refers to the prominence of the gastrocolic reflex in ulcerative colitis patients and, on the basis of psychoanalytic studies, regards colonic and rectal hypo- and hyperactivity as most accurately correlated with changes in the patient's unconscious oral intaking tensions. Cushing refers to the way in which the importance of orality in the illness is frequently suggested by the patient himself in attributing the illness to some food or combination of foods. She reports the analysis of an ulcerative colitis patient whose "problem was to secure enough food, or prestige, or success, or whatever was necessary to at least put off the day when he could no longer meet the demands, when he could only fail and die."

The symbiotic character of the relationship between the patient and one parent, usually the mother, and the intense ambivalence felt by the patient toward that parent, has been observed repeatedly. The mothers of ulcerative colitis patients are frequently borderline or psychotic. Characteristically, they convey to the child the feeling that they will take care of him in every way, that they will always assume all responsibilities for him, and that they will always be able to direct him. Sperling[67] has stressed the contradictory attitude of the mother, unconsciously seeking the maintenance of a lifelong dependence on her for the gratification of her own needs, and, at the same time, having strong unconscious destructive impulses toward the child. She regards ulcerative colitis as a somatic expression of an unconscious rage reaction occurring in response to the frustration accompanying the loss of the mother or a change in the relationship with her. Lindemann[41] has also emphasized the loss of a person important to the patient in ulcerative colitis, and has commented on the depression evident in these patients. Daniels[16, 19] noted the frequent presence of a fixation upon the mother among ulcerative colitis patients, and has described the crises which frequently precipitate colitis attacks as occurring when the patient cannot cope with forward steps in the process of emotional maturation, including engagement, marriage, and childbearing.

In the clinical course of ulcerative colitis, the alternation between active colitis and the appearance of other symptoms or illnesses has been commented upon frequently. Although some degree of depression is usually evident during active colitis, Grace *et al.*[33] have described the appearance of a psychotic depression as heralding the end of the colitis attack. However, the development of a paranoid psychosis in ulcerative colitis patients has been observed more frequently.[1, 19, 41, 42, 67] Engel[27] describes headache as the most common alternative symptom experienced by colitis patients. He observed fifty-six headache periods during the therapy of nine patients. Headaches occurred when the patients felt conscious or unconscious guilt after having taken an active stand, made a decision, thought something through, or felt themselves to be in control. In these instances the patients did not feel helpless or afraid, and others often commented on their

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unusual assertiveness which presented a striking contrast with their passive, helpless attitudes prior to their colitis attacks. The occurrence of a headache during an episode of colitis was often found to mark the end of the attack. Engel's work is particularly important in its correlation of different affective states, or configurations of attitudes, in the same patient with different somatic responses, the feeling of helplessness being associated with ulcerative colitis.

The psychophysiological mechanisms involved in the development of ulcerative colitis remain unclarified. Sullivan[69, 70] emphasized the effects of the liquid contents of the small intestine being carried down into the colon as a consequence of an emotionally induced hypermotility of the bowel. He postulated that the enzymes in this liquid may be of a higher digestive power than the normal, or that the natural protective powers of the colonic mucosa may be lowered, leading to a digestion of the mucosal surface of the colon, thus facilitating bacterial invasion and acute ulceration. Portis[63] has emphasized the damaging action of the enzyme lysozyme upon the colonic mucosa by depriving it of its protective mucin. Hiatt *et al.*,[36] however, consider the high concentration of lysozyme in the stools of ulcerative colitis patients to be a result of the inflammatory response rather than its cause, the invading granulocytes being the primary source of the increased lysozyme in the stools. Lium[43, 44, 45] and Groen[34] regard the prolonged spasm of the muscles of the colon, resulting from chronic anxiety, as responsible for ischemia of the colonic mucosa and the appearance of necrosis of the epithelium from which bleeding occurs on the relaxation of these muscles. Grace, Wolf, and Wolff[28] emphasize the association of sustained hyperfunction of the colon in its vascularity, motility, and secretion, resulting in increased fragility of the colonic mucosa with submucosal bleeding and ulceration. They view ulcerative colitis as part of a pattern of ejection unconsciously elaborated by the patient in response to overwhelming environmental demands, with the choice of the colon as the site for the expression of this response pattern constitutionally determined. Sperling[67, 68] views ulcerative colitis as an illness in which conversion mechanisms are operative, its symptoms representing the struggle against the incorporation of the frustrating maternal object and the effort to destroy and eliminate her. Engel[24, 26] and others, however, have questioned the possibility that conversion mechanisms can involve such functional divisions as the mucosal surface of the colon. Although the psychological phenomenology of the illness may include the conflicts described by Sperling, which have been confirmed by others, the illness is perhaps better described as a physiological expression of emotions rather than a conversion phenomenon. Engel believes that the tissue process in ulcerative colitis is nonspecific, associated with a separation reaction but having no primary psychological meaning. When separation is not or cannot be dealt with by psychological mechanisms, physiological changes are initiated in the body which interfere with other adaptive or integrative processes, permitting various types of tissue breakdown, local tissue-growth disturbances, and bacterial and viral invasion. Biological and psychological developmental factors will contribute to the determination of the bowel as the site of the tissue breakdown.

The psychiatrist must recognize the difficult problems involved in the medical management of ulcerative colitis. Although psychotherapeutic intervention may be effective in halting even a fulminating attack, the life-threatening nature and quixotic behavior of this disease requires that the patient be supervised by physicians familiar with its intricacies. A decision to stop all feeding by mouth, to use steroids, to put the bowel to rest via ileostomy, or that the time has come for a colectomy, must reside in experienced hands. However, colectomy is generally considered indicated when the bowel has been transformed by the disease process into a tube with no mucosal surface or with the occurrence of polyposis. Surgical intervention of this order requires careful discussion with the patient in preparation for its consequences, particularly explaining the necessity for and the problems attending a stoma. In psychotherapeutic work with the

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ulcerative colitis patient, an alertness to his experiencing feelings of loss and helplessness is particularly important. Such feelings may be evoked by an actual object loss, by an imagined or real slight or neglect from a person important to him, or by an event or even a comment understood as requiring that he take more responsibility or that he make a decision. The patient tends to respond well when he has the feeling that someone is in firm, understanding control, and to respond with an exacerbation of symptoms when strong support of this kind is not available or is threatened. The therapist most likely to work effectively with these patients when they are acutely sick is often characterized as willing to "take over," to take the patient and his situation firmly in hand, in contrast to the therapist who avoids directing the patient, or who limits himself to offering suggestions rather than providing firm control. Clearly, work with such a patient is extraordinarily demanding of the physician, requiring that he permit or even encourage an unusual degree of dependency, and that he devote himself to freeing the patient from responsibilities and from any need to make decisions. In addition, other psychotherapeutic measures of an unusual character are often required in the effort to ward off a colitis attack, or during an acute exacerbation.

In the initial phases of treatment it is often expedient to let the patient blame other people for his problems and difficulties, because the intensity of the patient's guilt feelings may otherwise provoke the use of psychotic mechanisms. In undertaking work with the acutely ill ulcerative colitis patient, the physician should be prepared to continue with him through periods of severe depression, of psychosis, and of crippling symptom exacerbations. The offering of extreme support of this kind, in combination with the effort to help the patient abreact feelings associated with their characteristic mourning reaction, is often required in the acute phases of the illness. The recognition of the necessity for these patients to work through their extraordinarily infantile dependency needs led Margolin[52] to attempt "anaclitic therapy" with them. This consisted in fostering their infantilization and then, in the course of treatment, trying to help them achieve a more mature reorganization. Others have stressed, however, that such measures can create more difficulties rather than lead to an improvement in the level of personality organization.

When the illness is relatively quiescent, a more conventional approach in psychotherapy is possible, and the treatment modifications useful in trying to bring an attack to an end, or to avoid an exacerbation of the illness, are not required. The goal of therapy may then be to help the patient make adjustments in his life situation which will enable him to keep his illness under reasonable control. The patient's dependency problems, his indecisiveness, his ambivalent feelings toward the mother, and his crumbling in the face of responsibility are areas of particular importance in this phase of treatment. Sperling[68] reports that her experience with ulcerative colitis patients does not support the contention that psychoanalytic treatment involves the risk of precipitating a psychotic break. She has found it possible to analyze their defenses without undue fear that they will be overwhelmed by the impulses against which these defenses were erected. The use of adrenocorticotrophic hormone has facilitated efforts at intensive psychotherapeutic work by permitting the control of acute toxic exacerbations, and the ataraxics have contributed to the patients' ability to handle anxiety better, often tiding them over crises which would otherwise disrupt treatment.

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CHAPTER 35

PSYCHOPHYSIOLOGIC ASPECTS OF RESPIRATORY DISORDERS

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RESPIRATION is the only essential bodily activity under both voluntary and involuntary control. Its initiation at birth marks not the beginning of life but the beginning of the infant's independent life apart from the aquatic confines of the mother's uterus; it is the only instinctual process for which the infant does not require help from another person. The primary physiologic functions of respiration are the exchange of atmospheric oxygen for surplus carbon dioxide in the venous blood of the pulmonary capillaries and participation in the vernier adjustment of acid-base balance. Like the skin, their predecessor phylogenetically as a respiratory organ, the lungs constitute barriers which regulate with exquisite sensitivity a continuous sequence of transactions between the individual and his environment, and in all their activities they are associated intimately with a wide spectrum of emotional responses. Laughing, crying, sighing, pain, anger, fear, and sexual excitement have respiratory and emotional components which are inseparable. Talking, with its variations in pitch, inflection, and volume, may be an important respiratory expression of feeling states. Finally, contemplation of physical activity, particularly in the presence of real or imagined danger, is known to be associated with increased respiratory activity in anticipation of increased metabolic needs.

The respiratory system has three closely integrated components, (1) a distributing system which extends from the mouth and nares to the bronchioles, (2) a musculoskeletal system protecting and operating the respiratory bellows, and (3) an extensive equilibrating system extending from the bronchioles to the alveoli where perfusion with venous blood and diffusion of gases takes place.[27] The primary control of respiration is divided between an inspiratory center in the ventral reticular formation and an expiratory center in the dorsal reticular matter. The former appears to be

the dominant center.[72] A basic postural tone of the respiratory musculoskeletal apparatus and inherent rhythmicity of respiration may originate in the respiratory centers[48] or may be partially subservient to a "pneumotaxic center" in the pons.[73] The latter probably receives afferent stimuli from the hypothalamus and the inspiratory center and contributes, together with impulses initiated by inflation of the lungs and mediated through the vagi (Hering-Breuer reflex) to the regulation of the inspiratory and expiratory phases of respiration. In addition to the stretching of the lungs during inspiration and the discharge of stimuli along the afferent pathways of the vagi, the respiratory center is directly responsive to metabolic demands mediated through changes in carbon dioxide tension and hydrogen-ion concentration, and indirectly responsive to changes in oxygen tension mediated through chemoreceptors in the carotid bodies and the arch of the aorta. Primary anatomic changes in the thoracic cage and in the lung parenchyma with consequent limitations to adequate diffusion of gases or perfusion of blood are reflected in alterations in carbon dioxide tension, hydrogen-ion concentration, or oxygen tension.

From the viewpoint of the present chapter, there seems ample evidence to indicate that the respiratory centers may also be readily influenced by stimuli from cortical and subcortical centers. The precise relationships have not been established clearly, but there is good evidence that medial and ventral cortical structures, perhaps via septal and hypothalamic areas, represent one possible pathway.[58] Changes in bronchiolar regulation of the gas distributing system and in the cardiac and vascular regulation of the perfusing system also may have their origins in the central nervous system as physiologic concomitants of emotion.[11, 13]

In addition to anatomic, physiologic, and behavioral links between emotional responses and respiratory activity, there are phylogenetic considerations which further suggest these intimate associations. On the basis of a clinical study of 100 patients, Harper[42, 43] has postulated the existence of a relatively "primitive" type of nervous system characterized by the coexistence of emotional lability, or "functional" nervous illness, allergic tendencies, and evidence of atavism in the form of pigmented nevi or supernumerary nipples. Support for this association is found in the observation that amphibians use both their skins and lungs for respiration, that coordination of the two is mediated through the nervous system, and that histologically the pigmented mole is a vestigial sensory organ, having a common phylogenetic origin with the cutaneous tactile organs of amphibians. Finally, the vagus nerves which conduct impulses resulting in bronchiolar constriction are embryologically composite nerves representing components to several of the branchial arches in aquatic vertebrates.

Clausen[13] has reviewed the numerous studies of respiratory patterns in relation to emotional states, mental disease, and levels of consciousness, and concludes that, with one or two exceptions, specific correlations are poor. The exceptions include demonstration of the rapid inspiration accompanying surprise and the rapid, shallow respiration accompanying pleasure, and Christie's[12] and Finesinger's[28] demonstration of the sighing, irregular respirations which frequently accompany anxiety and which may be interpreted by the patient as breathlessness.

¶ Breath-Holding Attacks

This common condition probably is more alarming than dangerous, but it warrants correct diagnosis and effective understanding at an early stage in order that potentially more serious behavior problems and possible damage from recurrent cerebral anoxia[77] may be prevented. Breath-holding attacks are characteristically a disorder of childhood, usually starting during the first two years of life and occasionally in the first few weeks of life before conscious mechanisms have developed. They customarily disappear spontaneously with the cessation of violent crying between the ages of four and six. However, accounts of voluntary death by breath-holding in adults have been reported.[17] The attacks are more fre-

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quently seen in tense, energetic, hyperkinetic children than in placid, hypotonic children. Both sexes are affected equally, and attacks are apparently rare among Negro children and more frequent among mentally retarded children.

The onset of each attack is usually associated with a physically or psychologically traumatic or frustrating event, often of minor character, to which the child reacts with disproportionate rage and violent crying. The latter, in turn, terminates abruptly in expiratory apnea. The position assumed is of interest, since it is the opposite of the inspiratory apnea and controlled expiration employed by the underwater swimmer and the patient with bronchial asthma. The apnea is followed by deep cyanosis, frequently by unconsciousness. Recovery from the attack is spontaneous.

Useful differentiating features in breath-holding attacks include the ready identification of the precipitating experience, the occurrence of crying and cyanosis before any convulsion, the limitation of the latter to the tonic phase, the presence of opisthotonos, and the finding of a normal electroencephalogram. According to Bridge, Livingston, and Tietze,[10] the incidence of epilepsy associated with this syndrome is no greater than in the general population. Other conditions to be differentiated from breath-holding attacks are laryngeal stridor, laryngospasm associated with tetany, and pertussis. In Kanner's series,[54] severe breath holding had developed in 10 per cent of patients following apneic experiences related to whooping cough.

The breath-holding attacks may be only one of several indications that the parent-child relationship is seriously disturbed. In Kanner's [51] experience the parents often are found to be overprotective, and the children are found to be resisting tense, rigid feeding schedules or premature toilet training. Hinman and Dickey[47] have reviewed the problem in detail and conclude that breath-holding spells are the concomitant of rage which is so overwhelming that self-control is lost and that basically they may be regarded as a reaction to feelings of deprivation and inadequacy.

Anticonvulsant therapy is of no avail for the treatment of breath-holding attacks and may be harmful. Careful psychological evaluation of the patient in relation to his family is important, particularly with regard to the manner in which anger and frustration are understood and handled by the parents in an attempt to prevent future behavioral disturbances such as temper tantrums. Clarification of the underlying sources of parent-child conflict, and therapy directed toward improving the parents' own emotional adjustments is usually essential.

¶ The Hyperventilation Syndrome

The hyperventilation syndrome is a common condition which has been diagnosed in as many as 10 per cent of a series of 1,000 consecutive ambulant patients.[78] Although primarily a pulmonary expression of emotional conflict, respiratory distress is rarely the chief complaint. In Ames's[2] carefully studied series of 40 patients, 15 denied any respiratory difficulties, 24 had some respiratory difficulty, and only 1 patient indicated this as the main problem. About half the patients present only what they believe to be cardiovascular symptoms,[2,61] and about 20 per cent have cerebral symptoms including "fainting," "black-outs," "feelings of unreality," and loss of inhibition. Some patients have musculoskeletal and peripheral neurological symptoms, and a few have gastrointestinal complaints. They usually have hysterical character structures,[21,31] and fear or anger are apt to be the dominant emotions precipitating the hyperventilation attack. The sources of conflict may be acute and transient, but more often they are deep-seated, chronic, and require prolonged psychotherapy.

Family physicians, internists, and neurologists are most apt to see these patients first; a careful historical review of the circumstances preceding and accompanying the attack and an evaluation of the patient's character structure together with a diagnostic trial of hyperventilation by the patient usually clarify the diagnosis. It is important, however, to realize that hyperventilation may be of two types, (1) deep, fairly rapid breathing with the mouth open—the commonest form—and (2) very fast shallow breathing, or panting.

The physiologic changes which accompany

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hyperventilation explain adequately most of the signs and symptoms. Following a few seconds of overbreathing, the alveolar carbon dioxide tension falls, and the resulting alkalosis produces cerebral vasoconstriction, electroencephalographic changes, and a mean decrease in cerebral blood flow of 33 per cent during active hyperventilation.[56] The peripheral vasoconstriction which is responsible for the characteristic findings of sweating, pallor, and cold extremities is probably mediated through sympathetic pathways, although the afferent path of the reflex is not known.[2] Varying degrees of tetany are observed in response to the diminution in ionized calcium secondary to the alkalosis. There is impairment in the process of nerve "accommodation," and spontaneous impulses arising in the ischemic cerebral cortex traverse sensory and motor nerves to produce characteristic paresthesias and, in the presence of associated neuromuscular irritability, tetany.[60] Peripheral vasoconstriction may also contribute to these phenomena. Precordial pain and diaphragmatic spasm often accompany the increased respiratory effort and are thought to be primarily musculoskeletal phenomena, but the former may also be associated with aerophagy and distention of the stomach. Electrocardiographic changes, which include lowering of S-T segments, inversion of T waves, and premature contractions, may accompany hyperventilation in response to constriction of coronary arteries, changes in the position of the heart, or tachycardia. Finally, the cerebral vasoconstriction of chronic hyperventilation when associated with loss of inhibition may account for certain behavioral changes, in addition to the underlying anxiety which is the dominant factor in initiating the whole process and its subsequent vicious cycle.[2, 61]

Treatment of this condition is best initiated by explaining to the patient the physiologic mechanism of his symptoms, by demonstrating their origin during voluntary hyperventilation, by having the patient rebreathe carbon dioxide from a paper bag held over the mouth and nose, and by the use of relaxation and breathing exercises under the direction of a physiotherapist. Much relief is usually afforded patients by these maneuvers and demonstrations, and the physician is then able to direct his major attention to uncovering the sources of the underlying anxiety.

¶ Respiratory Allergy

Bronchial asthma and vasomotor rhinitis usually have been regarded as psychosomatic disorders in the psychiatric literature, often without critical evaluation of *all* the data relating to the influences of various factors or to the physiologic mechanism through which emotional responses participate. The present brief account of these conditions is an attempt to understand the psychological problems in terms of the other elements which participate in the whole disease process.

The Allergic Diathesis

Allergy, or "altered force," is a term introduced by von Pirquet[96] to describe an acquired, specific, altered capacity of the tissues to react which is characteristic of a wide spectrum of disease processes in which interaction between antigens and antibodies is believed to be an important, but not an unequivocally essential, feature. Most of the interest of the allergist and the immunologist has been focused on this important mechanism.[36, 40] Another point of view is that of the pathologist who describes the final local tissue changes responsible for the patient's symptoms. These consist of several of the following phenomena: dilatation of small blood vessels, increased capillary permeability, edema, a cellular response dominated by lymphocytes and eosinophils, contraction of smooth muscles, hyalin degeneration, and secretion of mucus. Finally, there is the viewpoint of the physiologist who is concerned with the pathogenesis of the process and those factors which permit, facilitate, perpetuate, or inhibit the tissue responses. Interest in this area has centered on the roles of acetylcholine, histamine, 5-hydroxytryptamine, and adrenocortical steroids.[3, 14, 33, 34, 46, 82]

If local cellular injury is regarded as the primary anatomic lesion in the allergic diseases, it is quite compatible with available data to view the process as initiated either by

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antigen-antibody reactions which trigger a protease activating system and the release of acetylcholine and histamine, or by stimuli arising in the cerebral cortex and hypothalamic nuclei which trigger the release of acetylcholine, histamine, and 5-hydroxytryptamine. Both mechanisms may operate simultaneously, and both may be modified by the conditioning influences of the adrenocortical hormones.[3,95]

Current concepts of the allergic diathesis and allergic phenomena do not as yet provide adequate explanations for all the problems concerned with localization and the variability of symptoms, the specificity of selected antigens, and the initiation and perpetuation of the whole process. Present evidence is quite compatible, however, with the view that there are "allergic" disorders in which the prime stimulus is an isolated local antigen-antibody interaction, and that there are other "allergic" disorders in which the prime stimulus is experienced in the cerebral cortex. It is also compatible with the view that summation and facilitation may occur when these and other mechanisms are involved concurrently.

Heredity

The role of heredity in allergic disorders has not been clearly established; there is divergent evidence for its role and divergent interpretation of the data.[9] Schwartz[87] concludes that bronchial asthma, vasomotor rhinitis, and infantile eczema are probably related genetically and are different in this regard from other so-called allergic disorders. He concludes that asthma is probably inherited as a Mendelian dominant with failing manifestation, so that only 40 per cent of those who carry the genes ever develop symptoms. Ratner and Silberman[75] conclude from a review of Schwartz's[87] and other studies, as well as from data of their own, that the available evidence does not establish conclusively the theory that the capacity to become sensitized is controlled by genetic factors "within the scope of the antigen-antibody mechanisms." They emphasize, also, that the data do not support the hypothesis that a gene *does not* play *any* role in the production of the allergic state. From the data of Schwartz, they conclude that "what may be inherited is not the capacity to become sensitized, but a respiratory tract which may react with the production of asthma and rhinitis due to a multiplicity of stimuli."

Analysis of the detailed family histories of a small series of ten patients studied by the present authors lends support to the tentative hypothesis that a susceptible respiratory tract and a susceptible neurohumoral substrate may be the genetically determined elements rather than an "allergic" predisposition per se. In our series only unequivocal diagnoses in parents, aunts, uncles, and grandparents were included; the illnesses of the siblings were not included. It was found that strictly allergic disorders in the families of the patients were relatively infrequent in contrast to the frequent occurrences of definite, nonallergic, "psychosomatic" illnesses, that is, peptic ulcer, hypertension, rheumatoid arthritis, and thyrotoxicosis. In addition, the high incidence of fatal pulmonary disease, excluding bronchial asthma, suggested that the respiratory tract, as well as the autonomic nervous system, and neurohumoral regulatory mechanism, may be important areas in which to look for further genetic influences. Any adequate genetic study of bronchial asthma probably should not confine itself to the sole observation of "allergic" tendencies.

Bronchial Asthma

It long has been recognized that emotional factors may play an important and frequently a dominant role in the onset and course of bronchial asthma, but the precise means by which these influences are related to cellular and molecular events is not understood as yet. The present discussion is based on a review of the literature, particularly the discussions of French and Alexander,[32] Saul,[85,86] and Dekker and Groen[15,16] and intensive medical and psychiatric observations by the authors and their colleagues on 10 patients with severe bronchial asthma.[98]

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Psychological Factors

Given an inherited substrate of uncertain composition but which may consist of a *locus minoris resistentiae* in the respiratory system and given relatively labile autonomic and endocrine regulatory mechanisms, it is a matter of importance, from the point of view of prevention and treatment, to understand what, if any, nuclear emotional conflicts and associated behavioral and personality patterns are associated with bronchial asthma. The precise role of psychological factors in the etiology of asthma is still an object of study. There is compelling evidence that at least some of the observed emotional conflicts and personality patterns are a response to the presence of a chronic disease, since a carefully matched series of asthmatic and cardiac children did not show significant personality differences on psychological testing.[71]

French and Alexander[32] commented on the disturbed mother-child relationships experienced by asthmatics and on the tendency of the fathers to be passive-dependent persons. Attitudes and feelings toward their parents were discussed with our patients, and the available parents were interviewed. All 10 patients expressed marked feelings of ambivalence toward their mothers; their overt and covert hostility toward their mothers appeared related to the fact that they had been, or at least felt that they had been, deprived of maternal love as children. Four of the mothers had died, and 3 patients had had marked exacerbations of their asthma which temporally and psychologically were related to the bereavement. Nine of the mothers were characterized by the patients as rigid, insecure, and domineering and were described as frequently hostile toward their children. The tenth mother had such a large family that the patient, as the oldest daughter, found herself assuming the role of a second mother for her siblings. Six mothers were described as overprotective in what may have been reaction-formations against their own rejecting impulses or hostile feelings toward their children. Seven mothers apparently showed anxiety and hostility in response to their children's asthma by excessive restrictions, exhortations to "stop wheezing," or by leaving their care to siblings, fathers, maids, etc. Seven of the fathers were apparently meek, passive, dependent, and ineffectual in their homes; the remaining three fathers had died while the patients were young and before asthma had developed. Four of the fathers, either because of their wives' deficiencies or their own needs, assumed the maternal roles, dispensing medicines, nursing the patients at night, and making decisions usually reserved for mothers. All 10 patients revealed by their attitudes, speech, dress, childhood behavior, and marital and occupational histories varying degrees of pseudo independence. This behavior appeared to represent overcompensation of dependent trends and could be related to (1) maternal rejection by a sick or inadequate mother, (2) inability of the normal mother to satisfy excessive dependent demands of the child, (3) maternal demands for premature independence, and (4) maternal overprotection.

There is no evidence to indicate whether or not asthmatics are born with excessive oral drives. However, this instinctual drive had become the focus for emotional conflicts and unusual somatic behavior in all our patients. Bulimia or anorexia before an attack, or relief from an attack while eating or by induced vomiting was noted in 6 patients. (The latter two phenomena may have had a physiological basis.) Three other patients experienced great concern about their capricious appetites, variable weights, and poor physiques. Moderate to marked ambivalence with respect to their smoking habits and attitudes, which often reflected parental edicts and guilt over oral drives, were expressed by 8 patients.

The oral cavity and respiratory tract seemed to represent a *locus minoris resistentiae* for all our patients: 8 had a history of oral surgery, injury, or serious respiratory illness during the day, week, or several months preceding the onset of bronchial asthma; 8 patients had had tonsillectomies, and 7 had had other oral injuries; 9 had had recurrent severe pulmonary infections, 7 had had pneumonia (3 more than once), and 4 had had pertussis; 8

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had experienced morbid fears of tuberculosis, but none had had it.

Experiences with Water

The high incidence, in asthmatics, of dreams utilizing water symbolism and suggesting intra-uterine fantasies and wishes has been noted by French and Alexander,[32] Saul,[85] and F. Deutsch.[20] In the light of these observations, a specific inquiry was made about attitudes and experiences of our patients involving water. All 10 patients had had frightening experiences with water and drowning, and in 9 instances these antedated the onset of asthma. Marked fears of immersion in water in 9 patients seemed to follow these experiences. For example, one patient's mother stated that he had reacted with severe fright when his father tried to force him to swim several months after birth; another patient had been repeatedly threatened with drowning if enuresis did not stop; a third lost her closest sister in a mysterious drowning and shortly thereafter developed asthma; a fourth almost drowned when chased in the water by a vicious dog; and a fifth was forbidden to swim after his cousin "nearly drowned."

Although carefully controlled studies are necessary to establish the significance of such experiences, two tentative interpretations of these data seem possible: (1) The reality experiences of water as a destructive or hostile force initiated the fears in susceptible individuals, or (2) the experiences reactivated preexisting unconscious conflicts relating to the patient's intense wish for reunion with the mother as reflected in the intra-uterine fantasies and water symbolism described by French and Alexander.[32]

Observations on Endocrine Responses

Funkenstein[34] has described the autonomic lability and failure of asthmatics to respond to Mecholyl in stressful situations. Previous endocrine studies[95] differentiated the older intrinsic asthmatics with low excretion of 17-ketosteroids and 17-hydroxycorticoids, which increase to normal or slightly higher levels with ACTH treatment, from the younger extrinsic asthmatics with normal 17-ketosteroids and 17-hydroxycorticoids and a moderate to marked rise with ACTH treatment. Of our patients with long-standing primarily "allergic" extrinsic asthma, 3 had low normal 17-ketosteroids and 17-hydroxycorticoids which changed little with treatment, and 3 patients with long-standing asthma, in which emotional factors predominated, were observed to have wide mood swings and at times had substituted depressive reactions for asthma. Both 17-ketosteroids and 17-hydroxycorticoids were high normal initially in this group, and, with treatment, the 17-ketosteroids rose markedly, but there was little change in the 17-hydroxycorticoids. One of these patients, on leaving the hospital, had a severe panic reaction, lost his asthma, developed a psychotic depression, and, without any treatment, excreted the extraordinarily high 17-ketosteroid value of 140 mg. in twenty-four hours. Similar rapid shifts between asthma and psychotic states have been observed by Funkenstein[33] and Sabbath and Lucc,[83] although the careful work of Knapp *et al.*[58] suggests that a simple reciprocal relationship is unlikely. Another patient of the authors', with infectious asthma of only eight months' duration, had a strong emotional component in her illness and excreted low initial amounts of both steroids which increased to very high levels with only two doses of ACTH.

These limited observations invite further inquiry into the relationship between emotional factors in asthma and the conditioning influence of adrenocortical activity. The problem seems more complex than that of differentiating intrinsic from extrinsic forms of asthma.

Psychodynamic Considerations

There is general agreement among psychoanalytic writers that many patients with severe asthma (1) have an inordinate need for their mother's love, (2) that their attitude to their mothers is ambivalent, and (3) that they are afraid of "losing" their mothers or of "destroying" them. There is less agreement about the determinants of the regressive level of psychological defenses and of symptom choice. The

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asthmatic attack may represent an affect concomitant and specifically a repressed cry for the mother's help in response to separation anxiety, as French and Alexander[32] have proposed. This phenomenon seemed important in 2 of our patients, probable in 5, and unimportant in 3. Of our patients, 5 noted relief from asthma with crying, but this may have been related either to the expression of depressive feelings or to the physiological relief associated with the act of crying.

French and Alexander[32] discuss the asthmatic's undue fear of incurring his mother's disapproval, of losing her love, and of activating his underlying separation anxiety. These may occur in a variety of ways, for example, by display of sibling rivalry, by sexual temptation, as well as by real or threatened loss of the mother or a mother surrogate. The guilt experienced by patients in response to their real or fantasied transgressions is further supported by the observation that patients with severe asthma may have a great need to confess and to bring about a reconciliation. Of our patients, 8 had experienced attacks of asthma during sexual excitation; physical activity and increased respiration were not the complete explanation for the episodes, since these particular asthmatic attacks occurred as a very early concomitant of sexual excitement. One patient insisted that she consciously facilitated, if she did not induce, asthmatic attacks to ward off what she interpreted as "alarming" sexual advances by her fiancé, her attitudes toward sex having been conditioned by a mother who repeatedly denounced intercourse as "dirty," "messy," and "sinful."

An alternative interpretation proposes that asthma may constitute an expression of a conflict arising from the unconscious wish to return to the state of intra-uterine union with the mother where independent respiration was not experienced and the infant lived an aquatic existence in the protecting confines of the mother.[35] One of our patients spontaneously spoke of her disgust and anger at the thought of having once been a part of her mother in the uterus. As in the other hypothesis, from a psychodynamic viewpoint the "goal" is union and the "object" is mother. However, the evidence in support of this explanation lies largely in the intra-uterine dreams, children's fantasies,[52] and water symbolism observed by some students of the problem. Saul[86] has reviewed this evidence and concludes that the deep dependent longings, based on intra-uterine fantasies observed in patients with respiratory disorders, may be contrasted to the regressive oral dependent needs of individuals prone to develop gastrointestinal diseases.

Fenichel[25] has suggested that asthma may represent an unconscious attempt by the patient, on a regressive basis, to protect himself permanently and omnipotently from loss of maternal love by respiratory introjection of the ambivalently regarded mother. Fenichel's theory is complementary to Saul's. According to both theories, the aim of the asthmatic patient is to be united with the mother—projectively (Saul), or introjectively (Fenichel). But the patient rejects his wish (which is alien to his adult self), and he rejects the negative aspects of the mother, that is, the mother who has deprived him of love. The mother is then both a loved and a hated object, and the asthmatic seeks to retain the "good" mother and rid himself of the "bad" mother. In effect, the patient's unconscious attitude may be verbalized as follows: "I want to be united with my mother, to be unborn, to hold my breath, to die, but I also want to live an independent life, free from my inhibiting mother, to breathe freely and safely and reject my infantile trends."

Material obtained from several of our patients by interview suggested the presence of introjective mechanisms and of conflicts over introjective trends. One patient felt that his dead (maternal) father was part of himself; another seemed to internalize her coughing, consumptive mother, who was "just a little tot," and in turn she behaved like a "little tot," working in the protecting environment of physicians' homes selflessly looking after "little tots." A third patient assumed the inhibiting, rigid attitudes of his overprotective mother, but was overtly hostile toward her. A fourth internalized the strict, obsessive attitudes of her mother, but, following the latter's death, she attempted to emancipate herself by defying

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maternal injunctions, rearranging furniture, walking on the carefully polished floor, and taking a lively vacation. In this setting she developed asthma. A fifth patient developed asthma after the dramatic drowning of a sister who was regarded ambivalently and who played a maternal role for the patient. Where interviews with the mothers were possible, the patients' hostile distortions were often found to be of such proportions as to suggest projective mechanisms. Finally, there is the problem of explaining the association of the respiratory tract with the psychological mechanism of introjection. Fenichel[25] suggests that the physiological concomitant of "respiratory introjection" is smelling, in which a "particle" of the external world may be regarded "as taken into the body." This association is most meaningful in asthmatics with a predominantly anal-sadistic orientation.

Sadistic impulses directed against the deserting (hated and yet badly needed) mother, and feelings of guilt and of anxiety arising from them date back to early infancy. From this point of view it matters little whether the patient was, felt, or expected to be deserted. In this connection, reference may be made to F. Deutsch's suggestion[20] that the onset of asthma may be related to the concurrent disturbance in infancy of a somatic respiratory disorder and a major emotional conflict. In 8 of our patients, such a relationship seemed probable. Dekker and Groen[15] have demonstrated clearly, in an experimental setting, the reproducibility of "psychogenic" asthma in patients who are also sensitive to specific allergens. The role of conditioning in the production of "psychogenic" asthma is well-supported by the work of Dekker, Pelser, and Groen.[16]

Formulation and Speculation

Available evidence is compatible with this formulation: The individual with constitutional autonomic and endocrine lability, possibly genetically determined, and with a respiratory tract prone to dysfunction on a genetic or acquired basis, who also possesses intense oral drives, either inherited or acquired, that bring him into conflict with an "unsatisfactory" mother to the extent that she is unable to satisfy normal demands or is a relatively "normal" mother unable to satisfy excessive demands, attempts to protect himself from separation anxiety by respiratory introjection and projection in psychodynamic terms and by ostentatious pseudo independence on a behavioral level.

Undue emphasis on any specific factor, such as constitutional, autonomic and endocrine lability, allergy, inherited or acquired proneness of the respiratory tract to dysfunction, or psychogenesis, fails to do justice to the complexity of the problem. There is good reason to believe that a combination of these factors, or more precisely, a constellation of these factors with varying preponderance of one or the other, accounts for the etiology of asthma. As far as the psychological parameter is concerned, the presence of deep-seated oral-respiratory conflicts arising from the child-mother relationship appears probable. In the deep layers of his mind, not infrequently hidden by defensive psychological structures, the asthmatic unduly longs for his mother's love. In view of his intense longings for the mother's love, the asthmatic responds to any situation which entails actual or potential loss of the mother, or which imperils the good relationship to the mother, with anxiety which is perceived and experienced as oppression and suffocation. The mother, her love, and her good will are essential to the asthmatic just as is air.

Oral surgery, respiratory infections, allergens, a traumatic water experience, actual separation or fear of being deserted may all activate the patient's unconscious conflicts and overdetermine the respiratory tract as the organ for the somatic expression of hypersensitivity to an expanding spectrum of stimuli. Once the final common pathway is established, it becomes the organ of expression for a wide variety of internal and external influences.

¶ Vasomotor Rhinitis

Seasonal allergic rhinitis (hay fever) is such a common complaint in contemporary North American society that one must look for caus-

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ative influences which are equally widespread. With respect to the allergenic factor, the pollens of ragweed grass and of trees are the most prominent offending agents in North America. Nonseasonal allergic rhinitis is frequently associated with dust, animal danders, drugs, cosmetics, and local foci of infection in the sinuses or teeth. The presence of psychologic factors is suggested in the findings of an early personality study of hay fever patients, whose dominant characteristics were noted to be self-absorption, dreaminess, and overweening ambition, in contrast to a control group of patients with fractures or appendectomies.[103] Although this study confirmed independently the findings of others, it probably represents an oversimplification of the problem on the level of personality. It is conceivable also that there are some cultural and social factors, with their emotional sequelae, which are sufficiently widespread to influence all of the many varieties of patients who develop this condition, but as yet these factors have not been identified. The precise role of psychologic factors has not been established as clearly as the role of allergens.

In perennial vasomotor rhinitis, as distinct from the first two entities, emotional factors probably play a dominant role. These patients develop nasal obstruction, rhinorrhea, and sneezing associated with the cellular changes described previously. Such changes, although possibly related to alterations in barometric pressure, humidity, and temperature, also frequently are related to emotional responses associated with conflict and stressful life situations. From a phylogenetic standpoint, the nose is a sexual organ, and anatomically the tissue around the nasal turbinates is erectile tissue innervated by cervical sympathetic fibers from the superior cervical and sphenoidal ganglia. Nasal hypersensitivity accompanies menstruation, pregnancy, and erotic activity to minor degrees but becomes magnified and produces symptoms when conflicts are associated with these functions.[70] Situations associated with feelings of humiliation, frustration, and resentment were found by Holmes and his colleagues[49] to produce marked swelling of the turbinates, mucus secretion, and obstruction. They further interpreted their data as suggesting that the nasal turbinates responded similarly to a variety of noxious or threatening "agents" (pollens, dusts, odors, persons, and situations) in attempts to "shut" them out defensively.

From evidence obtained during the analysis of 7 patients with hay fever, Wilson[100] suggested the importance of repressed olfactory sexual curiosity. He concluded:

> The interplay between these inner conflicts, attempts at their solution, and the external agents (specific pollen allergens) which precipitated the actual hay fever attack remains unknown. Either a specific constitutional hyperosmia leads to the sense of smell as a regressive solution to dangerous curiosity or the regression itself produced the hyperosmia and nasal sensitivity to pollen. The physiological principle relative to summation of external and internal stimuli may solve the problem of the interaction of physiological and allergic factors in hay fever. Patients who, as a result of their psychosexual development have substituted olfactory for visual sexual curiosity may, because of this, become more sensitive to pollens.

Wilson's formulation includes the possibility of cases of hay fever in which local sensitivity alone, in the absence of psychological stimuli, may precipitate an attack, and other instances in which emotional factors alone may produce an attack. Most cases probably involve varying proportions of both these elements as well as others, and in rhinitis of any form the importance of summation of stimuli should be recognized in the production of symptoms.

The Common Cold

The widespread prevalence of the common cold and its social acceptability as an "organic" disease have tended to focus interest on the search for the specific disease agents involved to the exclusion of other environmental and host factors. Much progress has been made in isolating the one or more viruses believed to be associated with the common cold,[4] but the presence of a virus alone does not explain many of the epidemiologic observations, the variations in susceptibility of individuals to colds, or the precise temporal and environmen-

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tal circumstances attending the onset of a specific cold. For example, only about half the individuals "challenged" at any one time with infected nasal secretions develop symptoms, and this variation in susceptibility is apparently uninfluenced by the season of the year, length of time since the most recent cold, or by chilling of the environment, although changes in humidity may play some role in altering the permeability of the nasal mucosa.[87] It is probable that other environmental factors affect the virulence of the challenging dose, as well as the characteristics of the nasal and pharyngeal mucosa, but, as in the allergic disorders, particularly vasomotor rhinitis, it also seems probable that emotional stimuli, transmitted over autonomic pathways and perhaps conditioned by similarly activated humoral agents, can also alter the permeability of the mucosa or modify immune responses so that specific viral agents may invade the tissues.[90]

Data about emotional factors in relation to the common cold are scarce. Despert,[19] in a carefully documented study, observed 63 children in a nursery school during several school years. In a group of 8 of these children from broken homes, the mean total of absences for colds, calculated as a per cent of the possible days of school attendance, was 19 per cent, in contrast to 9 per cent for a group of 8 "well-adjusted" children from especially "happy" homes. When all 63 children were considered, the highest ratios of absences due to colds were found among the first group of 8 and among children with other obvious emotional stresses. There were also a few children free of such stresses in this group, and there were other children who had emotional problems but were relatively free from colds. The data do not prove that children from unhappy homes *have* colds more often than those from happy homes, only that the former are absent from school more.

In another study, Richter[79] reported emotional disturbances of rather severe degree following respiratory infections in children. He observed periods of apathy and depression which could not be attributed to any infectious process such as to the postinfluenzal depressive reactions which are believed to be associated with a transient encephalitis. The children all tended to show ready obedience, marked dependence, and subservience, were meticulous in their habits and dress, and carefully avoided quarrels or a display of anger. This behavior was interpreted as reflecting deep-seated conflicts related to aggression.

Menninger[68] reported psychoanalytic observations on a patient of forty who had had only four colds in her life and who, in the absence of an epidemic but while working out important conflicts in her analysis, developed a severe cold with an associated herpetic lesion. Similarly, Wilson[99] reported analytic data about a patient who expressed upwardly displaced anal-sadistic trends in speech and particularly in the form of obscene words. When passive homosexual tendencies were stirred up during analysis, the patient had to repress his impulse to "attack" back vocally and developed acute laryngitis with aphonia. Saul[84] reported psychoanalytical observations on 9 patients who, in situations resulting in frustration and strong, usually unconscious, receptive, dependent demands, and in varying degrees of repressed rage, developed colds, pharyngitis, and laryngitis. As he points out, this observation is by no means specific for the common cold, nor does it preclude the operation of the other important elements (infectious agents, allergens, and changes in temperature, humidity, and barometric pressure) alone or in combination. The data available suggest a fruitful area for more intensive investigation into the causes of this common though trivial disorder.

Smoking, Chronic Smoker's Syndrome, and Emphysema

Social and cultural pressures to conform are probably important in initiating the smoking habit, and nicotine, by means of physiological addiction, perpetuates the habit once acquired.[29] Emotional factors probably determine the amount of smoking and many of the occasions for excessive smoking as well as certain forms of compulsive smoking. Bergler[7] reported 5 cases of compulsive smokers, all of whom showed similar neurotic substrates. He found them to be masochists who wanted

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constantly to be refused. "To offset this inner reproach which objected to the wish 'to be refused' they 'proved' that they wanted the opposite, i.e., 'to get'." In Bergler's view, the outward sign was an oral "pacifier"—a cigarette. "Psychological drives combine with the pharmacological to explain the addiction. When tobacco was forbidden these patients they appeared to behave in a predictable fashion. They tended to feel unjustly treated and reacted with pseudo-aggression, perhaps toward a wife, or later the environment, in a rather childish fashion."

The deleterious effects and even potentially self-destructive implications of long-term excessive smoking are now a matter of public knowledge. Apart from the possible causative role of excessive smoking in the pathogenesis of carcinoma of the lung, coronary artery disease, and peripheral vascular disease, it is associated frequently with a syndrome characterized by chronic cough, dyspnea, wheezing, chest pains, and a tendency to frequent respiratory infections.[97] In its earlier stages it is a reversible disorder associated with excessive smoking and the emotional tension underlying this. Still another concomitant of excessive smoking is emphysema which, unfortunately, is often irreversible when first seen by the physician. The well-documented association between emphysema and peptic ulcer is of more than passing interest.[63] Physiological factors such as increased secretion of hydrochloric acid and anoxia associated with the smoking and emphysema are undoubtedly important, but the strong probability remains that emotional factors related to unconscious conflicts may also be important in the association of these two pathological conditions.

¶ Bronchitis, Bronchiectasis, and Pneumonia

"Stress bronchitis" in children[66] has been described clinically but not studied systematically. Alteration in the size of the bronchial lumen in response to emotional stimuli has been observed at bronchoscopy,[22,23] and variations in the secretion of bronchial mucus during periods of life stress were reported by Stevenson and Wolff[92] and Stevenson.[91] In the authors' experience, pneumonia, both bacterial and viral, in adults, is frequently preceded by periods of emotional strain and accompanying depression which develop over a period of several weeks and reach maximal proportions several days before the acute pulmonary symptoms develop. Although the presence of an identifiable bacterial or viral pathogen makes this element certain among the causal factors in any infectious disease, its presence does not necessarily afford a complete explanation for the occurrence of a clinical disease at a particular time, nor does it explain the association it may have with a stressful life situation. The influence of emotional factors in the causation of pneumonia is supported by the careful studies of Tigyi and Lissak[93] in the production and prevention of "vagus pneumonia."

An ingenious study by Selye[88] suggests the possible role of adrenocortical hormones in the pathogenesis of pneumonia and other inflammatory diseases. Rats prepared with subcutaneous air pockets on their backs, into which an irritant—croton oil—was introduced, were "stressed" by immobilization at varying intervals before and after the introduction of the irritant. When the "stress" was applied between three and five days after the croton oil, but not at other times within a two-week period, there was a maximal inhibition of the inflammatory response as measured by the thickness of the granulomatous response in the walls of the pouch and the volume of exudate. This study and the observations of Loumos[62] suggest mechanisms by which emotional or physical stresses experienced by a host harboring specific pathogens could inhibit the normal inflammatory and immune responses and facilitate multiplication and invasion by pathogens.

¶ Pulmonary Tuberculosis

The time has long passed when the riddle of the etiology of pulmonary tuberculosis seemed to be solved by the discovery of the tubercle bacillus and when the treatment of tuberculous patients was solely concentrated

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on the ravages which it causes in the pulmonary tissue. True enough, there cannot be tuberculosis without the tubercle bacillus, but it has been realized that there are many additional factors, including the psychological and the social factors, which determine the time of onset of the manifest illness, and which, for better or worse, influence the course of the illness.

Much work has been done regarding the psychosomatic, psychosocial, and somatopsychic aspects of tuberculosis. In fact, the literature is so extensive that it is impossible to review it adequately within the space allotted. Readers interested in specific problems may be referred to the surveys by Berle,[5] Barker, Wright and Gonick,[6] Korkes and Lewis,[59] and Merrill[69] and to the books by Antonelli and Seccia,[5] Derner,[18] Huebschmann,[51] Sparer,[89] and Wittkower.[102]

In this presentation we shall confine ourselves to a discussion of the personality of tuberculous individuals in relation to the natural history of their disease.

The Personality of Tuberculous Individuals

Two approaches have been used—the psychosocial approach and the psychodynamic approach.

Psychosocial Approach

The studies of Holmes and his co-workers[50] are based on examination of a random sample of patients representative of the tuberculous population in the metropolitan Seattle area. Free-association interviews, psychological tests, and sociological techniques were used.

The data of these authors indicate that cultural conflict contributes significantly to the natural history of tuberculosis. Striking features in the breakdown of the tuberculous population studied are the predominance of males, the high rate of first- and second-generation Americans, the frequency of broken homes in childhood, and the high rate of broken marriages, of residential mobility, of occupational transiency, and of consistent poor health.

Ecological studies revealed high rates of tuberculosis in Area I, including the city center and Seattle's skid-row population, and low rates in Area IV, including Seattle's well-to-do population. The authors conclude:

> These patients, when compared with the cultural norms, were in many ways marginal people at the time of onset of tuberculosis. They started life with an unfavorable social status and grew up in an environment that was for them crippling. They were, in essence, strangers attempting to find a place for themselves in the contemporary American scene. As perceived by the individuals with tuberculosis the poorly understood world in which they lived was a source of perennial danger, and the threat of being "walled off" and rendered "helpless" was always imminent. The nature of their attitudes and life experiences made it unusually difficult for them to decide what was expected of themselves. As a consequence, their attempts at adjustment were characterized by unrealistic striving, which was not only unrewarding but also productive of cumulative conflict, anxiety and depression.

Psychodynamic Approach

As could hardly be expected, no uniform personality type covering all sufferers from tuberculosis could be delineated. Yet the frequency of certain personality features and a fairly constant psychodynamic pattern long antedating the onset of the illness have been reported.

Investigations by one of the authors, the results of which have since been confirmed by others,[41, 44, 57, 86] have shown that an inordinate need for affection is an outstanding common feature of the premorbid personality of tuberculous patients. This need for affection may be openly expressed, thinly disguised, well concealed, or flatly denied. Coupled with it are conflicts over dependency. At one end of the scale are individuals who adopt a receptive, parasitic, or leechlike acquisitive attitude toward members of their family, if not to the world in general; at the other end are individuals who, by ostentatious insistence on independence, reveal their inability to recognize and to admit their need for dependence. Between these two extremes lies the whole gamut of defenses against admission of need

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for affection and dependence. A well-defined in-between group is one made up of rebellious individuals whose aggressive and sometimes antisocial behavior bears the characteristics of a defensive measure. Another group consists of individuals who usually fail to make use of acting out as a character defense—conflict-harassed individuals. Accordingly, the patients were classed as overtly insecure, rebellious, self-driving, and conflict-harassed types.

Life Situation at Onset

Irrespective of whether the one approach is used or the other, there is agreement that emotionally disturbing events frequently precede the onset of the illness.

Holmes *et al.*[50] plotted, in a group of patients, the occurrence of stressful events for a decade preceding the onset of the illness and compared their frequency with that in a group of individuals free from tuberculosis. They found that (1) in the last few years preceding the illness the patients had suffered a much greater number of difficult and potentially distressing events and situations; (2) they were people who were less stable, less able to handle difficulties comfortably, than those who remained well; and (3) they did not recognize or could not admit this personality defect.

As regards the authors' studies, in four fifths of the individuals labeled overtly insecure, situations which rouse aggressiveness or endanger the delicately poised security system of the patients were found to precede the onset of tuberculosis. These individuals react disproportionately to rebuffs, to separation from, threat of losing, and actual loss of, a supporting figure. In individuals of a rebellious nature, resentment of imposed authority and imposed hardships often assumes a precipitating function. The emotional situation of self-drivers is different and yet similar in some respects. In them, external precipitating situations hardly ever precede the onset of tuberculosis. Their basic conflict consists in compliance with the demands of one driving parent (usually the father) under silent protest. They differ from the previous groups in so far as the authority against which the opposition is directed has become internalized. The emotional conflicts in the conflict-harassed group, in contrast to the others, have reached a preconscious level.

Formulation and Speculation

Four conditions could be conceived under which, in adult life, florid symptoms of pulmonary tuberculosis may develop: (1) infection or reinfection by massive doses of tubercle bacilli; (2) reactivation of a dormant primary lesion (a) by an adverse environmental situation over which the individual has no control, (b) by a consciously or unconsciously self-engendered adverse environmental situation, and (c) by endopsychic processes. Some of these conditions are obviously not mutually exclusive. For instance, an individual may succumb to infection because he is susceptible to it owing to his disturbed emotional state.

Of these four conditions only the last may raise the eyebrows of some organically minded tuberculosis specialists. Most tuberculosis specialists, however, are familiar with the type of patient who, despite all efforts on the part of the physician, steadily goes downhill and who, on exploration, is found to have no will to live or, more precisely, in a state of severe depression, quite consciously wishes to die. Beyond this, psychiatric and psychoanalytic observations have indicated that tuberculous patients, in the deep layers of their minds, deflect aggressive impulses from objects in the external world to their own selves or to introjected objects.

Hartz[44] has suggested that in certain patients the disease process in the lung takes on a special symbolic significance, the character of which is determined by the nature of the patient's personality problem. "The lesion becomes personified and almost seems to be treated as if it had an existence of its own, separate from, but included in, the life of the patient." He reported the case of a patient who unconsciously identified the disease process with her mother—"it was her mother taken inside her who was symbolically being invaded and destroyed by this process." When psychological treatment enabled her to exteriorize the

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hatred of her mother, the patient's whole attitude toward her pulmonary tuberculosis changed.

The question has been raised why tuberculous patients so rarely commit suicide. The answer has been given that if the tuberculous lesion is regarded and understood as an "organic" suicide[67] or as a "partial" suicide,[44] there is no necessity for the patients to take active steps to terminate their lives.

These views have been supported by Rebner,[78] who, using the Blacky picture test and the Rorschach test, subjected to a careful investigation the role of personality as one of the factors in relapse in pulmonary tuberculosis. His research population consisted of a group of 20 persons, whose tuberculosis had become arrested after a relapse, and of two matched control groups, one composed of individuals recovered without a relapse and the other composed of relapsed tuberculous patients. Although other factors related to immunity and reinfection undoubtedly played important roles in the relapses, statistical analysis of the results obtained showed (1) that both relapsed groups manifested a greater degree of oral aggression than did the unrelapsed group, and (2) that persons in the relapsed hospitalized group had a greater tendency to direct aggressive drives onto the self than did persons in the relapsed arrested group.

Finally, the question may be justifiably posed: How can emotional conflict and disturbance on purely physiological grounds affect the organism in such a way as to precipitate the onset of illness and to influence its course? In this respect, once again, reference may be made to the work of Holmes *et al.*,[50] who studied the relationship of life stress and adrenocortical function in tuberculous patients and found that the level of 17-ketosteroid excretion was related to the emotional state of the subjects and to the type of tuberculous lesion. Rapid changes in 17-ketosteroid excretion accompanied changes in emotional states resulting from acute or chronic stress situations arising during the course of hospitalization. These alterations in adrenal cortical function persisted for the duration of the emotional experience. From their own work as well as that of others, Holmes and his co-workers conclude: "From these observations it is suggested that adrenocortical activity plays a role in resistance to tuberculosis and that the effects of life stress upon the course of tuberculosis, in part, may be mediated via the adrenal gland."

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CHAPTER 36

SEXUAL DYSFUNCTIONS IN MEN

Emil A. Gutheil

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THE SEXUAL FUNCTION of the man is dependent on a set of partly psychic, partly physiologic stimuli which are links in a chain of interrelated conditioned reflexes. Any disturbance of this chain—in its somatic or psychic parts—may lead to a disturbance of the sexual function.

In evaluating a disturbance of this sort in a patient, four main factors must be taken into consideration—the initial sexual charge (libido), the erection, the ejaculation, and the orgasm. The performance of a normal sexual intercourse is possible (1) if the individual shows a sufficiently high degree of initial libidinous charge; (2) if this libidinous charge is strong enough to stimulate his erective centers sufficiently to produce an erection; (3) if the erection is sufficiently strong and lasting to permit an insertion of the organ* (through subsequent friction, achieved by voluntary thrusts, that is, by summation of stimuli, the male must be able to reach a level of excitation high enough to flood with it the ejaculatory centers so that an ejaculation can ensue);* and (4) if this ejaculation occurs at the peak of excitement, by involuntary spasms of the pelvic floor musculature, and is accompanied by a distinct climactic pleasure (orgasm), experienced psychosomatically.

* The erective reflex leads to two synchronized nervous reactions: (1) There is a dilation of the arteries of the penis, with subsequent engorgement of the corpora cavernosa. (2) Simultaneously, there is a tonic spasm of the muscles of the urogenital triangle (bulbocavernosus and ischiocavernosus), with the result that no blood escapes the cavernous bodies through the venous system. These reactions are effected by the inhibition of the sympathetic (vasoconstrictor) centers, located in L_{1-2}, and by the excitement of the parasympathetic (vasodilator) centers in S_{1-3}. Both spinal centers are in communication with cortical, subcortical, and medulla oblongata (vasomotor) centers.

* The ejaculatory reflex is triggered off by impulses which originate in the genital epithelium. They are carried via the dorsal nerves of the penis to the common pudendal nerves and enter the posterior spinal roots at S_{3-4}. These impulses then reach L_{1-2}, causing (1) peristalsis in the ampulla of the deferent duct, the seminal vesicles, and the ejaculatory ducts which bring the semen toward the membranaceous part of the urethra, and (2) clonic spasms in the muscles of the urogenital floor (pudendal nerve, perineal branch) which cause ejaculation.

¶ Diagnosis of Sexual Dysfunction

The diagnosis of a psychogenic sexual dysfunction can be made only after a thorough somatic and psychic examination of the patient. Such an examination will have to exclude the physical forms of dysfunction. Among the most frequently encountered physical causes of impotence are diseases which affect the central and/or peripheral parts of the neurone, thus disrupting the function of the reflex chain. They are (1) infections and intoxications (for example, syphilis, multiple sclerosis, transversal myelitis, diabetes, saturnism, and others); (2) central and peripheral malformations which mechanically obstruct the conduction of stimuli (such as tumors) and peripheral pain-producing obstructions (such as phimosis or the like); and (3) hormonal hypoplasias, aplasias, and other hypofunctions.

The vast majority of sexual dysfunctions leading to impotence, however, are of psychogenic character. Some of them are symptoms of an underlying sexual deviation (paraphilia) or of a psychoneurosis connected with an immature sexual pattern (psychosexual infantilism).

The psychologic exploration needed to establish the nature of the disorder includes (1) the patient's family background, (2) details of his sexual development, (3) his moral training and education (as potential sources of sexual inhibition), (4) if married, the history of his marriage and the current state of the marital relationship, and (5) his own theory regarding his disorder. The answers to a number of special questions must then be determined.

¶ Special Information Required

Duration of the Dysfunction

We inquire whether the potency was lost after a relatively normal sexual period or whether the patient was unable to perform intercourse from his very first attempt.

In the first case, our interest must concentrate on the factors which may have contributed to the patient's current loss of potency. Inhibitions, fears, acute conflicts between conscious and unconscious desires, etc., will come into focus here. The analysis does not have to go far back beyond the onset of the disturbance. Only occasionally does the necessity arise for making farther-reaching forays into the patient's past in order to reconstruct some of his pathogenic patterns which had remained latent until they were set off with the acute outbreak of the disturbance.

In the second case, the pertinent inhibitions have apparently been carried into the sexual relationship from the patient's very early childhood. A thorough investigation of the past is, therefore, mandatory. The relevant causative factors may lie anywhere between infancy and the current phase.

"Absolute" or "Relative" Dysfunction

I should like to begin by expressing a pessimistic axiom[3] which may be formulated as follows:

Because of the existing "cultural neurosis," the man of today is no longer capable of having sexual intercourse with *any* partner, at *any* time, and under *any* circumstances. Given a proper partner, a suitable time, and propitious external and internal circumstances, he can have a satisfactory and thoroughly enjoyable sexual intercourse. Not that the ever-potent and "ideal" type does not exist any more; however, our selective affinities and specific idiosyncrasies in human relations play a greater part today than they used to centuries ago, when the psychic organization of the individual was simpler, the tempo of living less stressful, the personality and social status of the woman less complicated, and thus also the sexual intercourse closer to the purely biological, physical level.

Many sexologists[2, 4, 5] have pointed out that even the so-called normal individuals may have certain specific love conditions under which sexual stimulation may reach a higher degree—conditions involving position, type of partner, the partner's conduct during intercourse, etc.

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For example, there are men who, without being conspicuously neurotic, are more stimulated when their partner is in the inverse position; or who are especially aroused when their partner has voluminous breasts or buttocks, is aggressive and active in the sexual act, or passive and even motionless. There is no doubt that a deeper analysis of these specific sexual predilections, relying heavily on the patient's dream material, may reveal not only the deeper meaning of these preferences but also their origin and the conditions under which they have come to existence. However, this does not preclude that in evaluating a sexual disorder, we must draw a relatively wide margin of normality.

Although the moral code in some countries, including our own, has declared some commonly practiced variations of sexual relations as taboo, the modern psychiatrist will be inclined to favor the formula that what two mature people do in the privacy of their bedroom, to enhance their mutual enjoyment, without offending the sensitivities of any third party, does not represent a psychiatric problem.

We must not forget that man long ago abandoned the natural sexual rhythm of rut, or heat, which regulates the sexual life of animals. Man has extended his capacity to enjoy sexual relations and his need to mate beyond the regular mating seasons of the year. This capacity is dependent, to a high degree, on psychosexual stimulation from outside. A shortcoming of this universalization of the sexual rhythm is that, at times, the male may be ready to mate while the female may still be sexually uninspired, and vice versa. It may, therefore, be necessary for either partner to make an effort to increase the initial sexual charge by deliberate efforts to synchronize the sexual rhythm.

One of our queries at the initial interview is whether impotence was encountered in marital sexual attempts as well as in extramarital ones, if any. In some cases, owing to an overstrong super-ego reaction, extramarital intercourse may be impossible, while connubial relations may remain undisturbed. One of my patients, a traveling salesman, showed this form of "relative" impotence. His extramarital impotence proved to be the guardian of his marital fidelity.

On the other hand, there are individuals who are potent only in their extramarital relations, with harlot types of women, while their marital relations are entirely unstimulating. A forty-year-old musician had intercourse with his wife only on rare occasions. His usual way of obtaining sexual gratification was to visit bars, get semidrunk, pick up one of the female bar customers, and have intercourse with her. When he developed a stomach ulcer and alcohol was prohibited by his physician, he was automatically deprived also of his sexual outlet.

This patient, an inwardly religious person, could not perform sexually unless he had dulled the voice of his conscience by alcohol. In addition, his latent homosexuality and the general hostility toward women connected with it made women who were promiscuous, that is, "men-women," more attractive to him (the "triangle of latent homosexuality"). His guilt feelings toward women led him to self-punishment by self-degradation, which the alcohol daze helped him to tolerate.

Details of the First Failure

Various factors may have been responsible for a patient's failure in the first intercourse: (1) The first encounter may have been fraught with anxiety, to begin with, an anxiety carried over from old masturbation fears or from unresolved castration complexes. (2) The patient may have been subjected to an acute upsurge of unconscious hostility toward his partner. (3) He may have had another experience which had led to an intrapsychic shift of the sexual interests. (4) The external circumstances of the intercourse may not have been propitious.

In one of my cases, the patient's mother-in-law was sleeping in the adjoining room during the wedding night, and only a curtain separated the two rooms from each other. Inhibitions involving her, as well as some oedipal factors, conspired to make the sensitive patient unable to perform.

Another patient, a married dentist, who wanted to have intercourse with his office

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assistant in his main-floor office, was acutely impotent when he heard the rhythmic step of the policeman walking up and down in front of the windows of his office. It was impossible for him to perform the immoral act of infidelity "under the eyes of the law," representing, of course, also his super-ego.* In his unconscious, this fear fused with his oedipal anxieties† and evoked symbolic self-castration.

Traumatic Impotence

Under traumatic circumstances we occasionally observe impotence with or without loss of libido. It is not sufficiently known that impotence can represent also an unspecific symptom, as the result of an upheaval within the dynamic forces of the ego. Under conditions of prolonged stress, sexual energies may be included in the ego's attempt to maintain or regain its adaptive capacity and may have to be withdrawn from their specific contrectative goals.

Frequency of Intercourse

The next question to be asked at the initial interview is, how frequently, on the average, intercourse takes place. Many superstitions are encountered at this occasion. Some men are afraid that too frequent intercourse may be harmful, that it might lead to the exhaustion of the potency.‡ They may make every effort to cut down the frequency of intercourse and to increase the intervals, with the result that their performance steadily declines. Infrequent intercourse increases the inner sexual pressures and often leads to premature emissions, owing to a chronic engorgement and overstimulation of the genital system by many frustrative excitations.

Often it is the woman who prevents her husband from indulging frequently in intercourse. She may use all sorts of rationalization to dissuade him from approaching her, because she is frigid and hates sexual relations. Some women tolerate sex if they must, but they gladly grasp any pseudoscientific explanation to avoid their marital obligations. Intercourse in this type of marriage may then become the object of a struggle for power between both partners, with the man having to "deserve" it as a special favor, or having to forgo it as punishment. As time goes on, physical relations may lose much of their desirability for the male partner also.

The unbiased student of sexology cannot concur with the idea that physiologic glandular secretions of any kind should be harmful or could be exhausted. The opposite is true with most of our glands, as the phenomenon of "disuse atrophy" indicates.

Initial Sexual Urge

Attention should also be paid to the question of the strength of the initial sexual urge. Has it always been sufficiently strong? Does the patient still consider it adequate at the time of the current interview?

Analytic investigation reveals that hyposexuality and asexuality—with the exception of organic disorders—are products of transformation within the dynamic forces of the patient's ego. In cases of this type, the patient's libido moves along underground pathways, because it is not directed toward the mature sexual union with a woman but has either remained on a pregenital level or assumed homosexual character.

One of my patients, aged thirty-four, stated that he was not surprised at being impotent; he was not interested in sex to begin with (libidinal impotence). He went out with girls because this was expected of him, and because he frequently felt bored and lonesome; but he did not care for

* In his *New Introductory Lectures on Psychoanalysis* (Norton & Co., New York, 1933) Freud states as follows: ". . . the function which I am beginning to distinguish within the ego is the conscience; but it is more prudent to keep that function as a separate entity and assume that conscience is one of its activities, and that the self-observation which is necessary as a preliminary to the judicial aspect of conscience is another. . . . I will henceforth call this function in the ego the 'super-ego'" (page 86). [For a further definition of super-ego, see Greenson, Chap. 69—EDITOR.]

† [See Greenson, Chap. 69—EDITOR.]

‡ Old-fashioned sex-hygiene manuals (and, unfortunately, some more recent ones, such as of The United States Public Health Service, 1937, and the *Boy Scout Manual*, 1945, and others) exhort the youth to avoid "wasting" the vital fluids.

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women sexually, and the sexual interest he often noticed in women left him cold. He would have preferred to spend his time in a stimulating conversation with women. Homosexuality repulsed him, however.

The marriage of the patient's parents was very unhappy. His mother was a domineering woman, who, according to the patient, was the most despised person in town. She not only showed no affection for her children but also, by constantly demanding their services, discouraged any warm feeling for her. The children preferred to stay away from her rather than be constantly forced to respond to her whims. The patient's father was a taciturn person who was completely dominated by his wife. He knew nothing and cared nothing about anything but business, from which he had amassed considerable wealth. The patient often heard his mother say that women were "gold diggers," and that if they should ever show interest in the patient, it would only be for his money. The patient thus had learned in his early youth to suspect women's motives and was constantly on guard against any attempt on the part of women to "rope him in."

Gradually, the patient developed an asexual attitude toward women. When, in his adolescence, he failed in his first attempt at intercourse with a prostitute, his resistance toward sex obtained a realistic basis. He was, however, able, in his late twenties, to perform intercourse repeatedly with a neighbor girl, until the relationship led to pregnancy. This unexpected event not only represented the end of the relationship but also reinforced the patient's sexual inhibitions. In the course of a few years, the patient's sexual interest reached the zero point.

Some patients of this type use all sorts of artificial stimulation to get into the proper mood, for instance, by viewing some sexual pictures. Some of these pictures may reveal the repressed source of the specific stimulation, for instance, homosexuality, sadomasochism, pluralism, or other abnormal traits. Other patients behave as though their sexual urge had evaporated completely, and as if nothing were able to stimulate their sexual interest. It should be stated at this point that even if sex seems to have been banned from the patient's consciousness completely, this in itself does not represent any important indication regarding the prognosis of the case.

Erection

Our next questions are: Has the patient had any erections at all? Has he morning erections? Is he aware of having erections when he does not "need" them, while they fail him when he contemplates intercourse (erective impotence)?

In general, we may say that the presence of erections is a favorable sign, regardless of the context in which they appear, a fact which should be stressed by the therapist. Through a successful therapeutic intervention, it should be possible to synchronize the erective reflex and the sexual act.

The phenomenon of morning erections has received a great deal of attention from sexologists. Some experts consider them insignificant and only a response to the increased filling of the urinary bladder. Stekel[5] proved, however, that sexual dreams, and fantasies produced on awakening, are primarily responsible for the appearance of morning erections. In many cases the patient is unable to reconstruct them, but careful analysis can elicit the sexual images accompanying the dreams.

It is also valuable to investigate whether the erections are spontaneous or have to be stimulated by the woman, and whether the patient has the desire to insert his penis or waits for his wife to take the initiative. The patient's basic attitude toward women and sex is revealed in this manner. The erection of a normal man is a "penetrative" one; it creates an almost unpleasant state of tension which can be relieved only by penetration and the subsequent phases of intercourse. The feminine, passive, neurotic man has to be "taken," "milked," or "given" pleasure, instead of generating it actively.

Ejaculation

Is the patient's ejaculation adequate, premature, retarded, or absent? Does it occur with or without an erection?

Although in most animals ejaculation fol-

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lows soon after penetration, and the anthropoid apes ejaculate in a matter of seconds,[2,4] the average human male is capable of engaging in intercourse for several minutes and longer before the seminal emission takes place.

Nevertheless, premature emission (ejaculative impotence) is a very common disturbance in man. While many men make conscious attempts to delay the ejaculation in order to extend the enjoyment of the act or to synchronize it with the partner's orgasm, the duration of the intercourse is often so deficient as to leave the female partner unsatisfied. It is interesting to observe how the fear of being inadequate leads to the delaying tactics and how the delaying, in a vicious circle, gradually leads to a shortening of the act. It seems that along with the reduced sexual endurance of the average man goes the modern woman's lowered capacity for responding to the stimulation. As a result, a woman who needs a prolonged intercourse to obtain an orgasm is often faced with a man whose ejaculation occurs too soon. The male's attempts to reduce the mounting sexual tension, in order to avoid a premature climactic discharge—by physical means (such as, slowing down or interrupting the thrusts of the intercourse, or the like) or by mental efforts (such as, deliberately distracting his mind)—lead to hyperirritability and, as a consequence, to premature emission.

It is, therefore, preferable to increase the frequency of intercourse and to let the reflex chain take its normal course, even if, at first, it should lead to the usual premature ejaculation. The best way to reduce the speed of the act is by frequent regular intercourse. Some patients use the leisure time of a holiday or a vacation to increase the sexual relations to daily or even more frequent acts. As a rule, they notice, after some time, that the second intercourse is more successful than the first, and gradually they can delay the moment of ejaculation to a more satisfactory point. Concurrently, psychotherapy is being used to eliminate the effects of unconscious anxiety.

Ejaculation may occur without erections and thus combine two phases of the disturbance. The ejaculation, in many of these cases, is obtained by manipulation of the penis so that, diagnostically, the erective impotence still remains the presenting symptom.

In extreme cases, ejaculation is so rapid as to occur before introduction of the penis into the vagina (ejaculatio ante portas).

Analytic investigation of premature emission has attempted to cast some light on the nature of the inhibition underlying this condition. In the opinion of analysts, we are dealing here with the patient's unconscious pregenital trends, which show either urethral or oral predominance within his generally feminine orientation toward sex. In urethro-erotic cases the patient may have a highly erogenous zone in the prostatic part of his urethra, at the root of the penis, acquired at an early phase of his development, and he may experience his orgasm in that area. He may also show a history of enuresis (an infantile form of emission), and his unconscious attitude toward semen may prove identical to that toward urine. In the ejaculatory act, he may be spilling semen on the female genital (as though it were urine) instead of penetrating it. The oral trends within this generally feminine orientation include the identification of the penis with the maternal breast. In cases of this type, seminal emission on the unconscious level equals the discharge of milk; intercourse on this level may thus represent an act of nursing.

Premature emission may, at times, be misinterpreted by the patient. Some patients have to be enlightened that mucorrhea, which may accompany the initial sexual excitement and represent a physiologic lubrication of the organ, is not premature emission. Misinformation in this respect often leads to unnecessary hypochondriacal ideas and anxieties. Mucorrhea is even sometimes misinterpreted as spermatorrhea and thought to be of ominous import, although it only indicates that the patient is hyperirritable and inadequately satiated sexually. Frustrating excitations caused by so-called "necking" or "petting," without adequate outlet (at one time called "bridegroom neurasthenia" because it was found so often in young people about to be married) are usually the cause of this hypersecretion. The mucus in these cases is supplied by the urethral

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glands of Littre along with some prostatic secretion. There is rarely any semen in it.

Retarded ejaculation is usually a sign of a deep-seated disturbance of the sexual instinct and requires careful analysis. Resistance to ejaculation usually develops if dangers appear to be connected with it. In many cases, repressed sadomasochistic impulses play a role in the development of this symptom, but we also find anal (retentive) and oral (rejective) features in special cases.

One of my patients, a twenty-five-year-old man who suffered from a retarded ejaculation was once slapped on his buttocks during intercourse by an angry and impatient prostitute. This was enough to bring about a prompt and powerful ejaculation in this unconsciously masochistic man.

Ejaculation may be absent altogether; the orgasm then occurs without seminal emission. As an acute phenomenon, it may be due to a temporary exhaustion of the ejaculatory reflex as a result of repeated intercourses with too short intervals of rest in between. As a chronic condition, it bespeaks deep-seated sexual anxiety which has to be investigated analytically.

A twenty-eight-year-old fireman complained that he was lacking emission. He had been married for two years and desired a child. Because of religious reasons, he had had but little intercourse before his marriage. Once, at the age of twenty-two, he had intercourse with a girl of his acquaintance and, despite continuing the intercourse to exhaustion, achieved no ejaculation.

He had been brought up with the idea of a "clean" life, and his parents as well as his clergyman friend, who used to visit with his family, emphasized the blessings of chastity. When, at the age of fourteen, he noticed that he had an erection, he was sure that he was degenerate and that he had completely lost his soul.

In his childhood he had often witnessed acts of extreme brutality toward women. His father often shocked him by cruelly ill-treating his mother. The patient was, in general, shy toward girls. In addition, he read many books on sexual hygiene, supplied by his clergyman friend, which portrayed "self-abuse" in most dramatic colors and described it as a step toward physical and mental perdition. At the age of fifteen, the patient developed a strong yearning for girls but, because of his shyness, was unable to establish any personal relationships with them. The town's burlesque show represented the boy's only sexual distraction.

Because of his "sinful" behavior, he suffered from deep feelings of guilt and looked forward to his future sexual life with great apprehension. At the age of eighteen he was convinced that, should he ever have an opportunity to be with a girl, he would be impotent.

At the age of nineteen he was a witness of a family tragedy. After a violent quarrel, his uncle killed his wife by choking her to death. About this same time the patient also read Bram Stoker's *Dracula*, in which a human vampire attempts to kill a woman he sexually desires. The patient was deeply impressed by these experiences and made up his mind that he would rather give up sex forever than expose himself to such terrifying potentialities.

The next few years found the patient in the throes of a deep asceticism. He avoided all contact with women until, at the age of twenty-one, he followed the invitation of a streetwalker and had intercourse with her. He had no ejaculation on this occasion and had none after that.

The analysis of this case brought out the patient's strong sadistic component. His early and adolescent impressions of violence toward women triggered off latent lust-murder tendencies, against which the patient protected himself by blocking orgasm and ejaculation. The idea of lust murder by strangulation clearly filtered out of the dream material. The patient's attempt at asceticism was another form of ego defense.

An interesting detail of this case was that the patient had a phimosis which had not been discovered until he was twenty. An operation was performed at the age of twenty-four to set his glans penis free. According to some analysts,[5] such protracted cases of phimosis often form a physical matrix for the development of sadomasochistic sexual deviations. The prepuce, which squeezes and generally interferes with the function of the penis, forms a compulsive force which is set in motion in connection with sexual excitement, causing feelings of strangulation of the penis, physical pain,

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and discomfort. Thus pain and pleasure coincide, forming a somatic substratum for a sadomasochistic paraphilia. The patient's lust-murder idea characteristically involved strangulation of the type that the patient had seen performed by his uncle and that he himself had endured through phimosis.

Orgasm

Ejaculation is not identical with orgasm. There are people who ejaculate without feeling any significant pleasure (orgastic impotence). If this is not a symptom of a general anhedonic attitude which is to be found in some psychoses (schizophrenia), it bespeaks a severe conflict between the id and the super-ego. It is found in people who cannot love and whose psychosexual development has not reached the stage of genital primacy. It is also seen in people for whom pleasure, for some specific reasons, represents a threat. The type of threat varies—from oedipal castration fears to the fear of repressed sadistic impulses—but the result is always that the drive has to be renounced by the ego, together with the sensation of pleasure attached to it. In this way the ego is able to comply with the demands of the super-ego and to maintain the normal integration of the patient's personality.

Contraception

Among the questions to be asked at the preliminary examination, we consider it important that inquiry be made concerning contraceptive methods used and the patient's attitude toward them, not only because the fear of causing pregnancy may play a part in the inhibitory reactions responsible for the sexual dysfunction but also because the mechanical details involved may prove to represent unwelcome, annoying, or repulsive factors, capable of interfering with the normal course of the physiologic event.

If coitus interruptus is practiced as a contraceptive measure, we must explore the man's attitude toward it. He may be inclined to anticipate that it will bring him harm. Early psychiatrists (including Freud) believed that coitus interruptus — like masturbation — was harmful, and that it led to a so-called "actual neurosis." Today, this concept is no longer considered valid.

Accompanying Fantasies

One of our questions will be whether the patient has ever used any accompanying fantasies to stimulate his deficient sexual excitation during the act. Among these are fantasies of other women (who may fulfill the patient's specific sexual needs better than the available one), pluralistic scenes (more than one partner), and other deviations. Although the patient may, at first, hesitate to reveal these guarded secrets, knowledge of these fantasies is essential for the understanding of the dynamics of the dysfunction.

The Act

We stated above that the margin of normality in sexual relations must be drawn quite generously, yet it is of importance for us to know the type, amount, and scope of variations of the act which the patient had been practicing in the past. While an inverse position can be considered normal as a variation within a normal relationship, it may, by its exclusive character, bespeak the patient's unconscious desire to play the feminine part and thus may require further study. It is equally important to investigate any attempt by the patient at cross-dressing (man in woman's attire) or any attempt by him to demand from his partner ill-treatment, calling him abusive names, etc.

A forty-two-year-old musician had a peculiar condition of his potency—to have intercourse with the wife of one of his friends. Since the patient was only rarely able to fulfill this condition, he masturbated with the fantasy of being watched by the husband of his sexual partner during intercourse (triangle of latent homosexuality). He was once able to have intercourse with the wife of one of his friends, a dentist, in a room adjoining the dentist's operating room. The proximity and the danger of being discovered were the unconscious homosexual-masochistic stimuli he needed to se-

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cure his potency. It was as though he secretly wished to be discovered.

As in all paraphilias, this deviation had an infantile root. It was based on experiences from the patient's childhood, when he overheard parental intercourse and masturbated simultaneously.

Postcoital Reactions

Where intercourse is technically possible, reactions following it are of diagnostic importance. Although we know today that the old Roman proverb, *post coitum omne animal triste*, does not necessarily apply to humans, there are men who do show all sorts of negative reactions following intercourse, reactions which must be studied in detail. Some men become depressed, others have the feeling of repulsion, some drink excessively.

One of my patients, a handsome man of twenty-nine, regularly developed a severe antagonism toward his sexual partner, a feeling which began during the act and increased toward the end of it, so that he had difficulty in bringing the act to a close. It was torture for him to stay in bed with the woman for any length of time after the intercourse. Yet, a short time following the ejaculation, his mind would begin to wander, and he would contemplate intercourse with another woman. Its fate, in reality, would then be analogous to the previous one. Once the woman's cooperation was assured and intercourse undertaken, the same gamut of emotions would ensue, culminating in complete disappointment and disgust.

Analysis of this case revealed a strong hostility toward women in general, based on a repressed hate toward the patient's mother whom he suspected of having caused his father's untimely death. As a consequence, the patient had strong homosexual tendencies, an outgrowth of his repressed hate-fear of women. His "Don Juan complex" was an attempt by the patient to prove to himself that he was a man, and that women were desirable and not potential killers of their partners (like his mother).

Nocturnal Emissions and Masturbation

Nocturnal emissions occur in people who either have no sexual outlet (abstinence) or are, for some reason, flooded with sexual excitation. If a patient has no sexual intercourse and does not masturbate, nocturnal emissions are likely to occur. They play the part of safety valves by which surplus energy (like steam in an overheated engine) is automatically discharged. Through this discharge, the level of sexual pressure is lowered, and the sexual equilibrium is restored. Emissions of this type are usually connected with sexual dreams, although not all sexual dreams necessarily end with emission. For the psychiatrist, emission dreams are especially valuable because, in most cases, they carry traces of the so-called "specific sexual fantasy" of the patient.

Of special interest are nocturnal emissions which occur despite the fact that the patient has normal sexual relations and/or masturbates, that is, although no increased pressure of the sexual drive seems to exist. Such is the case, for example, if a nocturnal emission occurs the night following intercourse. Closer examination of the accompanying dreams will help explain this phenomenon in the specific case. We may find that the patient's "specific sexual fantasy" is not concerned with normal intercourse, and that parts of the sexual drive remain frustrated, to be gratified surreptitiously by way of the emission dream.

Persisting masturbation must be similarly explored. If the patient has a chance to perform normal intercourse and yet prefers to masturbate, then we assume that parts of his libido remain unsatisfied in the normal act. What the specific situation is that has to be invoked in the masturbation fantasy to fill the gap, is a subject which can be answered only by analysis. The specific masturbation fantasy is either conscious or it represents a part of the unconscious material to be elicited by dream interpretation. The details of this masturbation fantasy and the patient's specific disturbance may have a causal connection. This is particularly true in cases of paraphilia (sado-

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masochistic deviation, homosexualism, fetishism, transvestitic fantasies, etc.).

A forty-two-year-old chemist complained that he could not get an erection when in bed with a woman. He had been married twice before; his impotence was the cause of the breakdown of both his marriages, which ended with divorces. The patient had erections occasionally, especially in the morning. He had not had any contacts with women until he was twenty-seven. The reason for this was his fear of being impotent. His first physician encouraged him to get married, so he did, hoping that marriage would solve automatically his sexual problem. He had been in love several times prior to his first marriage, and was also in love with his wives. When the impotence persisted, he consulted several physicians, first a general practitioner, then a urologist, and finally a psychiatrist.

The inquiry about his masturbation fantasy (to which the patient replied under great resistance) cast a sudden light upon the case. The patient had masturbated since the age of thirteen, with a fantasy of a crippled woman. The fantasy woman had one leg shorter, or amputated, or one arm amputated, which made her movements laborious and clumsy. Whenever he saw such a woman, he had an emission, without having to touch his penis or having any contact with his object. In masturbation, erections were normal.

While it became clear that this disturbance was not a case of impotence but of a sexual deviation in which intercourse was not the goal, it was necessary to investigate analytically the psychology of the paraphilia. It was evident that what the patient characterized as "love," which he supposedly felt toward women, was a brother-sister type of relation and was apparently separated from the patient's sex life. All he felt for these women was a tender reaction of comradeship which did not go beyond that point.

The patient's paraphilia started with himself identifying with a crippled woman. He began tying his own leg, flexed at the knee, with a rope, and walking about in this clumsy fashion. This process was sexually stimulating and was accompanied by erections. The patient identified himself with wounded horses and even with the devil, who is described by some poets as limping. He wanted to have absolute power over women, and, since he knew that his self-consciousness would prevent him from having any outstanding success, he, like Faustus, sold his soul to the devil in exchange for that power. In his fantasy he was Mephistopheles. In one of his sessions he quoted the sentence which Freud used as the motto to his dream book—*"Flectere si nequeo superos, Acheronta movebo"* (If I don't succeed to influence the gods above, I shall try to move the gods of the underworld)—as being pertinent also to his case.

His first dream revealed that this patient harbored unconscious sadistic tendencies. It ran as follows:

"I borrowed a truck to use it over the week end. I was worried it might get damaged while I had it in use . . . ."

The analysis of the dream revealed the patient's fear of injuring his partner (truck) during intercourse (while in use). The further analysis showed that the patient's disorder had the purpose of protecting him against his own antisocial impulses, and that his marriages had twice rekindled his fears of violence toward his partner. The paraphilic fantasy which contained the picture of the woman on whom crippling violence had been committed before was one of the patient's own ways to neutralize and inactivate his "devilish" impulses. The crippled woman was a composite symbol. In his fantasy it was an end product of a sadistic assault, and, at the same time, it represented, as a warning image, a memento not to overstep the moral boundaries, the picture of castration. As stated above, the problem in this case was not impotence but a disturbed attitude of the patient toward the opposite sex.

The Partner

The personality of the partner and the patient's relation toward the opposite sex are the next questions to be discussed. Is the patient in love? Was he ever in love with his partner? How was their first sexual encounter? If the first intercourse happened to be a failure while the next ones were successful, what, in his opinion, were the inhibiting factors? How did his partner (wife) react to his initial diffi-

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culty? Was she patient and encouraging, or openly disappointed and/or derisive?

A woman can, under certain circumstances, make a man impotent. Expressions of reproach, derogatory remarks, indications of disinterest, or expressions of exaggerated anxiety may have a castrative effect on a sensitive man and lead to a lasting disturbance.

One of my patients, who was criticized by his sexually more experienced wife on their wedding night, lost his erection before the act and never was able to have it again—with this woman. He always felt toward her like a schoolboy who has been censored by the teacher.

Impotence of this type shows elements of revenge; it deprives the castrating woman of what she seems to value (or to need) and indirectly opens the way for an ultimate separation from an unacceptable marital partner.

Phallic women, especially those who have had previous sexual experience, often take over the conduct of the intercourse. They comment on the man's every move, tell him how to recline, how to regulate his motions—they wield his penis, as it were. The man, in the eyes of such women, is an unimportant appendix to his penis which these women use because they lack one of their own. They don't realize that most normal men want to feel that their partners appreciate their sexual approach as a "love offering" and want to feel that they are contributing to their partner's enjoyment. Any decrease of the man's feeling of masculinity may lead to a decrease of his performance.

A twenty-nine-year-old lawyer, who was sexually inexperienced, married an equally inexperienced woman. Her mother supplied her with the premarital instruction, one point of which was that the first intercourse was very painful and caused a severe hemorrhage. The girl was, nevertheless, ready to fulfill her marital obligations, no matter what the price. Before retiring for her wedding night, the woman placed all sorts of first-aid materials at her bedside—gauze, bandages, iodine tincture, and a washbasin with hot water. At the sight of these preparations, her husband lost all his sexual feelings. Because of the aroused castration fears, neither this nor subsequent attempts were successful.

The Patient's Own Theory

At this point we wish to know what the patient himself thinks about the cause of his dysfunction. We learn a great deal from the patient's answer to this question. Hypochondriacal ideas, fears of the consequences of past "sins" and "abuses," and all sorts of misconceptions regarding the current disorder may be elicited in this way.

Prognosis

The last question to be clarified concerns the circumstances under which the patient hopes to have intercourse after therapy. It is clear that the patient cannot consider himself cured "theoretically." Before the patient is discharged, he and his therapist may wish to have proof that the potency has been restored.

There are patients who have experienced their impotence in a premarital attempt and wish to be rehabilitated before they make their decision to get married. The situation in these cases may not be simple at all. Marriage will be rejected by such patients until they have regained the necessary self-confidence. However, they may be disinclined to risk "experimental" intercourse (with prostitutes or otherwise) for moral reasons. On the other hand, for the psychiatrist to declare after therapy that the patient "now can get married because the inhibitions have been removed analytically," entails a certain amount of risk and a moral (perhaps even legal) responsibility, which should not be underestimated.

¶ Two Types of Psychogenic Impotence

Anxiety Type

Patients themselves rarely know the cause of their disorder. Many rationalize it. They lay the blame to fatigue, business worries, etc. Others claim that they have "ruined them-

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selves" by "abuse" in their youth, and that "now it may be too late." The real reasons for this disorder lie deeper, however. Only few have the intuition of a Johann Wolfgang Goethe who once (about 200 years ago) himself experienced an acute case of impotence and was able to recognize its immanent psychogenesis.

Goethe described this event in his diary (*Tagebuch*) as follows: He was returning home from the city, when a wheel of his carriage broke. As the damage required prolonged repairs, the poet was forced to spend the night at a nearby inn. A young, attractive waitress caught his attention, and, on an impulse, he wanted to kiss her. She withdrew from his arms, however, and said that while she could not stay with him at that moment, she would visit him in his room at midnight. Goethe was full of pleasant anticipations when at midnight the young girl appeared at his bedside. Before she joined him, however, she made an astounding confession: She told him that she was a virgin, but that she was so impressed by his personality, that she had decided to give her first love to him.

At that point, Goethe experienced a peculiar and new, to him, sensation—he felt no sexual excitement. No matter how much he wanted it consciously and deplored his inability to enjoy something that was offered to him so freely, his situation did not improve.

Meanwhile, the tired girl fell asleep. Goethe was baffled. In his predicament he began to think of the success he had always had with his wife as his sexual partner. And while he tried, in his thoughts, to recapture the early spirit of his marriage, he became aware of the appearance of a strong erection. His sexual arousement disappeared promptly, however, when he attempted to approach the girl again.

Goethe jumped out of his bed and wrote in his diary the following words for the benefit of his wife:

> I was approaching my home, when the last hours threatened to move me away from you, my beloved. But then, on a peculiar place, and under peculiar circumstances, I have found back my faithful heart. You may not understand this and the following inference, beloved; but note the mysterious final verse: Often it is illness that helps to preserve our health.

The genius of Goethe made him realize that his impotence was purely psychogenic. Intuitively, he grasped the fact that the stimulus which suddenly rekindled his faded sexual desire had come from the thought of his wife. He recognized that the double challenge—infidelity and the defloration of a virgin—was too much for his sensitive conscience to bear. His super-ego was indeed a guardian of his virtue. Goethe pays tribute to this intrinsic moral force, when he says in the same diary, ". . . if a demon approaches us and tempts us —something happens and the virtue is preserved. . . ."

Impotence is a symptom of a common disease in our civilization. It affects men incomparably more severely than its equivalent (frigidity) affects women. While suicides are known to have been committed for this reason, especially in young men about to be married, suicides of women because of frigidity have hardly ever occurred. A few generations ago, women were often proud to be "above the animal level" of desiring sex.

Psychologically, we can consider every case of impotence as an expression of resistance against the performance of the act. As all neurotic symptoms, it has not only a cause but also a purpose. Stekel spoke of a "will to impotence" and considered it the last-minute effort to make intercourse impossible. The "will to impotence" stands in the service of antisexual, antifeminine tendencies. It is a precipitate of many fears, among which we find (1) fear of losing independence, (2) castration anxiety, and (3) fear of death.

1. Fear of losing independence is an outgrowth of our present civilization. It follows the association: intercourse, marriage, loss of freedom. Although some analysts consider this fear as another form of castration anxiety, it could also be viewed as a cultural factor, reflecting the modern man's fear of the responsibilities of marriage. In the deeper layers of the patient's mind, fear of losing independence through intercourse is based on the idea that

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the woman (more exactly her organ) bears hidden dangers, but these dangers do not necessarily represent a threat of castration. Man may consider his independence threatened by the fact that the woman exerts irresistible sexual influence on him.

2. Conscious and unconscious fear of venereal disease stands closer to the castration complex. Venereal disease is actually a damage to the male organ emanating from the female organ. However, even conscious castration fears may sometimes dominate the picture. They comprise fears of losing the penis in the act, or suffering direct damage to the organ. Fairy tales about cases of a *penis captivus* (a prolonged form of vaginismus which immobilizes the inserted penis in the female) that are supposed to have occurred in the past, have an almost global circulation.

Usually, the story has it that two people engaged in illicit intercourse are surprised by the sudden entrance of a third person, are shocked and, to their greatest embarrassment, are caught by a spasm of the woman's genital which prevents them from separating from each other. The phenomenon observed in dogs may be the basis for this story and also may be material for all sorts of anticipatory fears.

In reality, no such case has ever been reported in a bona fide scientific publication. No such case has ever been observed or treated by any reputable sexologist of the world. This story shows only the ubiquitous character of the latent castration fear in men, and of the fear of punishment for illicit sexual acts. Vaginismus hardly ever occurs after complete insertion. Its purpose is to protect a threatened organ (*défense musculaire*) and to prevent anticipated injury. We can elicit similar reactions of muscle spasm on McBurney's point (in appendicitis), on the shoulder part of the rhomboid muscle (in apicitis), and in many other regions in which a muscle group overlays inflamed and sensitive tissues. The defense loses its biologic purpose once a penetration has taken place. The specific structural and functional conditions in the dog's organ make it possible for dogs to be joined temporarily, after the ejaculation, by the spasm of the female's constrictor cunni, but this mechanism does not apply to man.

In some men, castration fears are easily aroused by phallic, that is, too-active, female partners. A woman who is too manipulative, too coarse, or lacking in feminine qualities may render some self-conscious men acutely impotent by arousing their homosexual and castrative fears. The impotence in such cases protects the man from imagined harm and/or from retaliatory aggression.

3. Fear of death may cause temporary impotence in individuals suffering from cardiac or pulmonary disorders. Such individuals are afraid lest sexual excitement bring about a fatal attack. Unconscious feelings of guilt usually play a part here, too. Having considered themselves as "marked" by fate, such patients unconsciously live in the expectation that, at some critical moment, punitive forces will take their toll. Intercourse mobilizes these guilt feelings together with fears of retaliation.

One of my patients, who was suffering from pulmonary tuberculosis, once experienced a severe coughing attack with hemoptysis following a petting session. When, some time later, he attempted intercourse, he was impotent. In analysis he admitted that he had never really overcome the fear that sexual excitement might bring about another pulmonary hemorrhage and even death.

This and similar—partly realistic, partly hypochondriacal—fears may account for the neutralization or paralysis of the sexual drive. The conscious thought, "I want," meets head-on with the unconscious command "I mustn't," and the result is "I can't."

The symptom of impotence can protect the individual against antimoral and antisocial id acts (Goethe) as well as against dangers to the ego (castration complex or fear of death).

The finding of a castration complex as a concomitant of oedipal strivings is too ubiquitous and too general to be accepted as a valid etiologic factor. We must be able to determine what gives this complex specific significance in an individual case. The patient's history and dream material, as a rule, offer the necessary clues.

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Some urologic operations, especially those connected with the use of sounds introduced into the man's urethra, and similar manipulations, may lead to a temporary increase of passive (feminine) tendencies, homosexual fantasies, etc., with the possible result that acute impotence ensues. (The urologic operation in man has been known to be an affect-charged experience, with repercussions often reaching farther than its topical character warrants.)

Of importance also are some of the patient's occasional hypochondriacal ideas concerning his physical appearance, which may lead to feelings of inadequacy. Foremost among them is the patient's idea that his penis is too small, or that the amount of his seminal fluid in ejaculation is insufficient. Examination may disprove the patient's complaints, without effecting any change in his outlook. Closer analysis then may disclose that the patient's feeling of inadequacy has sources other than his poor physical endowment. Lack of masculinity, latent homosexual trends, or fear of women are usually found behind this symptom. In reality, the length of the organ, especially in its flaccid state, is unimportant, for several reasons: (1) Many organs, while appearing undersized in the unerected state, reach normal proportions when erected. (And this is the only condition that counts.) (2) It is not the relative length of the penis that makes the difference in intercourse, but the relative degree of its engorgement, that is, the erection. (3) The length of the organ would be of importance if the woman's erogenous tissues, to be aroused in intercourse, were located in the back of the vagina, in its fornix rather than, as they are in reality, in its frontal part around the introitus. Anatomy teaches that the corpus cavernosum of the vagina straddles, as it were, the front part of the vaginal tube. (4) Barring a conspicuous disproportion between the male and female physiques, a gentle friction by the penis shaft should be sufficient to elicit an orgasm in a woman, even if the penis is of slender shape (small circumference). Under normal circumstances, the woman does not require a violent friction of the vaginal walls to be satisfied. (5) The capacity for orgasm in the woman is as much a function of her brain as it is in the man. It is the woman's psychic attitude toward the act that decides what kind and whose organ is satisfactory.

The fear of being sexually inadequate is often found in men who have an exceptionally good physique and are very popular with women. Their passive, narcissistic overvaluation of their appearance may lead them to a fear that in the sexual embrace they may not live up to the woman's expectations. As a consequence, they may develop fears of a sexual encounter or even outright impotence. Sexually, women, to them, appear as potential creditors who demand their due. Many men of this type develop unconscious feelings of hostility toward all women, an attitude which prevents them from displaying their normal sexual capacity.

Hostility toward women and various manifestations of the so-called "war between the sexes" account for many of the sexual dysfunctions in modern men. In the minds of such men, women may appear to be exploiting (gold diggers), dominating, faultfinding figures of whom they are secretly afraid. Much of this reaction stems from real life situations, from oedipal taboos, and from traumatic experiences, but much depends also on the cultural interrelations between the sexes. The man is most potent if he is most relaxed and least suspicious. Man's potency is lowest if he suspects entrapment, or if he is made to feel that, by yielding to his sexual desires, the woman has granted him a favor he does not really deserve. If a man has married this type of woman, then it still remains for the analyst to explore why he has made this choice.

One of my patients, a forty-eight-year-old man, complained that his wife demanded of him a "romantic behavior" from the early morning on, if he was to approach her at night. She claimed that otherwise she did not get into the proper mood for intimacies. The man was so anxious to be romantic all day that by night he was pretty tired and disgusted with his enforced part of a Romeo; he was then hardly in a condition to have relations.

A few words now about the so-called old-age

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impotence. Statistical data in this respect must be taken with a grain of salt. Theoretically, the limits for sexual potency cannot be established with validity. Much depends here on circumstances, the state of health, and autosuggestion. Although we may assume that a certain degree of decline in sexual interest normally takes place between marital partners who have been living together for many years, this factor alone is rarely the cause of a complete sexual insufficiency in man. Many men who are in their late fifties begin to show the inclination to "save" their sexual power, as though it were an irreplaceable material with which they have to economize. They develop typical symptoms of a hypochondriacal neurosis. They lengthen the intervals between the acts, increase the emotional distance from the opposite sex, and, with the declining degree of physical and mental attraction, gradually lose their potency. When Kinsey speaks of the fact that, at seventy, 30 per cent of men are sexually completely inactive, this may be statistically correct, but it is subject to changes. Psychiatrists with adequate experience in sexology know that the best way to preserve normal function to a relatively old age is to retain a healthy attitude toward sex in general, to practice sexual relations regularly, and to keep the intervals between episodes relatively short.

Compulsive Type

CHASTITY CLAUSE

Among the unconscious causes of impotence, none is more baffling than the secret chastity clauses by which some individuals attempt to render their sexual life less complicated. Unless a chastity clause is brought to light and worked out analytically, cases of this type may remain incurable. Religious people may, in hours of grave mental anguish, make vows of chastity, to which they then adhere, even though these vows meanwhile have lost their meaning and have disappeared from their consciousness.

Strong incestuous fixations, particularly those based on actual incestuous relations, are often behind this readiness to sacrifice sex. They may tie a man inseparably to the incest object, with the result that no other woman can attract enough of his interest to herself to replace the original object fixation. This is especially true with cases where the self-punitive element is one of the psychodynamic motives of impotence.

Some of the chastity clauses go back to the youthful struggle against masturbation. They may retain their inhibitory force in the patient's unconscious even after the conscious struggle is over. Anxieties may then go underground, may assume the character of hypochondriacal anticipations, or the like, but they will affect the patient's relation to the opposite sex.

DEATH CLAUSE

The second of the compulsive types of impotence is that based on the secret death clause: "If you have successful sexual relations, you (or someone else) will die." We have touched upon this subject in our discussion of the castration complex. On the unconscious level the intercourse may be considered as a challenge to the super-ego, inviting extreme retaliation. This is the case primarily if the underlying sexual object is a tabooed one; but even if this is not the case, early religious, puritanic influences may lead the patient (in his unconscious) to consider intercourse as an unpardonable sin and to mobilize self-punitive tendencies or fears of divine retaliation.

One of my patients kept himself in the condition of chastity by means of impotence in order to preserve magically the chastity of his sister. The analysis proved the existence of a magic "junction" between the patient and his sister; in their fantasy, they were like husband and wife. Neither was able to get married—she by choice, and he because of his impotence.

Only through analysis can one elicit such ideas which act from the patient's unconscious to obstruct his sexual function. In the case mentioned, it was the sister's death which ultimately made it possible for the patient to break the magic lock—one of the more fortunate coincidences of analytic practice.

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¶ Therapy

Psychic impotence requires dynamic and rather active forms of psychotherapy. The prognosis is, on the whole, good, and suggestion, which plays a great part in the origin of the disorder, plays its role also in the results of therapy. The task of the therapist is to recognize the nature of the inhibition, that is, the reflex-obstructing, affect-charged ideas underlying the dysfunction, and to help the patient overcome the inhibition. Anxiety, hostility, and guilt feelings are among the affects involved.

From what was said before, we can see that the therapist cannot add much to the patient's sexual strength; what he must do is to remove something that inhibits the patient's performance as a pebble between the cogs of a cogwheel interferes with the normal revolutions of the wheel.

The Partner

Therapy is limited by two factors—the partner and age.

As mentioned above, the woman, through the way she participates in the act and through her general demeanor, can decisively contribute to the man's success or failure in intercourse. If the woman is inaccessible to medical counsel, the man's chances of recovery—with this woman—may be seriously affected. Since intercourse is a matter of two people, we should have a chance to obtain a deposition by the other side and to get an independent idea of their mutual relationship. However, this may prove not feasible. The lack of cooperation on the part of the patient's partner can be so thorough that a direct invitation by the therapist to see him in his office may be flatly rejected.

The wife of one of my patients refused to accept my invitation with the statement that she did not need any "additional sexual enlightenment," and, since her husband was the one who was ill and in treatment, I would do well to concentrate on him. From this reaction as well as from the patient's description of his marital relationship, it was clear that the woman had no interest in her husband's recovery. She was glad that he was impotent, because she was not only free from his (annoying to her) sexual approach but she also had a welcome weapon with which she could humiliate and insult him. She was a frigid woman who, in conversations with her husband, was always complaining about the "exaggerated" sexual needs of men ("all men are beasts") and who liked to bask in her idea that she herself was above these base instincts.

I have been more successful by inviting the patient's partners to "help me understand better the patient's condition," to "make his case history more complete by adding to it her views," or by using similar phrases to stimulate the woman's interest in cooperating with therapy. (In general, a partner feels flattered if she has the opportunity to contribute something to the doctor's understanding of the mate's case. Once the woman is in our office, all pertinent problems can be discussed.) The woman's feelings of guilt, of inferiority ("with another woman he is potent; I am not attractive enough to him"), and similar reactions, may at first prevent her from exposing herself to the doctor's scrutiny. Her ego is bolstered, however, if he approaches her with a tactful request for assistance.

If the psychiatrist recognizes that the partner also requires therapy, then another therapist has to intervene in her behalf. Both therapists then proceed with their respective tasks, and they need not worry that they may not proceed synchronously. Conferences and consultations, in most cases, either will be unnecessary or can be reduced to a minimum. If they do take place, both therapists must be aware of the fact that they are treating not the marriage but two separate individuals, whose individual problems may be completely different. Greatest care must be taken not to yield to the pressures of the two marriage partners who would like to see the therapist in the role of an umpire, coordinator, and adjuster of their marriage. If the same therapist is handling

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both partners, attempts to influence the other partner through the analyst will invariably be made—at the expense of a systematic and effective personal analysis. The two patients should, therefore, be treated independently, and the two therapists will do well to concentrate on their own respective cases, with the hope that they can succeed in removing the essential personal conflicts which are impeding the normal development of the marital relationship. The problems in question may lie on different levels and require a different length of time and different approaches. It is only in the therapeutic goal that the therapy of both coincides.

A forty-year-old woman, in analysis with a reputable psychiatrist for a complicated personality disorder, complained that her husband did not satisfy her sexually, because he suffered from a premature emission. He was referred to me for therapy. His difficulty was removed in less than one year of treatment, but his wife's sexual response was not much improved. There was no indication for a termination of her treatment at that time. As years passed and the marital conflicts did not abate, she accused her husband of being at fault because he was not in therapy. She demanded several consultations with leading psychiatrists to prove that he needed additional treatment and kept on calling me with various complaints about her husband. I invited the man repeatedly to visit me in order to evaluate whether any traces of pathologic behavior could be found in the patient's relation to his wife, but I was unable to detect any. On the contrary, I was more and more convinced that the patient's wife, a severely sick person, in her extraordinary narcissism, considered as a major personal defeat the fact that her husband was finished with his treatment while she was still in therapy. Rivalry between husband and wife characterized this marriage from the very beginning. She was the daughter of a wealthy industrialist and could not accept the fact that her husband, who was once a "poor boy," had found a "soft spot" in her father's business. It was hard for her analyst to restrain her from incessant attempts to prove that the difficulties in her marriage were entirely his fault.

Age

Another limitation in the treatment of impotence is age. This does not mean the absolute chronologic point at which the prognosis begins to be unfavorable; it is governed, rather, by the relative state of health and the social circumstances which accompany the advancing years in a man's life. An elderly man may be sexually less attractive, may be suffering from all sorts of intercurrent discomforts of his age, such as greater fatigability, more apprehensiveness, more self-consciousness, discouragement, or even functional difficulties due to vascular or prostatic changes, but, as stated above, he may not show a distinctly lowered potency.

Psychotherapy of elderly patients, as a rule, is less promising—regardless of the neurosis involved—because they are not as flexible, not as ready to change their habits and traits as are younger individuals. The same applies to the chances of psychotherapy of the so-called "old-age impotence," although remarkable results of dynamic psychotherapy can be seen in some cases of this type.

Old-age impotence must be considered as unfavorable prognostically if it has existed for many years. While in younger individuals even a prolonged duration of impotence may come to an abrupt end, in older people, prolonged insufficiency creates, as a rule, so many secondary characterological changes and becomes so fixed as to be irreversible.

A fifty-nine-year-old physician had suffered from ejaculatio praecox since his early manhood. In addition, he showed various personality changes of a compulsive-obsessive character, and he was unable to establish a regular relationship either in his sex life or in therapy. He was married but had been separated from his wife for years, and even when he joined her geographically, he did not consider himself bound sexually to her. In his continuous promiscuous relations the pattern of premature emission remained unchanged. He failed to profit from psychotherapy, in which he did not believe, but he adhered to all sorts of faddist dietary regimes.

The experienced therapist does not promise

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cure, despite the value of such suggestive influence. However, the therapist must be firm and persistent in the face of the patient's discouragement, and must pursue the search for the unconscious pathogenic elements of the patient's neurosis.

While this is done, the therapist must gradually eliminate any individual fallacies concerning sex that the patient may harbor. It is not only indicated but is of definite value to make sure that the patient has correct ideas concerning sexual hygiene, masturbation, female anatomy and psychology, contraception, and all the problems involved in mature sexual relations, with all due consideration paid to the specific cultural, religious, and personal conditions existing.

It is regrettable that, despite analytic penetration and working through the individual problems of the patient, some cases of impotence remain unchanged. It is as though the impotence in these cases had become a habit, a fixed experience, a "pattern of defeat." To prevent such reactions and to counteract the patient's autosuggestion of failure ("I cannot"), at the beginning of therapy it is desirable to discourage intercourse attempts. (The patient must inform his partner about this.) One advantage is obvious: The patient spares himself additional disappointments, which previously reinforced his autosuggestion of failure. The other advantage lies in the fact that the fixed idea "I cannot" shifts—by doctor's orders—to "I mustn't." The experience teaches that it is easier to break the bond of a prohibition than that of a fixed idea. In many cases the artificial taboo is soon broken, the patient performs a normal intercourse, and the analytic work can proceed more auspiciously.

This method does not apply to cases of ejaculatio praecox or those where chastity or other clauses guard the patient's sexual activity. In the first case, we do not profit from expanding the patient's abstinence; in the second, sexual inactivity is the patient's unconscious goal anyway.

The chances are better when both partners are available for counsel or therapy. It is a poor policy to treat a sexual dysfunction "in a vacuum," as it were. To declare the analysis as finished and the patient as "ready" to go ahead and start looking for a suitable partner is a risky proposition. Even after a thorough analysis, many complications may still develop on the road to practical adjustment, and these must be dealt with as they occur.

An organic therapy of the psychogenic impotence is inadvisable for many reasons:

1. An endocrinologic treatment is justified only if proof has been established that a glandular deficiency exists. This expensive treatment remains otherwise unsuccessful. In some cases it may be harmful (carcinogenic). In cases where impotence serves as protection against antisocial tendencies, a sexual stimulant—even if it were effective—would be undesirable.

2. Drugs (introduced orally or parenterally), diathermy, prostate massage, instillations, sounds, etc., are contraindicated, except in cases in which psychotherapy is not feasible. They draw attention to an already overcathected organ; they cause the patient to expect help from mechanical devices without making an effort to effect changes by himself; they foster passive, feminine, and receptive, rather than active, masculine, penetrative tendencies.

We must not forget that psychogenic impotence is not a disease of the genital apparatus. Huhner and others, who pointed out that in many cases of impotence "chronic congestion" existed in the verumontanum, did not take into consideration that congestion, even if diagnosed, might have been a product of overstimulation of a functionally inactive organ, and that it would disappear without local therapy once normal intercourse had been resumed. The same can be said about the so-called Huhner operation (ligation of the dorsal vein). Its occasional success can be considered as purely suggestive.

Aycock[1] suggested cocainization of the glans penis, prepuce, and adjacent shaft to combat premature ejaculation. Intercourse with an anesthetized penis, even if possible, is not to every man's liking.

Psychotherapeutic methods such as sugges-

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tion (hypnosis), if effective at all, prove to be short-lived. As a rule, they do not reach the level of the patient's personality on which the pathogenic forces operate.

For similar reasons, a combined organic and psychic therapy must be rejected. The organic therapy appears to confirm that an organic disturbance is responsible for the dysfunction. Such ideas cannot be accepted without jeopardizing the psychogenic concept. Therefore, a combined therapy cannot but weaken the impact of psychotherapy.

After the patient has had his first successful intercourse, the psychotherapist should not express too much surprise. It is advisable to say casually: "You have now seen that your conviction of being impotent was wrong. Any man may fail under adverse circumstances."

However, this is not a point at which we can discharge the patient. The analyst must make sure that the success has a chance to be rooted, that all potential pitfalls have been discussed and worked through, and that the patient's self-confidence has been strengthened sufficiently to permit him to navigate on his own.

¶ Impotence and Marriage

We consider it a rule that the man's disorder must be treated before marriage can be contemplated. Marriage should never become a therapy. Only in exceptional cases can marriage be encouraged before the disorder has been eliminated, namely, if the moral and social circumstances make premarital ("test") intercourse impossible. But even then, the therapist will do well not to suggest marriage directly or to take any responsibility for its outcome. A good way to handle this special situation is to remark that, according to the analytic findings, the best possible condition for the man's potency lies in a marital union. Of course, such a statement can be made only after an extensive study of the case and after a thorough evaluation of all pertinent factors.

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CHAPTER 37

SEXUAL FUNCTIONS IN WOMEN AND THEIR DISTURBANCE

Therese F. Benedek

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THE AIM OF THIS CHAPTER is to present the interaction of physiologic and psychologic factors in the sexual functions in women and to demonstrate the dynamic principles of the psychopathology related to the female reproductive functions.

¶ Introduction

Psychoanalytic theory is based on the axiom that motivational forces originate in organic sources. The spectacular experiments, around the turn of the century, regarding the sexual glands seemed to confirm Freud's early assumption that the sexual drive and its concomitant psychic energy (libido) originate in a specific "sexual chemism." Freud[28] established his concept of the role which sexual energy plays in the development and integration of the personality. He limited his formulations to the observations obtained by psychoanalytic method and expressed the hope that endocrinology would hold the answers to the problems of normal and abnormal sexual behavior. In the same publication he formulated a sequence of psychosexual development from infancy on. Freud's thesis of infantile sexuality, a basic tenet of psychoanalysis, was at variance with both the general medical and the psychiatric thinking as well as with the results of endocrinology.

After isolation and synthesis of the steroid hormones, experiments on lower mammals seemed to confirm the thesis that sexual behavior is under simple chemical control. It was established that in lower mammals the cyclical function of the ovaries governs sexual behavior. Mating occurs at the height of the periodically recurring estrus (heat), which is recognizable in the animals' activities leading to copulation. Observations in primates, how-

ever, reveal discrepancies in the proportional relationship of gonadal function and mating behavior. Primates can be stimulated to sexual activity by a variety of factors independent of estrus. In man the complex and variable stimuli which motivate sexual behavior may almost completely conceal the physiological cycle. Further investigations regarding the function of gonadal hormones revealed that sexual behavior cannot be explained simply in terms of gonadal function. It is known that gonadal hormones are absolutely necessary for the completion of the maturational processes which lead to procreation. One assumes that the physiological role of the gonadal hormones is defined by a genetically determined responsiveness of the nervous mechanisms, and that hormones are merely facilitating agents which increase the reactivity of the specific neuromuscular system to stimulation; thus, they influence the thresholds of response patterns.[5] In man the primary reactivity of the nervous system to internal and external stimuli becomes highly complicated by environmental factors which modify the stimuli interacting with the organism, causing variations in the personality organization. These, in turn, account for individual variations in the responses to stimuli.

It is the specifically human quality of the psychic apparatus that allows for the variability of behavior patterns in response to hormonal stimulation. Psychoanalytic theories which bear upon these phenomena are usually presented from two viewpoints: one refers to the theory of instincts, the other to the theory of personality development. In Chap. 3, which deals with the theory of instincts, such processes as repression, displacement, symbolization, etc., are discussed. These processes, functioning unconsciously, make human instincts appear plastic and adaptable. Chapter 69 describes the development through which each individual, in the process of attaining sexual maturity, incorporates in his psychic apparatus the controlling functions of his ego and super-ego. As the super-ego develops in each individual, as a result of the interaction of the organism with its environment, it also participates in the organization of the sexual drive toward its mature function. In the transactional processes between sexual maturation and personality development, the physiologic substratum of the sexual drive may become disguised; the pattern of its organization and response may seem to be motivated by psychic processes so far remote from its physiological substratum as to appear independent from it. Another science—ethology—revived the interest of psychoanalysts in the theory of instincts. While there is a trend to emphasize what differentiates man from other mammals, it is to be hoped that careful studies of the psychologic and hormonal processes will elucidate the hierarchical organization in the chains of motivation of human behavior.

¶ Developmental Factors

The sex of the individual is determined at the time of fertilization of the egg through the chromosomal make-up of the gametes (the egg and the sperm nucleus). Through this, the embryo is endowed with a potentiality to develop toward one sex. All the necessary rudimentary tissues for the development of both the male and female sex organs are present in every embryo. Embryonic hormones (estrogens and androgens) and embryonic organizers[16] direct the maturation of the sex patterns toward the sex which, after the ninth week of gestation, begins to be recognizable to the embryologist as the sex of the individual determined at conception. There is evidence, however, that this development is not completely safe and secure. Experiments show that sex patterns can be reversed by inundation of the embryo with hormones given to the mother during pregnancy.[10] Thus, "sex intergrades" develop not on the basis of gene-determined heredity but by "external" hormonal conditions. This accounts for various degrees of bisexuality at birth.[33] In the neuromuscular and psychic structures of both sexes remain rudimentary patterns of response and activity characteristic for the other sex. (The significance of the clitoris for the psychosexual

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development and experience of women indicates that this may be more true for the female than for the male.) In our further discussion the term "bisexuality" refers, however, not to any physical form of sex intergrade, but to a specific predisposition for certain psychologic reactions to environmental influences which exert control over the further development of the personality.

The environment of the newborn is defined in a significant way by the still-existing symbiosis between mother and infant. Through lactation the mother transmits some of her hormones to the infant. But more significant is the fact that, through lactation and other activities of mothering, there exists a reciprocal interaction between mother and infant which determines the meaning of the primary identifications with the mother and the primary ego-structures which result from them.[10] When the infant integrates the memory trace, needs are gratified; with his developing confidence in his mother, he establishes confidence in his own well-being, in his thriving, "good self." With memory traces of frustrating experiences, he integrates the image of the frustrating mother as "bad mother" and himself as a crying, frustrated "bad self." These primary ego-structures, originating in the rudimentary emotional experiences of early infancy, are significant for the infants of either sex. Since the development of the male does not interest us here, it suffices to say that in the girl the primary ego-structures determine the emotional content of later identifications with the mother. The innate femaleness of the girl directs her development in step-by-step identification with her mother. The positive psychologic balance of the early alimentary phase, which accounts for confidence, facilitates a relatively conflict-free development toward the female reproductive goal. The incorporated reaction to frustration (ambivalence), on the other hand, charges the mother-identification with hostile tendencies which interfere with the development toward femininity. It brings about a development in which, because of the wish to reject femininity, the bisexual tendency becomes preponderant. Such an outcome of the girl's identification with her mother demonstrates the psychologic factors in bisexuality.

As far as our present knowledge goes, hormones play no discernible role in the psychic manifestations of pregenital development. Children of both sexes excrete in their urine both androgenic and estrogenic hormones. These remain on a low oscillating level until the age of six to seven years, when there is a fairly sharp increase in the hormone production in both sexes.[19] There is no evidence of an increase in hormone production in correlation with the oedipal phase of development.* The marked upward trend at the age of six to seven coincides with the beginning of the latency period. Both hormones show a slow and steady rise until the age of ten to eleven. However, neither the testes in boys nor the secondary sex structures in either sex show any acceleration in growth until after that time. This indicates that the hormone production during the latency period is extragonadal, originating in the adrenal cortex rather than in the gonad.†

The latency period slowly evolves into the period which Helene Deutsch[18] defined as prepuberty and characterized as the girl's "last stand" against femininity, which, in turn,

* There are investigations which report on the excretion of estrogenic and androgenic hormones as beginning at the age of two to three years.

The oedipal phase is referred to here only because of its significance for the intensification of bisexual tendencies. The prephallic development may determine the girl's tendency to identify with the opposite sex as a defense against heterosexual impulses. Through the intense wish to have a penis, the clitoris becomes highly cathected. In consequence, the psychosexual development remains fixated in the phallic (pregenital) level of organization. This interferes with an undisturbed development toward reproductive maturity.

† We may speculate whether the extragonadal steroid hormones have other than sexual functions. The study of the sexual cycle reveals that, corresponding to increased estrogen production, the ego appears to be supplied with more energy, which is manifested in an increased strength of the ego. The positive response of the integrative capacity of the ego to estrogenic hormones (androgenic hormones have the same effect in both sexes) is an impressive corroboration of Freud's concept that libido is a psychic energy aiming at greater integration. During the latency period the personality enlarges its field of action externally and stabilizes its organization internally. It is not impossible that in these processes the extragonadal steroid hormones (in synergy with the corticosteroids, etc.) have some function.

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gradually gives ground as the physiological maturation proceeds. From puberty (the appearance of the physiological signs of sexual maturation) until full functional maturity is attained, several years pass. Puberty is induced by the function of the anterior lobe of the pituitary gland which secretes a gonadotrophic hormone. This stimulates the ovaries to produce estrogenic hormones and to promote the growth of the ovarian follicles. At about the age of ten to eleven years girls show a marked rise in estrogen production but not in androgenic substances. Estrogenic hormone is the hormone of preparation. Produced from childhood on, at the time of early puberty its function is to stimulate the growth of the secondary sex characteristics and the genital organs. Estrogenic hormone levels continue to increase and later assume a cyclic variation as a consequence of the rhythmic ovarian activity, which is brought about by ovulation. Estrogens thus prepare the uterus and maintain it ready for the changes that will be imposed upon it by the corpus luteum.*[15]

Menstruation

Menarche—the first menstruation—may occur at any time from the beginning of puberty through adolescence. The onset of menstruation takes the central place among all events of the girl's puberty. As if menarche were a puberty rite cast upon women by nature itself, it is expected to be accompanied by intense emotional reactions. However, the anticipation of menstruation, as well as conscious response to it, are influenced by cultural factors. In our present civilization, education and hygiene prepare the girl for the menarche in a sympathetic way. This seems not only to diminish the manifest rebellion against menstruation but makes the girl expect it with eagerness. Yet the bleeding and the discomfort may stir up latent anxiety (originating in the bisexual aspect of development). It was one of the early psychoanalytic observations that women connect menstruation with the idea of mutilation. Even mature women may dream about bloody acts which they commit or which are committed upon them about the time of menstruation. This type of anxiety dream indicates that menstruation represents injury to the woman. But whether the injury necessarily means castration in the sense of penis envy remains to be investigated in each case. Menstruation forecasts the pain of defloration, and even more significant injuries connected with childbearing. It enforces the awareness of the uterus through more or less pain and discomfort. At the same time, it activates the process of integration of the latent partial identifications with the mother toward the future task of childbearing. Fliess[23] recently formulated this theory by calling attention to the womb (*Gebär-mutter*) as a symbol of the mother. When menstruation stimulates the awareness of the uterus as an integral part of the body, "mother enters the body" (*ibid.*, p. 216). The next step in the girl's development is to accept "mother = womb" as a part of the self, and with it to accept herself as a future mother and motherhood as a goal of her femininity. The maturation toward the female reproductive goal depends upon the previous developmental identifications with the mother. If these identifications are not charged with hostility, the girl is able to accept her heterosexual desires without anxiety and motherhood as a desired goal. This, in turn, determines the girl's reaction to menstruation. If the feminine sexual function is desired, the girl accepts menstruation without undue protest. In contrast, if the phallic (bisexual) fixation dominates the psychosexual development, the hostility toward the mother continues as a protest against menstruation, and also against other aspects of femininity.

The onset of menstruation used to be taken as a sign of sexual maturity. It is now accepted that menstruation begins in most girls before their ovaries are capable of producing mature ova, and ovulation may take place before the

* It should be emphasized that the sex and psychosexual development are not the function of estrogenic hormones alone. In cases of ovarian atresia, the woman may remain underdeveloped physically and emotionally, and certainly she does not menstruate or bear children, but she is neither a male nor a neutral individual but still a woman.

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uterus is mature enough to support normal gestation. This brings about a period of adolescent sterility* (Pratt,[41] p. 1277).

Knowing the adolescent's struggle for achieving psychosexual maturity in our society, one is inclined to assume that the processes which lead to super-ego development, that is, to the incorporation of parental and cultural inhibitions, necessarily lead to a delay of the physiological maturation of the reproductive functions. Yet the correlation is not a simple one. While arrestation of physiological maturation may occur on the basis of inhibiting emotional factors, one cannot make the generalization that the stronger the prohibitions, and the related anxiety and guilt, the longer will sexual maturation be delayed. In this regard, constitutional, genetic, and intrauterine influences may determine the effectiveness of the emotional factors. If all variations were to be arranged in a continuous series, at one end would be those cases in which the stability of the physiological processes is such that normal reproductive maturation is not influenced by emotions, and at the other end would be those in which emotional factors can permanently arrest maturation. The greatest number will lie between the extremes and present a variety of disturbances in sequence and coordination of the various phases of the sexual functions. Correct psychosomatic diagnosis tends to evaluate the proportionate relation and interaction of organic and psychologic factors in each symptom. This general principle of psychosomatic pathology is pointed out here in connection with menstruation, since we look upon menstruation as a cornerstone of female development, a focal point where physiologic and psychologic factors meet and reveal whether the adaptation to the sexual function will succeed or fail. Here again, it should be emphasized that the great majority of cases lie in the middle range and succeed in overcoming initial symptoms and intermittent difficulties.

* Young and Yerkes[46] collected data on chimpanzees indicating adolescent sterility. There appear to be differences in the timing and coordination of the physiologic processes of the reproductive function, even if maturation is not complicated by psychological factors imposed upon the individual by sexual restrictions. Concerning human development, adolescent sterility was detected at first in civilizations where there is free sexual play and copulation between adolescent males and females.[28]

¶ The Sexual Cycle

In woman, the ebb and flow of the gonadal hormone production renders the interaction between endocrine functions and psychodynamic processes accessible to study. The first such investigation was published by the author in collaboration with B. B. Rubenstein.[12] In spite of the complex and variable superstructure of human personality, it was demonstrated that the emotional manifestations of the sexual drive evolve in correspondence with the ovarian hormone production; the gonadal cycle and the psychodynamic response pattern represent a psychosomatic unit—the sexual cycle.

The cycle begins with the gradual production of estrogen; parallel with this the emotions are motivated by an active object-directed heterosexual tendency. Its biological aim is to bring about copulation. The estrogenic phase is usually accompanied by a sense of well-being and alertness. The normal manifestations of the heterosexual tendency are easily recognizable in dreams and fantasies, in conscious emotional attitudes as well as in behavior. If the desire is not satisfied, the emotional tension may increase; restlessness and irritability are often signs of thwarted sexual urge in adult women. For the psychologist it is important to recognize the heterosexual tendency in its disguises as it appears in immature or inhibited individuals. In these persons, parallel to the increasing hormonal production, the characteristic defense against sexuality can be observed; anxiety and hostility toward men may express heterosexual tendencies by covering them up.

About the time of ovulation the active sexual energy fuses with the passive receptive tendency and creates the highest level of psychosexual integration, that is, the biological and emotional readiness for conception. If frustration is anticipated, the increased physio-

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logical tension stirs up suppressed conflicts; these may be expressed through dreams and fantasies and may bring about exacerbation of symptoms. In the enhanced libidinal readiness, or if this is thwarted, in the increased emotional tension, the preovulative phase can be recognized.

After ovulation the tension is suddenly relieved, and a period of relaxation follows. Ovulation is a unique physiological event, since it is accompanied by systemic reactions. Of the physiologic signs of the systemic reactions, the best known is heightened basal body temperature. On the psychological side, a sense of relaxation and well-being seems to flood the woman with libido. As if the psychic apparatus has registered the somatic preparations for pregnancy, the emotional concern shifts to the body and its welfare. This is a high-hormone phase, since both estrogen and progesterone are produced. Yet the active heterosexual tendencies appear to be masked by psychological expression of the preparation for motherhood. Parallel with the preparation of the uterine mucosa for nidation, the emotional manifestations of intensified receptive-retentive tendencies represent the psychological preparation for pregnancy. Correspondingly, the overt behavior, as well as dreams and fantasies, reveal the wish to receive and retain. The manifestations of the emotional preparation depend on many factors such as age, the level of emotional maturity, and external conditions such as marital status. (Economic insecurity may turn the wish for pregnancy into fear.) In neurotic individuals and in growing girls, the tendency toward childbearing is often expressed as a wish to be a child and be taken care of by the mother, or it may appear in conflicts, complaints, and frustrations about inadequate love and care. Generally, the psychologic material of the progesterone phase in adolescents is characterized by the repetition of conflicts related to the mother in various phases of development. Mood changes, overeating, and/or anorexia may occur during this phase of the cycle. As the physiologic and emotional maturation progresses, the progesterone phase reflects the "reconciliation" with the mother, the resolution of the conflicting tendencies toward motherhood. The psychological material reflects the mature woman's wish for childbearing and her tendency to give and to take care of children.

Upon the decline of progesterone production, the premenstrual phase follows. Parallel with the diminishing hormone production, a regression of the psychosexual integration takes place; pregenital manifestations of urethral, anal, and genital eliminative tendencies motivate the psychodynamic trends. Very few women are completely free from mood changes and from discomfort during this part of the cycle. The symptom manifestations show great variation. Apprehension of what will happen to one's body, fear of mutilation, and recurrence of other infantile sexual fantasies may give rise to anxiety, excitability, and anger. In other cases, fatigue, crankiness, sensitiveness to being hurt, or weeping spells indicate a calmer but not much more agreeable condition. The psychodynamic regression and the generally increased irritability of the sympathetic nervous system are manifestations of "the moderate degree of ovarian deficiency of the premenstrual phase" (Hoskins,[38] p. 295). These factors are responsible for the fact that at this time all needs and desires appear imperative, all frustrations seem unbearable; the emotions are less controlled than at any other time during the cycle. While this explains the "recurrent neuroses of women,"[14] it is significant also for the manifestations of sexual behavior. The heterosexual desire which is stimulated by the estrogenic production of the premenstrual phase often appears more intense and demanding than the sexual desire at the peak of the cycle (ovulation).*

The end of the sexual cycle is marked by menstrual flow which, ushered in by a sudden decrease of hormone production, continues for several days. Soon after the flow is established, the tense and fearful mood relaxes, the excitability decreases. It seems that adult women accept the menstrual flow with emotional

* Comparative analyses of the heterosexual drive in the different phases of the cycle show that during the ovulative phase the sexual desire is modified by passive receptive tendencies, and during the late premenstrual phase by eliminative tendencies which may account for the urgency of the sexual wish.

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relief. The depressive mood usually lasts longer than the premenstrual excitability, and continues during the first days of the flow. Women then recall sad experiences and talk about death and abortions. The mood and the content reveal a regret over failure in achieving pregnancy. In other cases, or in other cycles, the mood is dominated by inferiority feelings; the women depreciate themselves and the female genitals which they feel are worthless, and complain about menstruation which is regarded as superfluous, senseless, dirty. This depressive mood usually continues until the new estrogen phase re-establishes itself. After a few days, normally during the flow, the estrogen development begins, and parallel to it the state of well-being recurs. This, with the increasing sexual desire, suggests the beginning of the new cycle.

This schematic outline of the sexual cycle suffices to demonstrate that the gonadal hormones force the emotional processes of the adult woman into regulated channels. On the other side of the ledger is the influence which emotions exert upon the hormonal cycle. A comparative study of a series of cycles in the same woman reveals the effects which stimulating and inhibiting emotional factors have upon the course of the gonadal cycle. It is well known that emotions may precipitate or delay the menstrual flow; less known is the fact that the time of ovulation also may vary under emotional influence. For example, gratifying or exciting heterosexual intercourse may facilitate ovulation, while sexual frustration or fear of childbearing may inhibit it. The variation in the time of ovulation is such that probably no immutable period of infertility exists in the human species (although this condition is approximately reached in the last week preceding menstruation). Besides such direct and immediate effects of emotions upon the hormonal cycle, psychic factors exert a long-term (developmental) influence on the gonads. The comparative study of the sexual cycle of several individuals reveals that the pattern of the cycle unfolds in interaction with the constitutional and environmental factors which determine the developmental organization of the personality. In the evolution of the gonadal cycle, estrogen production is necessary for the completion of ovulation and for the ensuing progesterone phase. Similarly, in the integration of psychosexual maturity, the capacity for heterosexual love prepares the woman for acceptance of the feminine sexual role, and, with it, not only for the physiological processes of childbearing but also for its emotional manifestations in motherliness. Just as the psychosexual maturation is an interrelated sequence of physiological processes, so the phases of the sexual cycle represent a transactional sequence, one phase determining the course of the other. Thus, the gonadal cycle shows individual patterns. The length of the cycle, the time of ovulation, the frequency of anovulatory cycles, menstrual symptoms, etc. appear to be peculiar to the individual. The most obvious characteristic of the cycle is the interval between menstruations. The average length is twenty-eight days. But the normal range extends from twenty-one to thirty-five days. Careful investigations, however, show that there are always slight variations in the length of the cycle even in those women who seem to be certain of their regular twenty-eight-day cycle. Most revealing for the pattern of the hormonal cycle is the intricate relationship between the estrogen and progesterone phases of the cycle.

Progesterone is the hormone of maturity.[15] While estrogen—the hormone of preparation—is produced in varying degrees from infancy on, progesterone appears only after puberty as a function of the ovum. It is understandable that its relation to estrogen production, its relative deficiency or its preponderance, determines the variations of the cycle. If the individual reaches normal sexual maturity without fixating traumata in the pregenital phases, the hormone cycles, that is, the relationship between the estrogen and progesterone phases of the cycle, will be normal; this implies practically normal ovulation and normal length of the cycle. If—because of organic disposition or crippling traumata, or on account of the interaction of both—fixation occurs on a pregenital level, the disturbance of the psychosexual maturation is reflected in the cycle. For example, in puerile bisexual individuals, the prog-

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gesterone phase does not develop fully; they usually have short cycles. Women whose infantile fixation causes a prevalence of receptive-retentive tendencies (as in cases of bulimia or obesity) usually have long progesterone phases and long cycles. If the psychosexual development is even more inhibited, long low-hormone periods characterize the cycle; menstrual flow may occur with irregularities still within the normal range.

The Organization of the Reproductive Drive

Study of the sexual cycle reveals that the sexual drive is organized differently in male and female in order to serve specific functions in procreation. The propagative function of the male under the control of one hormone group (androgens) is discharged in one act; the male sexual drive is organized to motivate this act. Corresponding to the two phases of the female propagative function, the female sexual drive evolves consecutively (1) to motivate the heterosexual act, and (2) to supply the psychodynamic correlates of pregnancy and lactation. The psychoanalytic concepts of sexual maturity are based on the organization of male sexuality. The term "genital primacy" refers to a drive organization which is consummated in heterosexual coitus climaxing in orgasm. Female sexuality cannot fit into this model, since heterosexual intercourse is, from the point of view of reproduction, only a preparatory act. Pregnancy and lactation constitute the completion of psychosexual and reproductive maturity in women. Yet the drive organization which motivates pregnancy and lactation is not genital in the same sense as is mating behavior. Helene Deutsch, in an early publication,[17] assumed that the female sexual drive achieves its orgastic discharge by reaching its reproductive goal in parturition. Parturition, however, is not orgasm, in spite of the immensity of discharge and detumescence. Lactation and the activities of mothering are complex behavior patterns; in spite of their oral drive-organization, these functions necessitate a higher level of cortical and psychologic integration than the heterosexual act requires.[5] Freud assumed that psychosexual maturity in women is connected with genital primacy which, parallel to male orgasm, culminates in vaginal orgasm.

Orgasm

The meaning of orgasm in women is obscured by the concept that sensations localized in the clitoris should be transferred, with genital maturity, to the vagina and the clitoris should lose its significance for orgasm. Thus, it is assumed that vaginal orgasm is analogous to male orgasm and, as such, is the badge of genital maturity. Recent histological investigations have shown that the sensory cells known as "genital corpuscles," which are end organs for the perception of orgasm, are confined predominantly to the glans clitoridis in women, just as in men they are localized in the homologous glans penis. They can be found also in the labia minora and in the muscles of the lower vagina. In general, the vagina has no sensory nerves; embryologically, it is homologous to the shaft of the penis. The mechanism of female orgasm and the interplay between clitoral and vaginal orgastic experience become understandable if one approaches the problem from its central neurological innervation. It is accepted that in man there is an orgastic spinal center in the sacral segment of the spinal cord; this receives stimuli from higher cortical sensory receptors. The normal male orgasm is a result of a combination of cortical and spinal mechanisms. The assumption of similar interaction in women clarifies several baffling problems of orgasm.[38] Since the spinal center responds with a reflex to mechanical stimulation, clitoral orgasm can be elicited in each instance, unless cortical inhibition is so severe that it suppresses the reflex. Cortical influences, sexual attraction, love, fantasy, and willingness to accept the sexual role, etc., not only stimulate the spinal center but permit the woman to relax and experience the pleasurable sensations, which, beginning in the clitoris, spread through the vaginal walls and finally encompass her whole body in orgasm. Since the physical stimulation in vaginal intercourse does not occur primarily

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in the vaginal wall and mucosa, and since some clitoral stimulation is an important factor leading to orgasm, "The difference between so-called clitoral and vaginal orgasm is explicable not in terms of the different origin or location of the orgastic response, but in the different intensity of it and in the degree to which cortical factors are contributory"[38] (p. 243).

¶ Dysfunctions of Heterosexuality

The processes of psychosexual development predispose women to pathology originating either in the heterosexual or in the childbearing aspect of the drive organization. However, because of the reciprocal interaction between the phases of the sexual cycle on the one hand, and between these and the emotional processes on the other, the manifest symptoms may represent disturbance of either or both phases of the reproductive function. Most of the psychosomatic symptoms discussed under this heading originate in heterosexual conflicts and in inhibitions of heterosexual development.

Frigidity

Frigidity is the most frequent psychosexual dysfunction and can be related to the ovarian function only in rare cases of severe hypogonadism. In all other instances, women may have any form and degree of frigidity and at the same time normal gonadal function. Sexual intercourse is a physiologic and emotional transaction of the partners; their mutual excitation facilitates the processes which lead to orgasm. In women, more so than in men, the quality of sexual experience depends upon the mate, upon his potency, skill, and ability to overcome her sexual fear. The complexity of sexual maturation in women is apt to create defenses against sexuality. Fear of being injured by the penis, fear of pregnancy, envy and hostility to men often bring about inhibitions in the woman's capacity for orgasm. Since the social and emotional significance of frigidity is different from that of impotence, women can use the suppression of their own sexual needs as a weapon against their husbands. This was especially true in times past when orgasm, or the desire for it, was considered unwomanly. Since most women now freely admit their sexual desire, they often respond to the lack of complete orgasm with a sense of inferiority. This increases the anticipation of frustration. Because of this, such women often anxiously watch the sexual act and control it with hostile impatience; thus they interfere with what they seemingly are eager to achieve. Underlying such behavior is a narcissistic defense originating in penis envy.[25] This may become increased by the modern woman's concept of sexuality, by the expectation or demand that she *has to* reach vaginal orgasm and suppress clitoral sensations. Women who are able to assume the role of passive cooperation, who are less anxious and more giving in their receptiveness, gain a greater emotional gratification even by partial orgastic discharge. Dyspareunia (painful sexual intercourse) may be caused by local traumata, by pathologic and inflammatory lesions due to mechanical and anatomic anomalies of the urogenital structures. Dyspareunia is psychogenic when psychogenic pain, or fear of pain, is utilized to render intercourse unbearable or highly unpleasant. Vaginismus is an involuntary spasm of the vaginal muscles, always psychogenic in origin. While it protects the woman from the pain she fears, she suffers a pain which is brought about unconsciously. This is a conversion symptom. Above and beyond the sexual fantasies which the symptom may express, vaginismus achieves its unconscious goal by excluding the penis, by expelling it, or by painfully enclosing it. Sadistic and masochistic tendencies fuse in this symptom with urethral and anal eliminative and retentive tendencies. Thus, vaginismus can be compared to ejaculatio praecox or ejaculatio retardata. Since the vagina is a receptive organ, vaginismus can be considered as an expression of powerful incorporative tendencies; it seems to be the realization of the idea of "vagina dentata," the hurtful female genital. Vaginismus occurs usually in young women whose psychosexual make-up reveals,

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beside pregenital fixations, a general sexual infantilism. This is expressed not only in their emotional life but also in the incompleteness of their sexual cycles. At present we can consider this as a corresponding manifestation of psychosexual immaturity. It is, however, justifiable to assume that the factors which cause frigidity suppress the ovarian function through the emotional media of anger, fear, and frustration.

Psychogenic frigidity is considered a causative factor in organic conditions, such as vulvitis, leukorrhea, vaginitis, some forms of endometritis, and even of tumors of the uterus.[37] The mechanisms by which the unreleased genital tension leads to organic and psychiatric symptoms are manifold and depend on the total personality. Freud assumed that, in cases of chronic frustration, the dammed-up libido brings about the symptoms of actual neurosis,[28] such as anxiety, hypochondriasis, pelvic pains, etc. These again might bring about more organic symptoms through the involvement of autonomic innervation, causing vasodilatation of pelvic and sexual tissues. Since the psychologic factors which lead to frigidity may suppress the ovarian function, these symptoms are not caused by dammed-up libido but rather by lack of libido because of faulty sexual chemism. Better knowledge of the metabolism of the ovarian hormones may throw light upon these processes.

Menstrual Disorders

The bulk of psychosomatic gynecology deals with disturbances of menstruation. In general, psychic factors play a role in all forms of menstrual disorders. Menstruation itself may be considered as a precipitating factor: it mobilizes unconscious conflicts related to female sexual function.

The term "dysmenorrhea" designates various forms of painful menstruation. Each individual has essentially the same symptoms with each dysmenorrheal state. This suggests some organic predisposing factors, such as immaturity of the pelvic organs, faulty response to gonadal hormones, or circulatory and autonomic imbalance. Four clinical forms of dysmenorrhea are distinguished: (1) pains resembling those of labor with discharge of blood clots; (2) pain from hyperemia and distention occurring shortly before the onset of menstruation and subsiding after the flow is established; (3) membranous dysmenorrhea; and (4) menstrual colic. Menstrual colic is the most frequent form of dysmenorrhea; its symptoms include abdominal distress, nausea, and vomiting. Migraine, tachycardia, bradycardia, anxiety states, and fainting spells may develop with any of these conditions.

Investigations indicate that women who suffer from dysmenorrhea have a relatively low pain threshold.[31] Whether this can be attributed to an infantile personality organization, to a "weak ego," or to other factors, the low tolerance to pain increases the anxious anticipation of the menstruation, and thus stimulates the emotional defenses against it. While most women adjust to menstruation, and by this diminish the experience of pain, the expectation of the cyclical pain renders the hypersensitive woman either sick, helpless, or rebellious against her fate.*

It seems clinically useful to differentiate between the commonly occurring premenstrual distress (as described in the course of the normal sexual cycle) and the more severe premenstrual tension and depression. While they are not necessarily precursors of dysmenorrheal states, the latter may be often accompanied by a feeling of helpless wrath. The syndrome may imitate an agitated depression; a sense of frustration, anger, and restlessness fills with activity the unloving "arid" woman. The other type of premenstrual depression is characterized by sadness, withdrawal, increased sensitivity, and hypochondriacal anxiety. Migraine and other forms of severe headaches often occur. The pathogenesis of the syndrome is complex. In a nutshell: hormonal imbalance is responsible for electrolyte and fluid changes in tissues and for reactions of the autonomic nervous system.[32] These, in turn, interact with

* In investigating the psychologic factors which may motivate a symptom, we now consider not only the developmental conflicts which cause psychic tension but also the ego's ways and means of dealing with that tension.

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psychic factors originating in the development of the personality. Just as there is a hypersensitivity to pain which predisposes to dysmenorrhea, so is there also an initially diminished capacity of the ego to maintain its integrating and controlling function under stress. This weakness of the ego accounts for mobilization of otherwise latent conflicts at the time of menstruation. It is a clinical observation of long standing that behavior disorders exacerbate during the premenstrual and menstrual phase. Overeating or alcoholism often become uncontrolled. Kleptomania and other psychopathic kinds of behavior occur more often during this phase than at any other time. There is a large literature on the conspicuous, although not completely clarified, relationship between various forms of psychosis and menstrual disorders.[20]

Oligomenorrhea refers to scanty menstruation at long intervals. It may be a sign of retarded sexual maturation on the basis of hypogonadism; usually, however, it is a defense against sexuality. Oligomenorrhea is often associated with obesity. Overeating occurs in adolescent girls who, as a defense against sexuality, regress to the oral level of development and become more or less depressed. The metabolic processes of obesity and depression lead to manifestations of hyposexuality. Obese women are often sterile on the basis of anovulatory cycles. The scanty menstruation occurs without pain and distress; dysmenorrhea may occur in the same women when, after weight loss, the normal gonadal function is established.

Under emotional influence, menstruation may be suppressed for several months, even for years. Among the psychogenic cases of amenorrhea, two main groups may be differentiated. One can be related to the repression of heterosexual impulses. Young women, even after menstruation has been established, may suppress the ovarian cycle more or less completely as a defense against mature sexuality. Without having anything to do with the "painful," "dirty," "dangerous" part of sexuality, they may go on with their adolescent fantasies of a life rich in sexual experiences. When these girls become able to accept sexuality, the amenorrhea usually disappears. The investigation of wartime amenorrheas has demonstrated that amenorrhea can be the result of long-lasting sexual deprivation and is not primarily the result (as it was assumed) of nutritional deprivation. After heterosexual relationship was re-established, the menstrual cycle recurred, in many instances, without a change in nutrition.

The other form of amenorrhea occurs as a part of the syndrome of pseudocyesis. It often happens that, under the influence of the wish for and the fear of pregnancy, menstruation is suppressed for a number of weeks, even for several months. While women begin to fantasy about pregnancy—with pleasure or with anxiety—as soon as menstruation is delayed, this alone does not account for pseudocyesis. The amenorrheas of long duration, with abdominal distention, breast changes, and weight increase imitating pregnancy, are complex psychosomatic symptoms which occur in women of hysterical character structure, or may be a sign of (incipient) schizophrenia. Pseudocyesis expresses on many levels the conflict regarding childbearing. These women are usually infertile. Being unconsciously afraid of pregnancy and guilty because of hostile wishes (toward mother and children), they clamor for motherhood, and, during the period of pseudocyesis, they enjoy gratifications which only pregnancy justifies. The opposite also can happen, as for example, when unmarried women, sometimes advanced in pregnancy, convinced that "what should not be cannot be," remain unaware of pregnancy. Often they can cite the fact that they menstruated several times during pregnancy. Such cases illustrate that physiological functions may become disassociated under the influence of contradictory motivations and needs.

Menorrhagia, noncyclic uterine bleeding, occurs occasionally under unusual emotional tension connected with anticipation of feared and/or desired intercourse. It often complicates matters between husband and wife after long separation; it is often cited as a symptom of brides. Each of these instances demonstrates the emotional control of menstruation. Yet its physiologic mechanism is unknown. The occasional untimely menstruation after which the

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cycle is re-established most probably is not a result of an imbalance of the ovarian hormones. Menorrhagia occurs often in young individuals before the ovarian cycle is definitely established. Suppression of the gonadal hormones may occur in adult women after many years of normal menstruation; it may be the result of frigidity, sexual deprivation, or of exhaustion after frequent pregnancies and accompanying depression. Menorrhagia is often a symptom of the imbalance of the ovarian hormones heralding the menopause. Thus, the symptom has different meaning in the psychosexual life of the woman, depending on her age and on the conditions which brought about the symptom. It is especially significant in young girls. The bleeding which seems to be always impending interferes with the normal life of the girl. Even if it does not cause anemia, it brings about an exaggerated preoccupation with the "unfortunate fate" of womanhood. In spite of more or less severe depression, these cases respond very well to psychotherapy.

¶ Childbearing

It is a physiological characteristic of woman that her reproductive function requires an increase of metabolic processes. Each phase of the reproductive function—the progesterone phase, pregnancy, and lactation—goes hand in hand with an increase of receptive and retentive tendencies; they are the psychic representations of the need for fuel to supply energy for growth.*

Pregnancy

When conception occurs, the cyclic function of the ovaries is interrupted and is not re-established with regularity until after lactation is finished. Because of the uninterrupted and enhanced function of the corpus luteum, the psychology of pregnancy is best understood as an immense intensification of the progesterone phase. The heightened hormonal and general metabolic processes, which are necessary to maintain the normal growth of the fetus, augment the vital energies of the mother. It is a manifestation of the symbiosis (the reciprocal interaction between mother and fetus) that the pregnant woman's body abounds in libidinous feelings. While some women enjoy this narcissistic state in vegetative calmness, others, especially in the second trimester of pregnancy, find outlet for their physical well-being by enlarging their activities. As the metabolic and emotional processes of pregnancy replenish the primary narcissism* of the woman, this becomes the wellspring of her motherliness. It increases her pleasure in bearing her child, stimulates her hopeful fantasies, and diminishes her anxieties. While the mother feels her growing capacity to love and to care for the child, she actually experiences a general improvement in her emotional state. Many neurotic women who had suffered from severe anxiety are free from it during pregnancy; others, despite the discomforts of nausea or morning sickness, feel emotionally stable, and have the "best time" during pregnancy. Thus, healthy women demonstrate during pregnancy, as during the high-hormone phases of the cycle, an increased integrative capacity of the ego. Indeed, the devoted patience "in the service of the species," which women of uncounted generations have proved, has its roots not in the necessities of woman's sociological dependence on man but in the drive organization of the reproductive function. This accounts for the gratifications as well as the inherent dangers of motherhood.[8]

Though pregnancy is biologically normal, still it is an exceptional condition which tests the physiological and psychologic reserves of women. There are many attitudes, realistic fears, and neurotic anxieties which disturb the woman's desire for pregnancy. Some of these may be motivated by realistic situations. Bad

* At the time of ovulation and during the progesterone phase, the actual increase in metabolic need must be minimal. Yet the physiologic and psychic responses are intense. This signifies that in the presence of signal stimulation the psychic apparatus sets in motion an innate pattern of responses, which, if actually not needed, affords learning by repetition.

* Primary narcissism is the libidinal state resulting from a positive metabolic balance, with its attendant "surplus energy."[2]

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marriages, economic worries, or conception out of wedlock may cause the pregnancy to be unwanted and the infant to be rejected before it is born. Usually, even such pregnancies have a more or less normal course. Only if the psychosexual organization is laden with conflicts toward motherhood do actual conditions stir up the deeper conflicts and disturb the psychophysiologic balance of pregnancy.

Since the complex steps toward maturity, motherhood, and motherliness begin in the mother's own oral phase of development, it is easy to describe the psychodynamic process of normal and pathologic pregnancy in terms of the oral-dependent phase. Passive-dependent needs revived, the pregnant woman thrives on the solicitude of her environment. If her needs are unfulfilled, the frustration of her oral-dependent wishes may motivate well-known symptoms such as perverse appetite, nausea, or morning sickness. These symptoms seem to diminish in frequency and intensity under cultural influence. The changing relationship between the sexes brings about a change in the conscious attitude of women toward pregnancy. The subjective symptoms of pregnancy are minimal in women who, becoming pregnant by mutual consent, can count on their husband's care and loving participation in their great experience. Mood swings, however, occur in every pregnancy, especially during the first trimester, when the endocrinologic and metabolic adjustment may cause fatigue, sleepiness, headaches, vertigo, and even vomiting. These symptoms are usually alleviated as the pregnancy progresses. During the last months again, the increasing bodily discomfort, disturbances of sleep, and fears connected with parturition interfere with the contented mood of pregnancy.

Self-centered and dominated by receptive-retentive tendencies, the pregnant woman is in a vulnerable ego-state. The physiological increase in receptive-retentive needs, the libidinal regression, brings about a regression of the ego. In evaluating the psychodynamic meaning of this regression, one should consider that the integrative task of pregnancy and motherhood—biologically, psychologically, and realistically—is much greater than a woman has ever faced before. In some cases the adaptive task appears greater with the first child, when the woman experiences something completely new. The physiologic and emotional maturation of the first pregnancy makes motherhood generally easier with the second and third child. Yet it may happen that women, fatigued by the never-ceasing labor of motherhood, experience pathogenic regression during later pregnancies.

Normally, the biologic regression of pregnancy and lactation serves as a source for growth and development. The same processes, however, harbor dangers for those who cannot withstand the regressive processes inherent in the reproductive function. External circumstances, such as a lack of love from or for the husband, may stir up the deep-seated conflicts of motherhood. In such cases any change inherent in pregnancy may become a source of irritation and may cause frustration instead of gratification. Then the pregnant woman, like an angry frustrated infant, cannot find gratification within herself. The symbiosis evolves then as a vicious circle. The frustrated, hostile pregnant woman becomes anxious, since she feels her inability to satisfy her child. The hostility toward the child and the rejection of the pregnancy, go hand in hand with the hostility toward the self, the rejection of the self. Anorexia, toxic vomiting, and consequent severe metabolic disturbance such as eclampsia may express the woman's destructive tendencies.*

It is a well-established concept of psychoanalysis that regression to the oral phase of development is the psychodynamic condition of depression. Since such regression is inherent in pregnancy and lactation—even in the progesterone phase of the cycle—depressions of varying severity and psychosomatic conditions of oral structure are the basic manifestations of the psychopathology of the female propagative function.[8] The further elaboration of

* These symptoms appear often in women who, as infants, had anorexia and psychosomatic illnesses of the gastrointestinal tract. As the psychodynamic processes inherent in pregnancy mobilize the ambivalence toward mother and motherhood, they reactivate the anxieties, frustrations, and pains referable to the oral phase of development.

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this primary pathology depends on the total personality of the woman. If the hostility is concentrated on the embryo, women have fantasies of harboring a "monster," a gnawing animal, a cancerous growth. This gives rise to panic and hypochondriasis. The aggressive impulses toward the embryo may be experienced as inadequacy in taking care of the child. Phobic reactions; even suicidal impulses, may represent defenses against the hostility toward the contents of the womb.

The contents of the womb has many meanings in the unconscious emotional life of the woman. Freud assumed that the frustration caused by the lack of a penis is the central motivating factor in the development of woman; he concluded that woman's wish for the child is motivated by the tendency to retain the penis (in the sense of the oedipus complex, the penis of the father). According to this, the male child represents the fulfillment of the originally repressed wish.[29] Freud's hypotheses, however incomplete from the point of view of psychobiology, demonstrated in many instances the motivational power of infantile fantasies. There are many common infantile fantasies. One or the other of these fantasies has a greater significance in the development of the personality. During pregnancy the individually significant fantasy may become recathected and may influence the emotional course of pregnancy. (Such an influence may be beneficial or may be anxiety-producing.)

The fetus is a part of the mother's body. What aspect of the body image does the fetus represent? It may be the missing penis in some cases; in others, it is the admired beauty, or the envied pregnancy, of the woman's own mother; most frequently the fetus is the token of the loved self. Normally, the fetus is cathected with narcissistic libido.[27] This, however, does not always mean pleasurable emotional sensations. There are many ambivalent, hostile manifestations of the feelings concentrated upon the self. Thus, the fetus can represent the "bad, aggressive, devouring self," engendering fear of having a "monster." Many women identify the fetus with feces and relive during the pregnancy the ambivalent feelings and mysteries of the infantile sexual fantasy of the anal child. There are many cases in which the anal or other regressive fantasies do not interfere with the pleasure of pregnancy. The mother's object-relationship to her unborn child becomes ambivalent or strongly hostile when the fantasy which is projected onto the fetus is highly charged with ambivalence. The fetus, then, becomes the representation of a hated and/or feared person, and motherhood becames an overwhelming menace (Deutsch,[18] Vol. II).

The anxiety and depression caused by such motivations may remain on the level of neurosis. In many instances, depending on the predisposition of the personality, the anxiety may activate a true psychosis, with hallucinations, paranoid defenses, and schizophrenic reactions endangering the woman and her fetus.[20]

Parturition

It is generally assumed that the fear of labor is universal and, in some instances, represents the immediate fear of death. Even in those cases where there is no fear of labor during pregnancy, such fear may rise suddenly to cataclysmic intensity during critical phases of labor. Modern obstetrics is very much aware of the significance which sudden and violent emotions have on the course of labor, just as psychiatrists are aware of the influence of obstetrical traumata upon the personality of the mother; it may alienate her from her child or activate serious postpartum reactions. For several decades general anesthesia was considered the method of choice to protect the mother and the child against the effects of labor pain. General anesthesia, however, deprived the mother of the deep gratification of experiencing the delivery, of hearing the first cry of the baby. Many women who were delivered under anesthesia complain that the lack of memory of the delivery made it difficult for them to relate to the baby and feel motherly. A better understanding of the psychodynamic processes involved in labor has resulted today in the use of general anesthesia often only as a last resort, or in surgical procedures.

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Pain is a subjective experience. Even if it is caused by organic processes, the experience of pain depends, in a particular way, on the experiencing ego (Chap. 49). Since G. D. Read described the fear-tension-pain syndrome in labor,[43] many obstetricians utilize the "mental hygiene" of pregnancy. This aims at diminishing the fear of delivery and, by this, reducing the tension-pain response. Read believes that a person adequately conditioned to minimize the discomforts of labor may have a delivery free from observable discomfort ("natural childbirth"). Kartchner[35] and others observe that women emotionally well oriented to childbirth benefit from training and education; those, however, who have serious emotional conflicts hardly ever will be influenced by indoctrination.

The exaggerated expectations of the effect of mental hygiene on parturition harbor psychiatric hazards. There are many unexpected obstetrical conditions which may interfere with the course of delivery. There are also many psychologic complications of labor. One of them is the woman's disappointment in herself if she cannot "behave" during labor as her self-respect demands. The sense of failure may then activate inferiority feelings hidden under the cover of a perfectionistic ego-ideal. The resulting shame brings about the condition which one wished to avoid, namely, the woman may "give up." Since the "natural childbirth" permits the woman to feel responsible for what she has to endure, the obstetrical trauma may become complicated by a narcissistic blow. The psychopathologic effect of this varies according to the personality of the mother and upon the maturity of her motherliness.

The Postpartum Period

The trauma of birth interrupts the biological symbiosis between mother and infant. The hormonal changes which induce and control parturition, the labor pains, and the excitement of delivery interrupt the emotional continuity of the mother-child unity. Under the influence of excruciating pain, the mother is concentrated upon her own survival. After delivery the love for the newborn wells up in her as she first hears the cry of the baby. This sensation reassures the mother about the continuity of the oneness with her child. There are, however, many mothers, especially primiparas, who, after delivery, experience an emotional lag. They are surprised by a lack of feeling for the child, by a sense of loss and emptiness. Disappointed in themselves, such mothers feel guilty and become insecure in their behavior toward the child. Such incipient postpartum depressions are not infrequent. The postpartum woman, for many reasons but primarily because of her physiological condition, has a regressive tendency and therefore a need to be mothered. Through the love which she passively receives, she may overcome her tendency to withdraw from the child. Whether the mother, through the feeling of love, is able to maintain the sense of unity with her child, or whether she has to miss this most significant gratification, the organism of the mother is not ready to give up the symbiosis after parturition: biologically and psychologically she prepares to continue the symbiosis through lactation.[9]

Lactation is stimulated and maintained by prolactin, a hormone of the anterior lobe of the pituitary. This usually suppresses the gonadal function and induces an emotional attitude which is similar to that of the progesterone phase of the cycle.

During lactation, just as during the progesterone phase and pregnancy, receptive tendencies gain in intensity, they become the axis around which the activities of motherliness center. The woman's desire to nurse the baby, to be close to it bodily, represents the continuation of the original symbiosis, not only for the infant but for the mother as well. While the infant incorporates the breast, the mother feels united with the baby. The identification with the baby permits the mother to "regress," to repeat and satisfy (on the unconscious level) her own receptive incorporating wishes.[8]

Lactation thus permits a slow, step-by-step integration of motherliness.

In spite of hormonal control, lactation is influenced by emotions. Galactorrhea, a free flow of the breasts during pregnancy or after

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weaning, occurs often under the influence of emotions, for example, if the mother sees a woman lactating. Suppression of milk production by a conscious attitude against lactation leads to such a statement as, "Ability to nurse is equivalent to the will to nurse" (Kroger and Freed,[37] p. 182). This is, of course, an oversimplification of the variety of processes through which emotions affect physiologic processes.

In regard to the postpartum period, it may be that the mother-child symbiosis can be best maintained by maximum physiological participation, such as in breast feeding; however, in many instances, permitting the mother to omit this physiological activity lessens the potentially disturbing maternal ambivalence and thus improves the mother-child interaction. Motherliness in women is not a simple response to hormonal stimulation brought about by pregnancy and the ensuing necessity of caring for the young. Instead, motherliness in humans develops through the cyclic repetition of hormonal stimulation, which, interacting with other aspirations of the personality, reaches functional maturity through a complex process of personality development.

In each phase of motherhood, even in each act of mothering, we might differentiate two levels of motivation as well as action. One is dominated by the emotional manifestations of the passive-receptive-retentive tendencies; the other, more accessible to consciousness, mobilizes the loving, succoring activities of mothering. In simple societies the biological and ego-aspirations of the woman are easily integrated in her ego-ideal. Our culture, however, conveys to the woman an active, extraverted, "masculine" ego-ideal. This may conflict with the passive tendencies inherent in the propagative function. Consequently, women may respond with guilt reactions to the biological regression inherent in motherhood. If they cannot permit themselves to be passive, to enjoy lactation, to breast feed the infant, they deplete their source of motherliness. Such women respond with anxiety and guilt, with a sense of frustration to their inability to live up to the biological functions of mothering. Yet, given time and reassurance, these women learn to relax, and their interaction with their infant becomes pleasurable and emotionally productive without lactation.[7, 13]

Not only the masculine-protest attitude complicates mothering. There are women for whom the physiologic gratification of mothering remains an everlasting temptation, who enjoy pregnancy and lactation and caring for the infant as long as he is completely dependent. As if the procreative function of these women were completely under physiologic controls, they are unable to develop an object-relationship to the child beyond infancy. Psychologically, such women do not mature through motherhood. They neglect each child as they become pregnant with the next, often abandoning their children, since they cannot cope with the responsibilities of motherhood toward growing individuals.

A discussion of the psychopathology of the postpartum period will be omitted here, since these problems are similar to those of development toward motherhood and to those of pregnancy. A less known manifestation of postpartum pathology is one which untowardly affects the transactional processes between mother and child, and thus becomes a source of pathology for the child. In recent years several observations have been published demonstrating that the infant, by some not clearly defined psychic process, incorporates the emotional attitudes of the mother, embodies her anxiety, and develops symptoms which are similar to or identical with those of the mother. Beata Rank[42] observed psychic transmission of conflict constellations to children who become feeding problems; René Spitz[46] demonstrated the infant's reaction to the mother's depression. Escalona[22] deals with the larger concept of "contagion." The present author interpreted these processes in terms of the postpartum symbiosis, "which is oral, alimentary for both infant and mother" (Benedek,[10] p. 398).

The oral-dependent needs of the child as a motivating factor in the child's responsiveness to the mother, to her security and smiling love as well as to her anxiety and insecurity, have been well studied. The mother's receptive needs toward the child, however, are not so easily recognized. From the time of conception, the offspring has stimulated the receptive tendencies of the mother; after parturition the

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newborn remains the object of these instinctual needs. Normally, the infant, by the very fact of his existence, represents the most significant fulfillment of the mother's receptive needs. With her baby the mother feels whole, complete, but not so without him. Many young mothers feel an "emptiness" when they leave the child, become anxious or depressed, and may feel compelled to eat. This indicates an increased tension of their receptive needs. The affect hunger of the mother, her need for love and affection, her wish to reunite with her baby, to overprotect and overpossess him, are all exaggerated manifestations of the very emotions which originate in the psychobiological processes of motherhood. The intensity of these emotions indicates the meaning of the separation trauma of parturition for the mother. As if the separation could be undone, mothering and each manifestation of love for the child are fused with an urgent need to "incorporate the child," to hold on to him. As the mother clings to the child, he becomes for her psychic economy (at least partially) the needed, loved, and hated object of her own past. Reciprocally, the child affected by the incorporative need of the mother, which does not allow self-differentiation, responds to any attempt toward independence as if it would mean separation and deprivation of love and protection. Such a hypersensitive reaction to emotional separation is a manifestation of the primary ego-structure which originates in the ambivalent charge of the symbiotic relationship between mother and infant. Recent investigations of psychosomatic illnesses in children demonstrate the significance of this pathology in the mother-child relationship for the psychosomatic illnesses of children.[21, 29]

Infertility, if not caused by organic pathology, can be considered as a defense against the dangers inherent in the procreative function. All those conflicts which interfere with the normal evolution of the procreative function may lead to infertility if the individual is constitutionally predisposed to it. The same conflicts which cause hypochondriacal panic in one woman and postpartum depression in another may be elicited as a causative factor of infertility in still another. The women who "suffer" from functional sterility are saved from the awareness of their conflicts, anxieties, and hostilities regarding childbearing; they may go on asserting their unambivalent attitude toward motherhood. Functional infertility is relative. It may be temporary and disappear with the maturation of the physiologic and emotional processes involved in motherhood. Infertility may be a conjugal phenomenon[11] caused by deep dissatisfaction with the marital partner and by sexual maladjustment. Chronic sexual frustration may lead to infertility. It happens frequently that women, after having practiced birth control for a long time, may not become pregnant easily or at all. Relative infertility may be the result of the inhibition of the heterosexual drive. Women who are afraid of men or of marriage are not considered "infertile" from a diagnostic point of view, yet analysis of unmarried women often reveals that fear of childbearing is the primary motivation for their sexual inhibition. Women may appear sterile if the desire for intercourse is suppressed during the fertile period and coitus takes place only during the infertile period. Such birth control is also practiced voluntarily. There is more organic compliance in instances where relative infertility is caused by a shift in the cycle so that ovulation occurs during menstruation, when coitus usually does not take place;[44] this is even more pronounced in those cases where the conflicts lead to a suppression of the gonadal function so that ovulation does not occur at all.

The unconscious conflicts which may lead to infertility can operate through interaction of psychic, neurologic, and hormonal processes, but they may act also through reflexes which have their origin in primitive sensations of fear and rage. Reflex action may play a role in infertility caused by spasm of the fallopian tubes, so that the ovum cannot reach the uterus. The spasm may be transitory or persistent; that is, it may be the result of a response to acute fear of pregnancy, or it may be a conversion symptom. This form of infertility occurs in anxious, hysterical women. Without outlining profiles of infertile women, it seems justified to differentiate between the dynamics of infertility in these women and in those active, adaptable women who, except for the functional infertility, are well integrated,

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healthy individuals. Infertility, in these instances, develops as a somatic counterpart of the characterological defenses.[6]

During the progesterone phase of each cycle, the woman responds more or less unconsciously to the tasks of motherhood. Normally, through the monthly repetition, she overcomes the anxieties and absorbs the conflicts of childbearing. It is different in those women who, perceiving the stimulation of the progesterone phase, recoil from the task, repress the conflict, and with it suppress the gonadal function which otherwise would charge the conflict with energy and would make repression impossible. Thus, along with the psychologic defense (repression), an organic defense develops; the gonadal function is suppressed, and infertility is attained. In comparing the women who become infertile to those who develop psychiatric symptoms, we may assume that infertile women have a stronger ego than those who become mentally ill as a result of motherhood. Indeed, among the infertile women there are many who have ego-aspirations which are in conflict with propagative function.

Under the influence of a variety of experiences, functional sterility can prove to be a transitory, curable condition. It is assumed that adoption often "works miracles" and facilitates successful childbearing. It would be easy to theorize that direct contact with a child relieves the woman's anxiety of childbearing. Psychoanalytic explorations of such couples reveal that the conditions which facilitate conception, the sexual and emotional relationship between husband and wife, improve before the adoption occurred. Indeed, the very idea of adoption is probably an indication of the diminishing intensity of the conflict about motherhood. The study of a large number of cases conducted by Hanson and Rock[30] shows that not more than a fortuitous correlation exists between adoption and ensuing pregnancy.

Miscarriage

There are many miscarriages which are not caused by emotional conflicts regarding childbearing in general, or regarding the particular pregnancy. Therefore, it seems justified to talk about psychosomatic miscarriages only in those cases where miscarriage becomes a "habit." Habitual abortion can be considered a variety of relative infertility. The same conflicts which produce the psychiatric pathology of childbearing also may cause spontaneous abortion. The symptom may be mediated by autonomic disharmony, causing uterine irritability; this, in turn, may be secondary to a balance in endocrine function insufficient to maintain the pregnancy. Abortion may occur as a result of a reflex in extreme rage. The psychologic meaning of repeated abortions is often revealed if one analyzes the motivations for therapeutic abortion.[36] The wish for therapeutic abortion is often motivated by social, ethical, and economic factors, but also by unconscious fears, which, in women of lesser fertility, may cause sterility or spontaneous abortion.

¶ Menopause

The reproductive period in women lasts on the average thirty-five years. Its decline approaches gradually; its end is marked by the cessation of the menstrual flow. This occurs in some cases abruptly, but usually there is a period during which the cycles become irregular and the menstrual flow scanty. Since ovulation usually ceases before menstruation, there is a lack of balance in the ovarian hormones even before menopause. There are few women unaware of the transition; most have some, others seem to have all, the well-known signs and symptoms of menopause. Increased irritability, mood swings, hyperesthesias, paresthesias, vertigo, and a multitude of other symptoms indicate a lowered tolerance to emotional tension. Many symptoms are related to an increased irritability of the vegetative nervous system, especially involving the vascular apparatus, giving rise to hot flashes, chills, palpitation, cardiac arrhythmias, etc. Since the same symptoms arise after surgical removal of the ovaries, and they can be controlled by substitution therapy, one is led to assume that the failure of the ovaries is the main cause of the symptoms. Yet, in natural menopause, the symptoms show great individual variations in intensity as well as in duration; since these

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symptoms are, in any event, only temporary, it seems that they are due rather to an imbalance of hormones than to simple deprivation. One indication of this is overproduction of *pituitary gonadotrophin*. "This characteristic feature of the climacteric may be one factor in prolonging, if not initiating, the disturbances" (Hoskins,[33] p. 310).

There is evidence of a difference in the process of tissue degeneration of the ovaries in women who have not borne children as compared to those who have had several pregnancies. The menopause sets in earlier and with more intense reaction in the former group than in the latter. This is in harmony with psychoanalytic observations, namely, that with complete sexual maturation and function, the regressive emotional manifestations (which characterize the low ebb of the premenstrual hormone phase) become absorbed by the adaptive processes of development. Thus, when the gonadal stimulation subsides permanently, the healthy woman is not severely threatened by this loss. The accomplishments of the reproductive period—not only the propagative function but also the total developmental achievement of the personality, its lasting sublimations, its capacity to love and to do for others—will sustain the personality when the gonadal stimulation abates and the woman faces the change of life.[8]

The anticipation of the climacterium—just as in the anticipation of a previous change, the menstruation—influences the symptoms and the woman's emotional response to them. As long as women considered the climacterium not alone as cessation of the reproductive period but also as cessation of their sexual attractiveness and ability for sexual experience, the mental stress of the climacterium was complicated by a deep narcissistic blow; it also implied the necessity for repressing sexual desires or being ashamed of them. This often brought about regressive and less mature sexual behavior and threatened the woman and her environment by breaking the previous moral code of the personality.

It is different in most women of today. Following the menopause, healthy women respond to the gradual desexualization of their emotional household with an influx of extraverted energy. Their still-flexible personalities, relieved from the responsibilities of child raising, seek and find new aims for their psychic energy. As in childhood the repression of sexual impulses led to super-ego formation and socialization, so in climacterium, the cessation of the gonadal function releases new impetus for socialization and learning. (See footnote on p. 729.) The manifold interests and production of women after climacterium, as well as their improvement in general physical and emotional health, serve as evidence that woman's climacterium may be regarded in a psychological sense as a developmental phase (Benedek,[8] pp. 352–372). In any event, it is a challenge for the reorganization of the personality. Many of the interpersonal attitudes of the woman change. She does not love with youthful ardor, but much of her ambivalence, jealousy, and insecurity have been overcome. Her love becomes more tolerant, and shows certain "post-ambivalent" qualities.[1] These evolve effortlessly toward grandchildren. Identification with her pregnant daughter or daughter-in-law permits the aging woman to be a mother again. One step removed, she is now less involved; her love toward her grandchildren is freer from the conflicts which, as a mother, she had toward her own children. Through the manifold gratifications within and without the family, healthy women approach unobtrusively—and many years after climacterium—the physical and mental involution of senescence.

In spite of all the positive aspects of climacterium, many women suffer from neurotic, psychotic, and psychosomatic manifestations of varied severity. Because these symptoms occur during climacterium, they are usually attributed to the stresses of the menopause. Yet the psychoanalytic study of such cases reveals that the symptoms which are aggravated during this period have existed before, or had been preformed in the precarious integration of the personality. The role of the endocrinological aspect of the menopause as a trigger for psychiatric disturbances can best be understood in terms of the psychodynamics of the premenstrual phase of the sexual cycle. As the

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premenstrual hormone levels decline, the libido regresses from the level of genital integration to the infantile level. Together with this, the ego's integrative capacity diminishes, bringing to the fore the premenstrual symptoms. Their persistence, severity, and character have a prognostic significance for the climacterium. Those women who were unable to adapt to the premenstrual hormone decline and suffered from premenstrual depressions and dysmenorrhea usually suffer severely with the permanent cessation of gonadal activity.

The general irritability, lack of emotional stability, and diminished integrative capacity, which accompany the decline of hormone production, interact with the developmentally determined psychic factors and thus determine the experience of internal frustration of climacterium. In psychoanalysis the term "frustration" indicates that a drive is thwarted in attaining its goal. Thus, frustration may be the result of external prohibitions or of internal prohibitions of the super-ego which exclude the instinctual need from gratification. Here, however, the term "internal frustration" refers to the patient's inability to feel gratified. In correlating the sense of internal frustration with the inefficient ovarian function, we assume that it expresses the lack of libidinous emotions, rather than dammed-up libido. Describing it from the point of view of the affective experience, it appears as if the ego, aware of its diminished integrative capacity, responds to the inability to feel, to act, to love as before, with anger and hostility toward the self. The internal frustration is in the center of the emotional experience of climacteric women.

The symptoms which develop as a result of internal frustration depend on the total personality of the individual. This determines the intensity of the sense of frustration as well as its further pathologic elaboration. The study of the personality structure and life experience of women who manifest severe psychiatric disturbances in climacterium reveals that in these cases: (1) the bisexual component played a dominant role; (2) the psychic economy was dominated by narcissistic ego-strivings; and (3) both these factors interfered with the primary emotional gratifications of the female sexual functions. Such individuals gratify the usually strict demands of their super-ego with perfectionistic performance. Such ego-gratification may protect the woman from awareness of her basic lack of fulfillment as long as "everything goes well"; however, she is often unable to tolerate the disappointment which comes when the ego loses the power to perform as usual. As long as the woman is able to relate her difficulties to actual situations, and to respond to them in the degree and manner that she did during her adult life, she is safe. In many instances, however, the external, interpersonal situations activate responses which the woman cannot reconcile with her accustomed behavior or with her ego-ideal. Whether it is a physical symptom which she cannot accept, or her emotions, fantasies, or hostile impulses, she collects her ego-strength; "this cannot happen to me" is an often-heard defense of the climacteric person. Yet just this activates a "defensive tail spin." As the patient perceives her failure in maintaining the usual level of ego-mastery, inferiority feelings and self-accusations mount, causing depression and anxiety. The anxiety brings to the fore the previously compensated pathological potentials of the personality organization. Oversensitivity, paranoid projections, phobic, compulsive, and paranoid reactions may develop in the course of the struggle to retain the old self. The process may continue on to full-blown psychosis. Psychoanalysis of menopausal women reveals that severe psychiatric conditions occur in individuals whose adaptation to internal and external stress occurred throughout their life at a cost of an increase in narcissistic defenses. It can be expected that the narcissistic armor will crack when it becomes overtaxed by the internal and external frustrations which the woman faces at this phase of her life.

In evaluating the factors which enter into the psychopathology of menopause, we have to assume at present that the endocrine imbalance and the accompanying autonomic symptoms are precipitating agents; the causes of the psychiatric symptoms are deeply embedded in the psychic organization. This is indicated by the fact that endocrine therapy affects primarily the autonomic-nervous-system

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reactions and not the psychiatric symptoms.

Many women go through climacterium without any psychiatric disturbance and develop depression later when physical or psychologic manifestations of aging bring about dissatisfaction with their functioning capacity. The perception of any sign of aging, especially in the area which is most significant for the individual, can bring about similar intensification of defensive processes, as described above, even without acute endocrine imbalance. Every single phase of life involves a shifting and reorganization of psychic structures in accordance with the supply of vital energies. As they decline, the vector of psychic and somatic processes changes. The giving and expansive attitudes needed for the reproductive period become outweighed, step by step, by the restricting, self-centered tendencies characteristic of old age. Yet, this, too, is the result of the adaptive function of the ego, which tends to maintain the individual as he knew himself, as he used to be—to the last.

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CHAPTER 38

DISTURBANCES OF THE BODY-IMAGE

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BODY-IMAGE DISTURBANCES are receiving wider recognition, particularly in psychiatric and neurologic practice and in their consultive services to medicine and surgery in general hospitals and clinics. The psychiatrist is frequently called upon to assess the unusual problem of the patient with such a disturbance and to provide an opinion as to the nature of the clinical phenomenon and the treatment. In the general field of psychiatry, knowledge of the body-image concept has been applied in furthering understanding of the bodily sensations in the schizophrenias, involutional psychoses, hypochondriasis, neurasthenias, and the multitude of phenomena that occur with acute and chronic brain disease or result from various toxic, metabolic, and degenerative states. Sound data on the specific developmental factors which predispose or determine disturbances of the body-image in the major psychoses and psychoneuroses are sparse.

Body-image phenomena, as observed in the general clinic, may represent either a healthy psychophysiologic reaction or be evidence of psychological and emotional maladaptation. The differences between expected and healthy presentations of body-image phenomena and their pathological variants are not widely recognized and hence not generally diagnosed. The distinctions between health, disease, and the rationale of much of the clinical phenomenology may only be understood in the context of the developmental process of the personality and by consideration of the detailed accounts of phantom phenomena.

The material presented in this chapter deals mainly with the general principles and phenomenology underlying body-image disturbances, discussion of disturbances which follow dismemberment or disfigurement of the body or body surface, and considerations for prognosis and treatment. The concept of the body-image is discussed in the following section.

Historical Perspective

The first written account of body-image disturbance was that of Ambroise Paré,[66] a six-

teenth-century surgeon. Noting the frequent occurrence of the phantom limb following amputation, Paré advised surgeons that this disturbance should not prevent their proceeding with additional amputation if such were indicated. It is most unlikely, however, that Paré's report was man's first awareness of this overt expression of his body-image. Recognition probably dates back to the earliest days of man, with the phenomenon providing him with an experience as impressive and of as great psychological import as his dreams and other reactions to death.

Following Paré, Weir Mitchell[64] provided one of the better descriptions of the phantom, observations which were noted a few years later by Charcot. Head[38] was responsible for the description and development of the first basic concepts of the body schema or body-image, as well as for the interpretation of its significance for the perception of body functioning in relation to motility, localization of tactile stimuli, and the phantom phenomenon. The broader concept of body-image presently utilized in psychiatry was developed largely by Schilder.[78]

The concept of disturbances in body-image derives from observations of the affected individual's failure to perceive his body and its parts and adapt to them as they actually exist. The outstanding examples of acute disturbances occur as a result of traumatic or surgical dismemberment, where the basic body-image persists, despite the visible or apparent loss of a body part. The phantom limb is one of the most dramatic and convincing expressions of the phenomenology. Similar disturbances are seen following radical excision of tumors or masses of the face, head, and neck; thoracoplasty; paralysis of extremities following poliomyelitis; sudden paraplegias or hemiplegias; and distortions of the body resulting from hyperadrenalism or other endocrine dysfunctioning.

At the present time, body-image disturbances may be classified as consequent to the following categories of illness: (1) disorders following neurologic diseases and affecting any part of the sensory or motor system connected with movement and posture, whether involving the peripheral or the central nervous system; (2) disorders occurring with changes in the body structure as an expression of acquired or induced toxic or metabolic disorder; (3) disorders consequent to progressive deformities, occurring either late or early in life and caused by other somatic diseases; (4) disorders after acute dismemberment; and (5) disorders of personality development, including the psychoses, psychoneuroses, and psychopathic states.

Head, the neurologist, visualized the body schema not simply as the integrated resultant of past sensory experiences but more as a unity deriving from past experiences and current sensations organized in the sensory cortex. These postural schemata, often functioning outside central consciousness, were considered to be modifying impressions of incoming sensory impulses for their localization on the body surface. Also, they made possible the intricate and delicate motor activities through the constant relationship of the body to other objects. Thus Head conceptualized an area of sensorimotor functioning, a postural model of the body, which brings about the possibility of projecting the recognition of posture, movement, and locality beyond the limits of the body to the ends of instruments held in the hand, or operated by the body. Anything which participates in movement of the body was seen as added to the postural model and as becoming a part of the body schema. The postural model of the body, as described by Head, is of major importance in understanding many phenomena which occur in the area of practice shared by the fields of neurology and psychiatry or the levels of functioning of the central nervous system.

In contrast to Head, Schilder[78] extended the body-image concept to include not only an individual's personal or psychological investment in his body and its parts but also a sociological meaning for both the individual and society. To Schilder, the image of the human body is that picture or scheme of our own body which we form in our minds as a tridimensional unity involving interpersonal, environmental, and temporal factors. He also related the body-image concept to curiosity, expression of emo-

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tions, social relations, duty, and even ethics. In his considerations, the borderline between body-image and the psychoanalytic concept of the ego is obscure. He specifically suggests that one go beyond the purely perceptive side of the body-image development to that of the expressive. Schilder conceived of the ego as constant and underlying throughout life, something which takes or views the body as an object toward which it has percepts, thoughts, and feelings.

Federn,[81] in discussing the individual's consciousness of himself, differentiated the ego from the body-image. He writes of the mental and bodily ego as felt separately; the mental ego is identified alone in the sleeping state, but it is experienced as inside the bodily ego when awake. According to Federn, ego is not body-image except when the body-image is invested completely with ego-feeling. Similarly, the ego, in contrast to the body-image, is considered to be capable of complete dissolution yet to have a capacity for preservation of the somatic organization which allows for proper use of the body and its perceptions. (Federn equates ego-feeling with unity, in continuity, of contiguity and causality of the experiences of the individual: "The body scheme represents the constant mental knowledge of one's body; the body image is the changing presentation of the body in one's mind. Throughout the changes, the bodily ego is the continuous awareness of one's body. Image, scheme, ego all three are themselves not somatic but mental phenomena.")

Szasz[88] has recently reviewed the thinking of Schilder and other psychoanalysts relative to the relation of the body-image and ego. He proposes that the ego relates not only to other people as objects but also to the body (of the self) as an object, with mutual interaction between the ego and the body as an object. His discussion of his position versus that of Schilder is in terms of modern theories regarding the ego. His effort to synthesize disparate viewpoints poses an interrelation between the ego and the developing bodily functions. This interrelation could be considered theoretically as "a process of progressive mastery of the ego over the body (as an object), or, to put it more generally, as the evolution of a progressively more complex ego-body integration."

As indicated in this brief historical account, the phantom phenomenon, as representative of body-image phenomena, was studied by surgeons and neurologists. The first theoretical explanations for the changes in modifications in the limb phantoms were derived from neurology, namely in the context of Hughlings Jackson's laws of dissolution and restitution of function consequent to lesions within the nervous system. These data have never been contradicted, and the theoretical explanations advanced suffice to describe the modifications of the body's postural image organized in the sensorimotor cerebral center under ordinary conditions.

The second primary source of information on body-image has come from psychoanalysis. The observations of psychiatrists and psychoanalysts are based on studies of percepts, thoughts, and feelings toward the body, as well as personality reactions to disruptions of the body-image. Since these data represent an organization of information which occurs in the central nervous system at the highest integrative level, they may be best understood in terms of the theoretical constructs of modern psychology. Within the later framework it is possible to predicate current unusual modifications, perceptions, attitudes, or reactions to the body as consequent to the individual's previous life experiences which determine conflict between the body-image as perceived and that maintained by the ego as ideal.

For the purposes of this chapter, the term "body-image" includes both the postural model of the body as defined by Head and also the perceptions, attitudes, emotions, and personality reactions of the individual in relation to his own body.

The descriptions of the consequences of dismemberment are now sufficiently extensive to allow discrimination between healthy and pathological psychological adaptations to modification of the body-image resulting from trauma, surgical procedures, or disturbances of the central integrating mechanism. Where the consequence of disturbance of the body-image does not follow the general expectations of the

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recognized healthy adaptation, the influence of neurotic or psychotic personality development or social factors will be found operative.

The discussions appearing in the succeeding portions of this chapter are arranged to help the reader gain a clear picture of the factors influencing the development of the body-image and some of the known consequences of the expression of the body-image in healthy persons in the face of the acute stress procedures. From this information, the variations which constitute pathology and pathological psychodynamics in an individual case may be inferred.

¶ Development of the Body-Image

Over the years, the individual organizes his body-image through the integration of multiple perceptions, a process beginning with the earliest stages of development. The embryonic and infantile nervous system is exposed to proprioceptive sensory impressions from the vestibular apparatus and the receptors in muscles and joints. (The hand-to-mouth movements appearing initially *in utero* are the precursors of the complex and significant face-hand relationship.)

With the progressive acquisition of motility, the newborn acquires knowledge of his body from tactile impressions. In the sucking and feeding process, the mouth is the first area to be stimulated, regardless of whether hand, breast, or both are presented. Tactile impressions arising from the regions of the cheeks and oral cavity become closely linked with the increasingly prominent role of the hand sucking. From approximately the twelfth week following birth, the structuring of the hand-to-mouth relationship is accelerated.[35, 41, 57] The child begins to use both hands and arms to grasp and knead the mother's breast. From this movement, he then proceeds to use his hands to explore his own body surface and to contact others. Concomitantly, he finds that the hand can also substitute for the nipple as a pleasure mechanism and thereby can relieve tension.

The infant's exploratory movements of the hands over his own body, the hands in contact with the mother, and their use in projecting into and grasping objects in space provide the primary kinesthetic and tactile sensations underlying the definition of the postural model. These are the processes upon which are founded the beginnings of self-awareness, of individuality, and the sense of the ego. Important perceptions also develop in the early period from exposure to sensations which arouse varying degrees of pleasure and displeasure; stimulation by self and others, thermal stimuli, and, occasionally, direct painful contact.

In every instance, however, those sensations subserving optic, olfactory, auditory, thermal, and pain stimuli are of secondary importance to the kinesthetic and tactile exploration and perception of the body to form the postural model. This is in keeping with our knowledge of the embryological development of the nervous system in humans. As Langworthy[53] found many years ago, those sensory paths subserving kinesthetic and tactile activities are the first to complete myelinization.

Even the influence of visual percepts of the body must be considered as subsidiary to the kinesthetic and tactile. The fact that the congenitally blind develop the capacity for adult patterns of response to Bender's[12] test of double simultaneous cutaneous stimuli demonstrates the fundamental importance of the processes of kinesthetic and tactile sensation in structuring the postural model to subserve location of touch on the body surface. The significance of early sensory experience for the development of the body-image is further strengthened by the observations of Pick[68] and Riese and Bruck[76] that infants and young children who sustain an amputation before the age of five do not develop a phantom extremity. Similarly, Souques and Poisot[85] and Simmel[83] have reported that children born without limbs (congenital aplasias) do not experience a phantom limb.

With growth of the individual in size and shape and with evolving capacities for intricate motor activities, the body-image is continuously modified. The progressively developed images of the body and the body parts remain as memory traces within the nervous system and reappear in states of neurological dissolution or psychological regression, as clinical

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observations have demonstrated time after time.

In addition to the modifications resulting from developmental and sensory influences, the character or quality of the body-image is also a function of the socialization experiences of the individual. The socially determined qualities commence to appear with the earliest experiences of the individual in relation to the significant person in his family or home environment. Toward his body and its various parts, the child acquires social percepts, attitudes, and affects culminating from his interaction with his parents and members of his family as they represent the molding forces of the culture. The attitudes of parents impart an indelible impression on the child's concept of himself, his body, and its function. Depending on the experience with the parents, the body and body parts may be conceived as good or bad, pleasing or repulsive, clean or dirty, loved or disliked.

Among some families as well as some cultures, certain aspects of body development tend to be prized, while others are derogated. In general, these attitudes are related to the sex of the individual. Strength and prowess may be emphasized in boys and men, with a major investment in the development of strong limbs and muscles. In a similar manner, the parents and the culture may emphasize the aspects of the body-image which are regarded as qualities of beauty for girls. Apart from these sexually defined values, there are also specific body parts which may be de-emphasized for both sexes. This de-emphasis can manifest itself in concealment by clothing; denial through prohibitions of exposure, touch, or examination; absence of verbal communication (except in jokes); and outspoken derogation of certain body features.

Attitudes toward the body also derive from the individual's perceptions, comparisons, and identifications with the bodies of other persons. Usually, children who are accepted by and conform to their family and cultural expectations for them neither over- or undervaluate their body. Derogatory attitudes with overcompensatory mechanisms frequently develop to obscure either actual or fantasied body defects when the child feels, or is made to feel, that his body fails to meet the expectations of those about him. Where families tend to exploit the significance of body functioning and appearance, overevaluation and reliance upon security through bodily beauty or activity inevitably follow. Should there be a disruption of the body-image, persons with such security reliance are less able to adapt and are thus more susceptible to emotional disturbances.

In so far as knowledge of the surface of the body and its parts is concerned, the individual has many sources upon which to draw. Early, and relatively easily and quickly, he gains a concept of the orifices, including the mouth, the nose, the ears, anus, and urethra. In contrast, knowledge of the internal organs is gained from sensations of discomfort. These sensations may be displaced to the contiguous body surface, referred over related surface segmental impressions, or transferred to the surface through the mechanism of segmental pain. The incorporation of internal organs into the body-image is customarily vague except when a sense of pain or discomfort is referred to the surface. The influence of body knowledge and awareness on language and usage of words referring to the body is shown in such studies as that of Wright,[87] who analyzed the names of parts of the body that occur most in literature. The most frequently used by referents are linguistically the oldest and are found to conform with our accepted personal body-image.

Szasz has recently suggested an extension of the concept of the body-image or, as he calls it, the ego-body integration, to include not only the percepts, affects, and attitudes experienced historically in the life of the individual but also body parts which occur in fantasy as wish-fulfillment in defensive operations of the ego. Thus, Szasz, in broadening the concept of the perceptive ego to the expressive, would include penis-envy in females, castration in men, fetishism, and transvestism. In the case of the transvestite, he is seen as creating, with the aid of garments, a materialization of female phantom parts and an image of the body to which the ego clings.

In evaluating Szasz's concept from the standpoint of human experience, the writer holds that the expression of a phantom part

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is of a different quality and order than that expressed in a wished-for and envied missing body part that has never been experienced in reality. Persons who have not experienced the existence of a limb do not have the capacity for consciously experiencing the existence of a phantom, even though they may wish for a limb. There is a basic physiologic substratum imposed upon the cerebral cortex as the result of perceptual experience which allows development of quality of experience over and beyond that observed in the case of ego-adaptive wish-fulfillments. In line with this rationale, the writer has considered in this discussion only those disturbances of the body-image which are derived from actually perceived body parts. Disturbances representative of partial ego-adaptive mechanisms are discussed by other contributors.

¶ Physiology of the Body-Image

From a neurophysiologic standpoint, the postural model of the body is maintained through integrations of spinal neural activity and those of higher cerebral levels. That modification of peripheral sensory activity may influence the subjective appreciation of the body-image is shown by the following observations. Souques and Poisot found that cocainization of the peripheral nerves leads to temporary disappearance of a phantom extremity. Schilder states that Gallinek and Forster had success in removing a phantom by peripheral changes, and also that Adler and Hoff noted diminished perception of the phantom with application of ethlyl chloride to the stump. Head has described the disappearance of the phantom limb following a cerebral operation. De Gutierrez-Mahoney[23] and Echols[27] reported abolition of a painful phantom by surgical excision of the posterior central gyrus. De Gutierrez-Mahoney found, on follow-up studies, that the original impression of abolition of the pain or phantom did not hold. Kolb[45] observed three patients after removal of the somatosensory cerebral cortex done in an attempt to eradicate a painful phantom extremity. The phantom was not lost, but it became less vivid. Also he[49] has observed that there are no significant modifications in phantom percepts following explorations of the stump with removal of terminal neuromata, or with rhizotomies, sympathectomies, cordotomies, injections of alcohol into neuromata, paravertebral anesthetic blocks of the sympathetic ganglia, spinal anesthesias, and prefrontal lobotomy.

The body-image is, as Schilder so properly inferred, integrated in the parietotemporal areas of the cerebral cortex. Pool and Bridges[72] have reported that unilateral surgical ablation or cortical undercutting of the parietal lobe does not destroy phantom percepts. From his study of patients with hemiplegic anosognosia, allachesthesia, and various aphasias, Anastasopoulos concludes that the right parietal lobe is the major cortical area for corporeal representation. However, it would seem that imperception of the body occurs only in those with bilateral cerebral vascular lesions that have led to extensive cortical damage. Cook and Druckemiller[21] have suggested that the body-image is represented in the cortex as the function of a widespread neural network in the postrolandic area. This network, they postulate, may be activated by stimuli from the periphery or centrally from other areas of the brain when the individual turns attention on problems of body functioning or is actively motile.

¶ Family and Cultural Attitudes Affecting the Body-Image

Genetic and intrauterine processes and those later accidents of life in the form of traumatic or surgical experiences determine the bodily structure adapted to and perceived by the ego. From this ongoing interaction between perceived body and perceiving ego, consciously and unconsciously, there arise percepts, attitudes, and affects leading to adaptations of the body-image. Gross deformities such as aplasias lend themselves to the development of body-image concepts at both the physiological and psychological levels of integration, which differs from that where there have been less

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serious disturbances of the body structure. The body-image of the blind, the deaf, and persons with other dysplasias has been less well studied than that of individuals who have acquired deformities as a consequence of illness, trauma, and surgical procedures.

For the most part, the influence of family attitudes on the development of disturbed body-images has been neglected in study and practice. In point of fact, however, the capacity for a satisfactory social adaptation among those with bodily defects depends more upon the family and cultural attitudes toward body structures than upon the presence of defect. When the family or social attitude toward serious body defect is constructive and supportive, there is greater possibility for successful compensatory development without personality disorder. In the family with healthy attitudes, the defect is accepted, and personality development is directed by the parents along lines where other assets can be developed and strengthened. By these means the afflicted can obtain a kind of satisfaction which, to a degree, compensates for the effects of the inadequacy of the body-image. MacGregor *et al.*[59] have well summarized much of the existing knowledge concerning family patterns that contribute to a healthy and satisfying body-image concept.

The attitude of society toward physical disfigurement is generally that of disapproval, repulsion, and rejection. The deformed child is rejected on grounds that his deformities are due to "sins of the fathers," "punishment for wrongdoing," "incestuous parentage," etc. These myths and conceptions exist not only among the ignorant or uneducated but also among the well-educated and highly intelligent. Large adoption agencies report that it is difficult to place children with deformities. For this reason, it is not an uncommon practice for agencies to offer disfigured children to people who would otherwise not be considered suitable as foster parents. But even under these circumstances, the agencies report that they have difficulty in finding foster parents for children with physical disfigurement.

The use and misuse of superstitious rationalizations regarding deformity have a psychological value in that they provide a means for expressing and projecting an individual's own conflict and fear about deformity in his own body. In the case of the parents, the acceptance of these unsound and unrealistic values provides a means or an excuse to project the blame for the deformity onto another source, to strengthen their existing guilt feelings, or to support hostile or rejecting attitudes toward those whose appearance is different.

Despite evidence of social, vocational, and intellectual competency, the deformed are exposed to a kind of stereotyping which is socially disadvantageous. Pervasive as these attitudes are, there is a reality basis for the high concern manifested by patients with physical deformities. As a rule, the type rather than the severity of the deviation evokes the stereotyped responses. A receding chin is often associated with weakness or effeminacy. A large nose may assign its possessor to a minority group. Persons with protuberant ears, knock-knees, or pigeon toes are frequently ridiculed or become the butt of jokes and hostile humor. Some facial configurations precipitate immediate typing as a moron, gangster, drug addict, or sufferer of some serious disease. On the other hand, certain physical deformities carry a degree of social prestige, as the broken nose of a prize fighter or the scar resulting from a war injury.

With the birth of a deformed child, the mother usually responds with mixed feelings of humiliation, sadness, guilt, or depression. A small group of mothers consciously fail to see the defect as being as serious as other family members and the physician do. While this minority of mothers will have feelings of protectiveness toward their deformed children, they will also feel jealous toward other mothers with healthy babies. Comments about her baby's defect tend to increase the mother's sensitivity.

MacGregor *et al.*, in their study of persons with facial deformities, point out that the attitude of the mother varies according to the sex of the child with the defect. These investigators noted that overemphasis on physical beauty by mothers led to maladjustment in daughters. The facial defect of the female

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child was seen as producing feelings of rejection, hostility, or guilt in the mothers. As pointed out in this study, boys born with facial deformities were less likely to suffer from such maternal attitudes. It appears that the mothers and the culture as a whole did not make a strong connection between the idea of beauty and the equally desirable idea of "masculinity."

The attitude of the mother toward the defective body of the child is strongly influenced by her perception of the attitude of the husband-father. As a rule, if his response is sympathetic and positive, she finds it easier to accept the disfigurement. However, in some cases, mothers are less anxious about the child if the husbands show more distress than they do. In other cases, the guilt feelings of the mother may become magnified when the father blames her for the defect and when she has reason to believe that there is a basis for the accusation.

If the mother has a realistic awareness of the importance of physical appearance but does not exaggerate this value to the exclusion of all other assets, it is possible for her to accept the disfigured child. In such instances, and with the help of teachers and friends, the mother can be instrumental in helping the child to compensate through good manners, gracefulness, careful grooming, and attractive clothing. The usefulness of encouraging compensating personality traits depends, however, on the genuine acceptance of the child by both parents. Otherwise, parental urgings of compensatory behavior can aggravate or increase feelings of inadequacy in the deformed.

In a study of children with excessive body sensitivity but without particular deformity, Levy[54] found that the specially conducive factors were parental oversolicitude, histories of significant illnesses and injuries in the past, exposure to sick persons or frequent discussions of illness, bodily variations differing significantly from that of peers, and special bodily values of the group subculture. Parental solicitude leading to excessive bodily concern in the child was secondary to a variety of conditions in the life of the parents. For the mother particularly, marital conflict, death of the father, difficulty with the spouse's parents or family, absence of neighbors, and narrow emotional outlets tended to cause them to focus their interests on the child. To compound this difficulty, the interest carried with it displaced hostility and also destructive drives and the reaction-formation of protection. In sum, parental exploitation of the child to resolve emotional conflicts or satisfy ambitions, parental ignorance or immaturity linked with vacillatory overprotection, the death or deformity of siblings, miscarriage and stillbirths, and other special concerns resulting from personal experience served to sensitize the protective parent.

Observations of family life indicate that the deformed child does not receive the same treatment as the other children of the family. The afflicted child is usually treated either with greater consideration or with less approval and warmth, and sometimes even with outright hostility. The responses of the siblings are not necessarily the same as those of the mother to the child. In families where mothers reject the deformed child, the siblings may compensate by providing friendship and help to the child with a defective body. In some other families, the siblings will treat the defective child with outspoken impatience and resentment. Observations suggest that mothers and siblings have less pathogenic attitudes toward children who are accidentally deformed than to children born with a congenital defect; there also appears to be less likelihood of guilt reaction, resentment, and hostility on the part of the mothers.

Emulating the rejecting attitudes of their families and society, most patients with body defects manifest unhealthy attitudes and behavior in relation to their bodies. The majority of children are unwilling to look into mirrors, dread making trips away from home, and try to slip into corners and hide their faces from public view. Contacts at school with other children, who may jeer or ridicule them, often result in the deformed child's returning home in tears or sulking. In small children the ridicule may not at first be understood, but, once it is within the child's comprehension, it can lead to his avoidance of other children.

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Frequently, a deformed child will persist in questioning the parents as to why he is different and why he is the only one in the family who is different. Some children attempt to diminish the importance of the deformity by joking about it, while still others studiously avoid mentioning the subject. In every instance, however, these types of behavior are related to the parents' behavior and attitudes concerning the deformity.

The parental attitude is a composite of the parental health and acceptance, and particularly that of the mothers. Some mothers attempt to protect their deformed children from hardship by insistence on their avoiding any activity where they might be questioned. The consequence of this isolation is that both relatives and strangers are kept from contact with the child. Another type of mother will attempt to hide the defect by requiring the child to wear certain concealing clothing or to assume certain postures. In the reports of these instances, the mothers failed to recognize that this hiding was also their effort at withdrawal, although they did mention feelings of anxiety in the presence of strangers. In studying the children who deny the existence of the body defect, it has been found that their mothers attempt to deny anxiety by insistence on exposure of the child to strangers, relatives, and others. The mothers themselves are reluctant to make personal contacts or to discuss the disfigurement. When the subject of disfigurement arises in conversations, parents holding these attitudes tend to minimize their concern. Still another group of mothers compensate for their belief that the children are stigmatized by using the mechanism of "undoing." Here the deformity is spoken of as "cute," and a lack of personal concern is stressed. It is noted in these circumstances that the presence of strangers does not produce feelings of discomfort, but discussion of the defects does.

Differences between healthy and unhealthy attitudes of mothers have been comprehensively discussed by MacGregor *et al.*[59] Healthy mothers do not consider disfigurement as a stigma or punishment for their own behavior. They do not hide concern, and they are able to seek advice from professional persons and their acquaintances. In contrast, mothers whose behavior fits the child's pattern of "avoidance" are likely to become angry when the child fails to follow instructions to conceal the deformity. Such mothers regularly react by blaming the child when the child complains of discrimination. While the denying mother may allow the child with a defect a greater degree of freedom, his complaints of the attitudes of others usually meet with her rejection. She is inclined to "brush him off" with statements that he should learn "not to concentrate on the defect." Those mothers who "undo" the defect attempt to have the child develop a sense of distinction, which leads to impairment of reality sense.

The foregoing description of specific interaction between mother and child in relation to body structure provides the matrix from which the body-image and consequent ego attitudes and adaptation to the body-image arise. This knowledge, derived from studies of family instruction with deformed children, may well apply to children who later show body-image disturbances in the context of schizophrenic and psychosomatic conditions. Unfortunately, detailed studies are not available on the family patterning that leads to body-image disturbance in these conditions—information which is very likely crucial to understanding the personality character of the schizophrenic, whose conviction of bodily ugliness is a well-known clinical phenomenon. This knowledge is essential to formulating rational methods of prevention and treatment of the body-image disturbance.

¶ Special Examinations for Body-Image Disturbance

Attitudes toward the body and its parts may be elicited, and ego adaptations to such attitudes may be inferred from the data provided in the course of the psychiatric anamnesis and examination. While the usual examinations and techniques underemphasize this aspect of personality, procedures are now available which may be used to assess the body-ego integration. These techniques include modifications of the

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regular diagnostic examination, new rating scales for measuring body cathexis and appraisal, projective techniques, and specific perceptual tests.

Years ago, Levy[55] suggested a method of integrating physical and psychiatric examinations for children. In Levy's method, the child, at the termination of an ordinary physical examination and while still undressed, is asked to play the role of physician and examine his own body. The physician asks him to comment on what he has noticed about the various parts of his body, observable differences between himself and others, and preferences as to how he would like to see his body parts when he is grown. In addition to these questions, inquiry is made regarding ideas and feelings about the importance or lack of importance of height, weight, strength, and appearance. Reporting on his study, Levy noted marked discrepancies between children's attitudes toward the various body parts and their actual physical structure. The visible mouth area produced the most frequent number of responses. Eyes and hair produced frequent responses from both boys and girls. On the other hand, mammary and genital responses were more evident in boys than in girls, a finding related by Levy to the fact that there is no censor of boys in exposing these parts to nakedness. Children showing a sensitivity to secondary sexual traits appeared to have many doubts as to their sexual identity. Individual points of body sensitivity were displaced to other parts of the body by some children. Jacobson[46] also suggested a method of evaluation.

Secord and Jourard[82] have developed a rating scale as a means of appraising body cathexis. Secord[81] has also devised a word-association test utilizing homonyms as a means of investigating bodily concern. Secord's test discriminates three groups of individuals relative to body concern: the narcissistic who overvalue and overprotect the body because of its intrinsic personal value; anxious persons who register bodily concern owing to physical pain, injury, or sham; and overcontrolled individuals who apparently rid themselves of body concern through denial. The first two groups in the Secord test gave numerous responses on the word-association test, in contrast with the few responses by the third group. Using two tests, the body-cathexis scale and the word association, Secord found that the narcissistic group scored high for body acceptance and high on the word association. The scores of those with high anxiety were low on body acceptance and high on word association. Overcontrolled persons scored low on both tests. Secord's testing has stimulated much interest and has considerable significance, but the work needs further study and validation.

Machover[61] recently described in a monograph the Draw-a-Person test, a projective technique which elicits unconscious attitudes and percepts of the body-image. Using this test or its modification, the Man-Woman-and-Child test, Noble *et al.*,[65] Kolb,[50] and Wille[95] found that some limb amputees include amputated extremities in their drawings. It has not been determined whether the amputated percept might have existed prior to amputation, nor is it now known whether all amputees provide such mutilated percepts and, if this is not the case, the factors that differentiate this group from those who fail to do so.

Figure drawings similar to Machover's have been used by Abel[1] in studying patients with such facial disfigurements as congenital absence of ears, harelips, absence of the nose, scarring from burns, oversized nose, or the sequelae of facial cancers and surgical interventions. Abel has found same-sex drawings to be especially productive of information supplied by the patient. Severely disfigured persons seeking corrective (plastic) surgery portrayed their problem fully in the same-sex drawing. The mildly disfigured were less likely to do so. The projections of the face in the drawings have been categorized by Abel into these four groups: specific portrayal of the individual's disfigurement; distortion of the disfigurement (a large nose for a small nose); omission of all features of the face; and a face with features but without disfigurement.

Fisher and Cleveland[32] have recently utilized the Rorschach test in relating a single dimension of body-image concern with the manner in which the individual sees his body damage.

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These investigators state that individuals may see their body as having firm protective surfaces, or as open and without protection. Definite body boundaries are linked in the Rorschach responses to emphasis on protective values of the percepts. Definite body boundaries are correlated with responses such as caves with rocky walls and with men in armor. From the information revealed by such responses, Fisher and Cleveland have suggested a relation between boundary dimension of the body-image and the development or choice of psychosomatic illness. These investigators hypothesize that individuals with definite boundaries usually develop symptoms involving exterior layers of the body. Those persons with indefinite boundaries develop symptoms involving body interior organs. The study also indicates a correlation between adjustment to body handicap and crippling. Persons supplying definite boundaries are seen to adjust significantly better than those with indefinite boundaries when amputation or poliomyelitis occurs. Definiteness of boundary also appears to correlate with a variety of personality traits in healthy individuals. This promising work remains to be verified and amplified. Bard[9] has utilized psychological tests to predict psychogenic invalidism following radical mastectomy.

Perception, as related to the postural image of the body, has been studied intensively by Asch and Witkin.[4] In this work, subjects were placed in a small, tilted room and were instructed to adjust a rod, presented on the back wall, to the true upright. Judgments were obtained with the body of the subject upright and with the body tilted. Striking individual differences were found in the extent to which the perceived upright is affected by the surrounding tilted field. Individual consistency was considerable. Witkin is continuing these studies.

M. B. Bender's[12] studies of double simultaneous stimulation of nonsymmetrical areas of the body provide a special technique of examining perception of the body-image.

During double simultaneous stimulation of the face and another part of the body, the facial stimulation is not only invariably reported but is consistently dominant to all other body parts. The genital region is only slightly less dominant, with the hand the least, and other body areas falling in between. Normal persons who make frequent errors in initial trials of reporting double stimulations tend to correct errors. Persons with brain disease and schizophrenics appear to modify their responses less readily. Linn,[57] utilizing Bender's test in studying patients with organic brain disease, suggests that the face-hand response is fused and the hand-touch response is not discriminated verbally. Linn's patients reported through nonverbal gestures for the hand-touch test but gave oral responses in the face-touch experiment. He concludes from these observations that the hand response is not the result of extinction by more dominant face perceptions of body-image but rather a nondiscriminated manifestation of fusion of the face-hand response. Linn's hypothesis is in keeping with what is known of the early experiencing of the body by the developing perceptual ego. Pollack and Goldfarb[71] tested both institutionalized schizophrenic children and institutionalized nonschizophrenic children with the Bender technique. They found that, by the age of seven, all normal children perceive both face and hand stimuli within ten trials, while the pattern of response of the schizophrenic children was significantly different and more similar to that of younger children and those with mental changes due to severe brain disease.

¶ Phantom Phenomena

The phantoms of amputated limbs, the first to be recognized, are also the most frequently encountered, best understood, and best described. To a lesser degree, phantoms also occur following removal of other body protuberances such as the nose, eyes, teeth, nipples, penis, and the breasts of women. Since the phantom is the expected healthy response following sudden loss of a limb, a detailed account of this phenomenon is presented as a means of discriminating the pathologic reactions to limb mutilations.

The phantom limb or digit is almost a uni-

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versal phenomenon following amputation, having been reported in as many as 98 per cent of cases. Ewalt and his associates[30] studying 2,284 amputees in an American Army hospital during World War II, have developed some significant data on the occurrence of the painless phantom as compared with the painful phantom. Their report shows that only 8 patients of the total group complained of painful phantom limb, whereas the remainder had a painless phantom. From Bressler's study of the breast phantom,[15] it appears that approximately 40 per cent of the women noted their occurrence following amputation. Figures are not yet available as to the frequency of observation of the phantom of other lost body appendages.

Riddoch,[75] Henderson and Smyth,[39] and Lhermitte[56] have provided excellent descriptions of the characteristics of the phantom delusion. These writers point out that the amputee is most aware of the distal portions of the phantom such as the hand and foot. They also note that following amputation, the individual initially perceives the phantom as consisting of the whole extremity. Henderson and Smyth have characterized the sensory phenomena of the phantom as consisting of three general types. The first is a mild, tingling sensation, the basic phantom phenomenon, which is dependent upon the function of the sensorimotor cerebral cortex. The second experience is a stronger, momentary pins-and-needles sensation such as that felt in the phantom when the neuromata in the stump are touched. This sensation is apparently dependent on the functional activity of the lower spinal center. The third type consists of certain superadded disagreeable or painful sensations which are described as "twisting," "burning," "pulling," "itching," or various other complaints couched in bizarre terms. These epiphenomena are discussed in the excellent clinical reports of Bailey and Moersch.[7]

Most phantoms, regardless of type, are intermittent and more annoying than agonizing. The introspective and observant amputee may notice aggravation of the basic tingling sensation by stimulation of the stump. The aggravation, when a leg has been lost, may also be occasioned by urination, by changes in the weather, or by emotionally disturbing incidents.

Related to these general types of sensory phenomena, especially the pins and needles, are sensations referred into the phantom in the presence of dysfunction of other organs. Referred sensations into the phantom are most often elicited by deep pressure on the amputation stump, less often with algesic skin stimulation, and least by tactile stimulation. Erickson and his associates[29] have demonstrated that similar sensations may be referred into the phantom by stimulating the appropriate portion of the postcentral gyrus of the cerebral cortex. Cohen and Jones[20] have described pain of cardiac origin referred to the phantom left arm. Cronholm[22] has extensively studied the sensations referred to the phantom by various stimuli applied to the amputation stump and skin areas contiguous to this stump.

The phantom is experienced as a reality, the absent extremity occasionally described as feeling swollen, numb, or tight. Following an acute traumatic dismemberment, the amputee may forget his loss and fall as he attempts to step on the foot which has been removed. It is not unusual to obtain accounts of reflex movements in the missing extremity. The amputee often describes volitional wiggling or movement of his fingers or toes and flexion of the extremity—wrist or ankle. Weir Mitchell has observed that the conscious awareness of the phantom may be greater than that of the contralateral intact limb. The patient, preserving an alignment of the phantom with the stump, is likely to comment upon its capacity to penetrate solid objects unaccompanied by any sensation of touching. Thus, a patient lying in bed with a mid-thigh amputation may feel as though his phantom leg is flexed at the knees and the lower part is penetrating the mattress without experiencing contact with the mattress.

The phantom extremities existing after denervations of limbs or severance of the spinal cord are similar in many respects to the phantoms following limb dismemberment. Patients report that they perceive the phantom extremity in positions other than those actually maintained by the intact extremity. Occasion-

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ally, they speak of a reduplication of the phantom in which one phantom coincides with the paralyzed limb and another coincides with the limb in its healthy state. Reduplication is encountered most often in patients with high cervical transverse lesions of the spinal cord or among those with lesions in the cerebral hemispheres.

Differing from the phantom produced in the amputee, the phantom of the paraplegic does not shrink away or telescope, provided the cord transaction is complete. Also, in the paraplegic, the length and position of the phantom usually remain unaltered by postural changes of the body or by vasomotor stimulation. However, paraplegic patients do report volitional movements of the phantom and occasional homolateral associated movements. As Bors[18] reports, the most frequently willed movement in the paraplegic is in the anal sphincter.

The initial perception of the phantom becomes modified through continuing experiences. With time, the patient comes to feel certain parts less vividly than others. The faintly perceived parts tend to fade away, while others persist with undiminished intensity. In the case of the extremities, the parts which recede first are the upper arm and thigh. Next to disappear are the lower arm and calf, and these are followed in turn by the joints and parts of the hands and feet. Among the last to disappear are the toes, instep, the heel, the lateral margin of the sole of the foot or the fingers, the palm and the ulnar part of the hand. The great toe, the thumb, and the index and little fingers are retained longest.

The phantom modification and dissolution take place over varying periods of time and in some amputees are fully completed. The sequence of the disappearing parts follows the well-known neurological homunculus as represented in the sensorimotor cortex. It appears that those body areas having the most cerebral representation are richly endowed with sensory fibers that make for high sensory acuity and fine discrimination. On the motor side, the areas have high innervation ratios and the capacity for discreet and skilled movements. These highly innervated parts, dominantly perceived through usage, have not only the longest phantom life but are also subject to earliest exploration and stimulation.

Telescoping is another characteristic of the reorganization of the phantom. As the distal portions of the phantom become conspicuous in relation to the proximal segments, the position of the phantom hand or foot is at first unchanged. The patient is unaware of empty spaces or gaps between the stump and the well-perceived distal portions of the extremity. Then the amputee experiences the emptiness of the inner space, and the persisting phantom seems to become disconnected. Although it remains in its customary place and position, it has no sensation of intervening segments. Subsequently, the distal phantom hand or foot approaches the stump. In some patients the distal segment of the phantom, once connected to the stump, fades away, leaving only the toes or fingers, which may also disappear in time. In other patients the phantom hand or foot may remain intact, but in these cases it is gradually displaced into the stump, with the toes or fingers protruding. Occasionally, the stump comes to enclose both the foot or the hand. It is important to note again that the phantom extremity or portions of the extremity may diminish in size. This disconnection of the phantom size, which is frequently overlooked, is only observed if the patient is requested to compare the size of the phantom to the healthy foot.

The telescoping phenomenon is never complete. The phantom may be restored to its former extent when the peripheral stump is stimulated by pressure, as with the fitting of a prosthesis and during disturbances of consciousness in the course of severe intercurrent illness. Jackson's theories of dissolution and restitution of function within the nervous system, following either temporary or complete cessation of function of cortical or higher segmental areas of the brain stem, provide insight into the basis of the process. According to Jackson, a loss of the most recently acquired and most highly organized function ensues, with a re-emergence of more primitive functions with later acquisition of new or reappearance of some of the lost functions. Thus

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earlier infantile and childhood perceptions of the lost limb are seen in the telescoping phenomena. As a whole, neurological theories lend themselves to appropriate and satisfactory explanations of the reorganization of the phantom parts representative of the postural model of the body. Neither the psychoanalytic theory of wish-fulfillment nor gestalt psychology succeeds in explaining the failure to experience the phantom extremities by those who have an aplasia of the limb from birth or an early amputation.

In the case of an acute illness effecting loss of consciousness, there is a reduction in the recently acquired modification of the body-image among those patients in whom the phantom has disappeared. The more primitive, intact body-image concept, which includes the phantom, re-emerges. It is of interest that a paraplegic patient with phantom does not experience telescoping under these circumstances. With these patients the continuing optical image of the intact extremities prevents reorganization of the body-image.

The life of the phantom has been variously reported to persist from a period of a few months to as many as twenty or thirty years. While it is common to hear that the usual phantom disappears within two years after amputation, no firm evidence is available on the period of survival. It seems probable that the failure to reorganize the body-image with disappearance of the phantom extends over a much longer period than is usually thought.

Facial phantoms, following loss of the nose, eyes, teeth, and other portions of the face, are less frequently reported. It is uncertain whether this infrequency results from the attending physician's failure to examine completely because of psychological denial by the patient, or from psychophysiological lack of organization of this area of the body. Hoffman[42] has recently pointed out that the examination for the phantom of the facial organs should be made in terms of the subjective perception of the function of the organ. This is in accord with the description of the phantom eye of patients who have lost an eye. They report scratching or itching sensations in the eyebrow, expectancy of movements of the eyeball as though the eye were present, and sometimes blinking of the phantom eye. Among patients having resections on the nose, there may be a compulsion to touch or palpate the end of the nose. Some data exist concerning facial phenomena relative to the eye, nose, and eyebrows following radical maxillectomy with enucleation of the eyeball for carcinoma of the maxillary sinus. Similar disturbances have been reported after resection of the mandible for carcinoma.

Mammary phantoms, which are discerned as a percept either of the whole breast or of the nipple, are observed principally when the patient scratches or reports itching. Their perception is episodic and less realistic than that of the limb and is accentuated by menstruation and changes in the weather. Anal-genital phantoms include those of the testicles, penis, and rectum. There appears to be no direct correlation between the occurrence of actual erection and the presence or absence of the flaccid or erect penis phantom. In the paraplegic patient, Bors has reported that phantom sensations of the bladder and rectum are more rare than the flaccid and erect penis.

The infrequency of breast, penis, and testicle phantoms has been ascribed by Gallinek[34] to the lack of proprioceptive sensibility in immovable organs. However, the fact that they occur occasionally makes this explanation inadequate. Bressler's comment[15] that the breast is not integrated into the primitive body-image of the female child in the early years of growth and that full development occurs later seems especially pertinent. Moreover, it is not unlikely that psychosocial and cultural attitudes toward the genital and procreative organs contribute to the tendency to deny the phantom phenomena that follow their loss.

The effects of psychotomimetics such as mescaline and d-lysergic acid diethylamide (d-LSD_{25}) as they induce perceptual disturbance and modify the phantom have not been elucidated. Zador[98] has described changes in the size, shape, and position of the limb phantoms of two amputees and of a patient who was paralyzed by poliomyelitis. The latter developed a phantom of a limb after an Esmarch bandage was applied. The writer and his associates have conducted a series of ex-

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periments on an amputee who continued to have pain in a phantom arm following resection of the contralateral posterior central gyrus. In this study, 18 micrograms of d-LSD_{25} administered intravenously produced no change; 86 gamma of d-LSD_{25} led to perception of more definite form; with a larger dose (95 gamma), the size of the phantom enlarged. Phantom pain was unaffected in both trials with d-LSD_{25}.

¶ Adaptation to Disturbance of the Body-Image

A series of emotional, perceptual, and psychosocial reactions are a natural consequence of disturbance of the body-image. The nature of these reactions determines whether the individual's adaptation is healthy or pathological. The existence of a phantom is the expected healthy response to amputation of a limb or body part occurring after early childhood. Similarly, patients who have undergone changes in body configuration as the consequence of metabolic disorder frequently report bodily perceptions at variance with those observed by the patient's medical attendant and his family. The reports of sudden changes in the body configuration which result in personality disturbance are in part reactions to disturbance of the body-image.

Whether a sudden change in the body-image results from a surgical procedure or from a metabolic disorder, it always arouses anxiety in the patient. The distortion of the customary body-image is experienced as a distortion of the self. In instances of dismemberment, mourning for the loss of the part, similar to that of separation from significant persons, is expected. Further complications are introduced, with resulting anxiety, as the disfigured person is threatened by fears of separation from and rejection by the significant persons upon whom he is dependent. Feelings of hostility may emerge toward these persons as part of the separation anxiety. The perceptual life of the patient is disturbed as regards his unreal appreciation of his own body and also his perceptions of other persons. Some amputees report unusual sensitivity and discomfort upon seeing other amputees. The extent of perceptual distortion among patients with body-image disturbance is not known. The unconscious mental life of the patient is also modified by the distortion of his body-image. The dream-life may become a wish-fulfilling type in which the disfigured person sees himself performing activities in which the lost part plays an active role. Repetitive dreams recapitulating the incident that led to disfigurement are associated with the affect of anxiety.

A healthy adaptation may be measured by the patient's willingness to discuss his disfigurement or dismemberment or functional loss and the phantom and by his ability to accept offers of aid. With plastic surgery, eyeglasses, hearing aids, dentures, and other aids to social and vocational rehabilitation now widely available, the healthy person reacts by accepting his defect and cooperating with those who can assist in readaptation. Usually, the limb amputee is willing to accept the prosthesis. Similar attitudes normally obtain among those who have lost an eye and require ocular prosthesis.

Psychopathological responses to the disturbance of the body image are manifested variously. Denial of disfigurement as a wish-fulfilling mechanism to maintain the pre-existing body-image is occasionally seen, as in the failure to report the phantom after a limb amputation. Another manifestation of denial is the unwillingness to accept devices that aid rehabilitation. Scott[80] has reported the phenomenon of psychological denial in a manic patient (amputee) after a suicidal attempt. The question of the frequency of the phantom phenomenon and its significance as an indication of psychopathology will remain undetermined until more systematic study has been made of other than limb amputees. The failure to report a phantom with absence of a body part must be distinguished from conditions in which the body-image never included the absent part or where slow modification of the image took place with progressive dismemberment, as in leprosy.[83] The presently known causes for failure to report a phantom with absence of a body part are: (1) aplasias of the part (congenital defect), (2) amputations in infancy and early childhood, (3) loss of internal organs, (4) slow

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dismemberments (nonsurgical) as in leprosy, and (5) psychological denial.

The failure to reorganize the body-image over a period of time subsequent to its distortion represents a psychopathological adaptation. This maladaptation is frequent among those individuals in which the integrity of the body-image, as it existed prior to illness or trauma, is overevaluated for maintaining self-esteem. Limb amputees, in whom the presence of a limb symbolized either masculinity or femininity, generally adapt poorly to limb loss. Renneker and Cutler[74] have found that successfully married women with children adapt easier and faster to the loss of the breast from mastectomy for cancer than do those who have been unmarried or whose marriages have not been successful.

Depressive reactions occur frequently as a result of the body disfigurement. Psychodynamically, these reactions represent not only a mourning for the loss of the part but have a relation to feelings of overexpectation of rejection and fear of separation from those upon whom the patient is dependent. Repression and introjection of hostile impulses toward the significant persons are part of the reaction complex. Frank paranoidal reactions are particularly apt to express themselves following surgical procedures on patients with a self-derogatory body-image. As the expectation of a satisfying social acceptance cannot possibly be met without modification of the total personality of the neurotic patient, the hostile expectation becomes focused upon the surgeon and any others involved in the corrective procedure and toward whom the patient had built up feelings of dependent hopefulness.

Complaint of pain in the phantom or in the area of the physical disturbance may serve as a symbolic expression of the anxiety over the loss and the threat to the individual's dependency needs as well as an expression of a sadomasochistic identification, a depressive equivalent, and as a substitute obsessional symptom. The writer has found in his study of individuals with painful phantom limbs that 70 per cent had lived in close association with an amputee prior to their own loss. This appears to demonstrate the high frequency of identification as a determinant for this complaint.

TABLE 1. Comparison: Affirmative Answers to Certain Questions as Given to Amputees with Painful Phantom Limb (Without Other Physical Lesions) and Other Groups

GROUP	PERSONS QUESTIONED	PER CENT RESPONDING "YES" TO QUESTIONS 1 THROUGH 3*		
		1	2	3
Amputees	22	73	25	13
Healthy	100	20	8	8
Psychoneurotic	100	33	14	9
Psychotic	100	29	9	9

* Each person interviewed was requested to answer "yes" or "no" to the following questions numbered 1 to 3, as indicated in the table:

Question 1. Have you known intimately a person with an amputated limb (friend or member of family)?
Question 2. Was the person with the amputation a member of your own family?
Question 3. Have you lived with a person with an amputated limb?

As Kolb[49] pointed out, the characterization of the limb amputee as a terrifying and threatening individual is well expressed in English literature by Melville's Ahab, Stevenson's Long John Silver, Barrie's Captain Hook, and Poe's General A. B. C. Smith.

Fantasies of personal mutilation, usually repressed, may become remobilized by the threat or actuality of trauma of surgical procedure. Many patients with limb phantoms disclose terrifying and superstitious rationalizations which they utilize to explain the existence of the phantom limb. Magical thinking and fantasies concerning the mishandling of the separated limb or about the nature of the phantom commonly serve a guilt-allaying function. Patients with limb amputations frequently express a desire to have the separated part disposed of tenderly and respectfully, as if it were their whole body or that of a close family member. On some occasions they may even fantasy arrangement for disposal of the limb. This behavior is less likely where the illness causing the loss of the limb has been prolonged and the mourning period has been worked through prior to separation.

Psychotic reactions involving distortions in body-image follow either acute trauma or prolonged somatic disease. L. Bender,[11] in particular, has described psychotic reactions in

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patients suffering Paget's disease, osteogenesis imperfecta, and dwarfism. The acromegalic presents a similar symptom picture. In the slowly developing disease processes which distort the body structure either directly or through interruption of the growth process, discrepancy develops between the body-image of the sufferer and the physical personality. As Bender indicates, the sufferer is made anxious by the obscurity and mystery of the poorly understood disease process. Moreover, the patient is thwarted in all his strivings, whether social, sexual, or vocational, which were predetermined before the illness. In adolescents the conflict over the idealized image and the fixed image ensues when the developing body structure fails to conform to the wished-for or ideal image. For adults suffering any of the somatic disorders described above, the body-image distortion by illness requires the difficult adaptation from a level of established satisfaction to one of ill-understood acceptance and accomplishment. Bychowski[17] and Eickhoff[28] have reported specifically upon the body-image disturbances in adult schizophrenics, and Pollack and Goldfarb[71] have studied the image in the institutionalized schizophrenic child. Kolb[49] contrasts body-image of the schizophrenic and the narcissistic in his discussion of responses to amputation.

L. Bender[10] has examined the body-image disturbance in the brain-damaged, Schontz[79] in those with hemiplegia. The body-image disturbances represented in the neurological defects are considered elsewhere in this volume by Weinstein.

While not specifically concerning body-image, the general responses to disfigurement are considered by Dembo *et al.*;[24] to plastic surgery by Updegraff and Menninger;[82] to harelip and cleft palate by Brophy;[16] to the face by Baker and Smith,[8] MacGregor *et al.*,[59] and Meerloo;[62] to radical maxillectomy by Hoffman;[42] to rhinoplasty by Linn and Goldman;[53] to mastectomy by Renncker and Cutler;[74] and to genitalia by Heusner.[40]

¶ Prognosis

Since body-image disturbances may occur within the context of any personality structure, only general statements may be made in regard to prognosis. The outcome of this form of personality disorder is basically dependent on the meaning of the bodily defect to the individual. The extent and disabling nature of the defect and the availability of rehabilitative services have a meaning to the patient which exists, as Kubie emphasizes, on several levels of psychological functioning—the reality level, the level of conscious fantasy, and that of unconscious symbolic fantasy. Depending upon the individual, the loss may have any meaning such as a heroic sacrifice or a deserved punishment, a realization of helplessness and vulnerability, a conviction of loathsomeness, a despicable mutilation to be hidden or accepted, or a rejection of the part with defiance toward society and social customs. The meaning may be determined only through the psychiatric study of the individual.

A productive and satisfying social existence depends on acceptance of the changed body structure and the eventual establishment of a new body-image. The need for psychiatric treatment is evident in order to modify pathological and unconscious meanings of the change in the body structure which tend to perpetuate motivations that impede maximum recovery. But this treatment alone may be ineffective if it is not coupled with the skilled help of prosthetic experts and evaluation of vocational counselors. For some patients the attitude of responsible relatives and the local society may finally decide their success or failure in readapting to productive living. In these circumstances, educational programs designed to avoid cultural stereotyping and rejection relative to one or another disability are necessary. Attempts to predict psychogenic invalidism as a consequence of the disturbance of the body-image have been made by Bard[9] in relation to mastectomy, MacGregor and Schaffner[60] in relation to nasal plastic operations, and Fisher and Cleveland[32] in relation to amputation.

¶ Treatment

Prevention of body-image disturbance includes all those measures designed to avoid genetic and constitutional defects in bodily development. Consideration extends also to

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the role of industry and society generally in protecting the individual against accidental trauma. The individual's own psychological capacity for protecting himself against accidental injuries is certainly a preventive to the development of the body-image disorders. However, not only is the current state of knowledge in this area inadequate, but what is known is ineffectively applied or implemented by our present social structure.

In the instance of the individual confronted with an elective surgical procedure known to produce deformity, the psychiatrist and his medical colleagues may aid in the prevention of serious disturbance through proper use of the knowledge at hand. For those undergoing amputations or exposure to medications which produce body-image disruption, the preventive effects of proper preparation include advice as to the variety of body changes that may occur. In the case of amputation, the patient should be made aware of the occurrence of the phantom. Considerate inquiry into the patient's fears and anxieties is desirable. If a limb is to be amputated, the patient's desires as to its disposal and possible burial should be ascertained. Some initial discussions of the disability, its meaning to the patient, and compensation for it are advisable.

The family and other persons who are significant to the patient should be advised as to the expected post-treatment psychological and emotional phenomena. This is important so that their aid may be immediately enlisted in the rehabilitation process and especially in ascertaining the possibility of the operation's emotional destructiveness to the patient. Watson and Johnson[93] have emphasized the significance of the attitude of parents in determining the management of amputation in children. Despite excellent preoperative preparation of both the child and her parents for amputations for a bone tumor, the postoperative syndrome was complicated and aggravated by the denying and rejecting attitudes of the parents. Treatment should be instituted as quickly as possible when disruption of the body structure leads to personality disorder. Failure to do so can result in fixation of chronic psychopathic reactions. In panic reactions with pain after limb amputations, the writer has utilized a brief psychotherapeutic technique in which the following topics have been penetrated in successive order from the initial interview: (1) the concept of the phantom-limb phenomenon and any attendant rationalizations regarding this; (2) wishes and fears relative to the disposal of the amputated part; and (3) the significance of present and past attitudes toward the body in relation to real or fantasied experiences with significant persons. This procedure has proved effective in alleviating panic and painful complaints in a number of limb amputees, among those with facial disfigurement following surgery, and in women with breast deformity consequent to thoracoplasty. It has also been utilized in initiating psychotherapy on amputees who have remained chronically disturbed for years following their loss.

In disturbances of the body-image that have led to chronic personality disorders, whether psychoneurotic or psychotic, the choice of therapy is dependent on the particular variety of reactions suffered by the individual. Various forms of psychotherapy,[8, 49, 50, 87] including psychoanalysis, hypnosis,[19] narcosynthesis,[36, 50] electroshock therapy,[70, 72] frontal lobe injection,[20] and outpatient treatment with chlorpromazine[63] have been reported effective. Indications for and techniques of application of these treatments are presented elsewhere in this volume.

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CHAPTER 39

FUNCTIONAL DISTURBANCES IN BRAIN DAMAGE

Kurt Goldstein

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Our knowledge of functional disturbances in brain damage is based on the patient's symptoms. Symptoms are modifications of behavior in various performance fields. If one considers the symptoms as directly dependent upon damage of the brain matter in various regions and as directly related to defects in different performance fields, one can draw some conclusions about the relationship between a disturbance of a particular performance and a specific brain damage. Although the results thus reached are useful for practical purposes, we learn little of how a lesion modifies the specific function, and of the origin of the symptoms.

First of all, the pathological-anatomical picture seldom indicates the degree of functional disturbance produced by the injury, since this depends primarily upon the extent and intensity of the injury—factors which cannot be correctly determined even by careful microscopic investigation. Furthermore, the difficulty is increased by the fact that the kind of damage —such as hemorrhage, tumor, inflammation, or intoxication—has a different effect on the functional disturbance.

The question of the relationship between the symptom and the disturbance of the brain matter's function is by no means as simple as has often been thought; indeed, one can say it has become increasingly problematical. The main difficulty consists in determining which of the observed phenomena are actually directly related to the defect of the brain—a question which is, as yet, far from clear. Increasingly, we have learned that, when we refer to disturbance of performance caused by a brain lesion, we must consider not only the disturbed performance but all the observable modifications of the patient's behavior. We know from Jackson's distinction between different groups of sequelae of brain damage (see p. 772), that this is a very difficult task. When one further realizes that, in a brain lesion, the symptoms can differ because of various conditions of the whole organism, and that they may become understandable only as phenomena depending also upon the organism's general condition, it

is doubtful whether one can speak of symptoms as caused by brain lesion alone, or whether one can do so only in an abstract, theoretical consideration of the facts.

As clinicians, we cannot be satisfied with merely theoretical interpretations of the symptomatology—interpretations based not on clinical experience but derived from studies in normal physiology and psychology—as has frequently been tried in the past. We have to try to reach a better understanding of the functional disturbances in brain damage by taking into consideration all that we observe about the patient, his whole behavior at a given moment, especially its deviation from the norm. This is what I consider to be my task in this presentation.

The material available for this procedure is so vast that to discuss a considerable part of it here would be impossible. I shall therefore try to show, by use of typical examples of symptom complexes, which factors must be considered for an understanding of the structure of symptoms in brain damage, thus enabling the reader to apply our results to other symptom complexes.

¶ Previous Views Regarding Brain Damage

Until recently, the symptoms observed in damage of the brain cortex were considered to be expressions of a loss of so-called "images," the aftereffects of previous experiences deposited in different circumscribed regions of the brain cortex, according to the different performance fields. It was also postulated that the symptoms could not result exclusively from the effect of these circumscribed defects—that additional factors must be involved; only thus could the variations, the alternation between normal and abnormal reactions of the patient in seemingly the same task, be understood. These other modifying factors were considered to be "general mental capacities" such as attention, memory, interest, and emotions. The additional factors were brought more or less into relationship to localized or general brain functions. The influence of the atomistic theory of brain function was so great that one overlooked the fact that, by introducing these general functions, nothing was gained. As a matter of fact, closer observation showed that these "general functions" varied in the same way as did the single performance. Attention, for instance, may seem to be sometimes grossly disturbed, and yet the same patient, under other conditions, may appear attentive or even abnormally so (cf. Goldstein,[18] p. 249). Thus we found ourselves in the same situation as before when we tried to understand the variations of the phenomena by assuming the influence of such general functions.

Today it is hardly understandable that the solution to the problem was not discovered earlier, namely: to consider the symptoms not only in relation to the dysfunction of limited parts of the brain but in relation to the individual in whom they appear; in other words, to consider them as performances of the sick individual. The concentration of study not on the single symptom but on the behavior of the total personality of the patient, during examination and in everyday life, made it more and more evident that the symptoms could only be correctly evaluated if one considered them in relation to the condition of the total psychophysical personality. This instigated an intensive study of each single symptom in relation to the behavior of the total patient at a given moment, which, in turn, became the point of departure for the concept of the so-called organismic approach to psychopathology in general (see in regard to this Goldstein[19]). It is this organismic approach which is the basis for this presentation.

The new approach was not the result of a new theoretical concept but the outcome of better observation and investigation. Closer scrutiny led to the concept that the symptoms are consequences of the sick organism's struggle with the demands of the tasks confronting it; in other words, symptoms are forms of behavior by which the individual tries, in spite of his defect, to come to terms in the best way with the outer and inner world. The approach grew out of the necessities of neuropsychiatric practice, out of the task of retraining a great number of young men with brain injuries and different mental defects with which we were confronted during and after World War I, and out of the recognition that the psychopatho-

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logical theories prevailing at that time, and the methods of training based on them, were insufficient to fulfill the task. There was an urgent need to find a more successful interpretation of the phenomena, particularly so because the subjects with whom we were dealing could not any more be considered as interesting objects for theoretical studies, as was often the case in psychopathology in earlier times. The disastrous condition of the young men confronted us with a strong challenge to help them in every way possible. The approach became particularly promising after the analysis of the symptomatology of a great number of patients with various brain injuries had revealed another point of view in the consideration of organismic life in general and of man's in particular, namely: that the basic motivation of the living being is to realize its own nature; that is, to realize all its capacities to the highest degree possible in a given situation. By applying this viewpoint, many seemingly contradictory symptoms became understandable, and much better results of retraining were achieved.

The structure of the organismic approach will become clearer when we consider individual symptoms in brain damage. We shall see, then, that phenomena which were once considered to be different, isolated defects appear now to be simply different expressions of the same brain damage under different conditions of the whole organism.

Before entering into the subject, I want to make a few general remarks about the period in which the organismic approach originated and the place of this new approach within the ideas of that time. It was related to the new "holistic" orientation in physiology and medicine in general, which finds its expression in such a saying as, "There is no sickness—there are only sick human beings." I refer in this connection to a congress held in 1932 under the topic *Einheitsbestrebungen in der Medizin*,[10] where men famous in anatomy, physiology, and different fields of medicine came together to discuss this question with great enthusiasm.

While the new approach brought deeper insight into the function of the organism and a better understanding of pathological phenomena, it confronted us with a number of new methodological problems. When one considers each symptom as dependent on the condition of the entire organism, great difficulty arises in determining the relationship of a symptom to the specific brain damage. This particular problem had been seriously considered fifty years before by the famous English neurologist and psychopathologist, John Hughlings Jackson, who reached a general point of view in psychopathology to which ours bears much similarity.

Jackson, as an outgrowth of his experiences with aphasic patients, emphasized that psychopathological phenomena can be understood only if one gives up the theory of images, and he stopped considering disturbances of images in brain defects as causes of symptoms. He believed that, in order to understand psychopathological phenomena, one has to begin by analyzing the modification—due to its damage—of the function of the brain, and by considering the different symptoms of aphasic patients as expressions of a disintegration of the brain matter; expressions of a lowering of the function of the brain to a level where automatic and emotional reactions still are possible, while the highest function, the propositional symbolic function, is more or less lost.

Jackson's ideas were so far ahead of his time that he found little approval. In the famous discussion between him and the French neurologist, Broca, at the British Association for the Advancement of Science in London in 1868 in which both men defended their contradictory theories about the function of the brain, Broca emerged as victor; afterward, Jackson had little influence on the work in psychopathology. Although some great men in the field at that time, A. Pick, C. von Monakow, Adolf Meyer, and others, stressed Jackson's great significance, referred to his ideas, and used them in their work, he was nearly forgotten for a long time. He had to be newly discovered. This rediscovery occurred during the period referred to previously when clinical practice demanded better procedures for helping brain-injured soldiers in England. It was the English neurologist, Henry Head, who based his treatments on Jackson's ideas and demonstrated their fruitfulness for understanding much of the aphasic symptomatology and for its treatment. A little earlier, other unbiased

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studies by Storch, Heilbronner, Pierre Marie, Lotmar, Bonmann, Gruenbaum, Woerkom, and K. Goldstein, influenced more or less by Jackson, gave different new interpretations of psychopathological phenomena which can be considered as precursory to the organismic approach.

By stressing the organismic approach as the best one for an understanding of the symptoms in brain damage, I do not want to imply that this approach has found full acceptance. Although a considerable amount of psychopathological research is more or less influenced by it, certain men prominent in the field are strongly opposed to it, for example, in this country, Nielson and some others.

Adherents to the older "classic" theory, founded on associationism and the assumption of isolated, circumscribed disturbances, base their opposition primarily on the argument that the new approach is too general and does not therefore do justice to the problem of localization, and, even more important in respect to the problem with which we are dealing here, to the great variety of modifications of performance of the brain-damaged patient.

As to the opposition concerning the problem of localization, I would like to point to various papers of my own, particularly the presentation of the subject in the German *Handbuch der normalen und pathologischen Physiologie*.[16] There I have shown that this problem is by no means neglected by the new approach; moreover, *that the approach put it on a more realistic basis*, so that many mistakes originating from the old concept can be avoided.

Proof that the new approach emphasizes the great variety of symptoms and the problem of understanding them will become apparent when we now discuss the symptomatology of patients with severe damage of the brain cortex.

¶ Effect of Impairment of the Abstract Attitude Owing to Brain Damage

I shall not start with a description of patients with defects in special performance fields, such as speech, motility, vision, sensation, etc., but with patients who show disturbances in all these fields in such a way that some performances in each field are impaired and even lost, while others seem relatively well preserved. This clinical picture occurs particularly in severe lesions of the frontal lobes or in diffuse damage of the brain cortex by injury or intoxication, in general paresis, etc. It can be shown that the complex and outwardly very inconsistent symptomatology of the patient can be understood as an effect of the damage to a special mental capacity which we call the abstract attitude. Before going into this matter, it seems necessary to make some remarks concerning the concept of the human mind which underlies this interpretation.[24, 26]

The normal individual displays two kinds of attitudes toward the world—the *concrete* one and the *abstract* one. In the concrete one we are given over passively and bound to the immediate experience of the very things or situations in their uniqueness. Our thinking and acting are determined by the immediate claims made by the particular aspect of the object or situation. For instance, we act concretely when we enter a dark room and turn on the light switch. If, however, we refrain from turning the switch, reflecting that we might awaken someone asleep in the room, then we are acting abstractly. We transcend the immediately given aspect of sense impressions, we detach ourselves from the latter, and consider the situation from a conceptual point of view, reacting accordingly. The abstract attitude corresponds approximately to what Henry Head has called—in relation to speech—symbolic behavior.

The healthy individual is able to shift voluntarily from one attitude to the other, according to the demands of the situation. Some tasks can be performed only by virtue of the one, some only by virtue of the other attitude. For the beginning of any activity, the abstract attitude is a presupposition. During activity, the concrete attitude is often dominant, but, should the course of action be interfered with or disrupted, abstraction is required to correct such disturbances and to continue the activity properly.

Patients with impairment of abstract attitude may not appear to deviate grossly from normals in everyday behavior, because many routine tasks do not require the abstract atti-

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tude once these tasks have been set going. During observation of the patient in a variety of situations, however, it becomes evident that he does not react like a normal individual; he appears more stereotyped and reserved. He seems to lack initiative and spontaneity. Tasks which demand choice or shifting particularly reveal the defect.

From analysis of the behavior of a great number of such patients in various everyday and test situations, we[25] have compiled a list of modes of behavior in which the performances are disturbed owing to impairment of the abstract attitude.

The patient fails if he has

1. To assume a definite mental set.
2. To give an account to himself for acts and for thoughts.
3. To shift reflectively from one aspect of a situation to another.
4. To keep in mind various aspects of a task or of any presentation simultaneously.
5. To grasp the essential of a given whole, that is, break it up into pieces, isolate them, and synthesize them.
6. To abstract common properties reflectively.
7. To perform concepts, symbols, to understand them.
8. Voluntarily to evoke previous experiences, for example, images.
9. To assume the attitude toward the "merely possible."
10. To detach the ego from the outer world or from inner experiences.

It has often been said that the defect of the patients consists of an inability to cope with new situations, but that they are able to proceed in an abstract way as far as old experiences are concerned. The fact, however, is that patients fail equally in familiar situations and in new ones, if the situations demand the abstract attitude. On the other hand, they can cope with new tasks successfully, but they can do so only as long as these do not require the abstract attitude. Indeed, patients are more likely to fail in new situations rather than in old ones because the former frequently demand new sets, in other words, the abstract attitude.

The analysis of many patients' failures in different tasks has shown that a great number of symptoms are explainable as the result of this one defect and that in the same way the variations of the patients' reactions in apparently the same task can be so explained. If the patient seems to be successful at one time and fails at another, this seeming inconsistency is resolved when we realize that the tasks which appear equal to us may (as a result of the disturbance of this function) not be at all the same for the patient. The following example may illustrate this. If we present to the patient an angle built of two little sticks, with the opening downward, and ask him to copy the presentation after it is removed, he produces the angle correctly. If we present the same angle with the opening upward, the patient, after the angle is removed, is not able to produce it. For us, the angles are not different; for him, they are not only different, they have nothing in common. He says that the one (with the opening downward) appears to him like a roof; the other structure does not mean anything to him. His correct response was determined by the fact that the first structure appeared to him as something which corresponds to concrete experience; he failed with the second structure because this was not the case, because he could not assume the abstract attitude which is necessary to fulfill this task.

This is one of numerous examples which definitely show not only that the patient can react only to (for him) concrete conditions, but also how careful we should be in our interpretation, since the task set before the patient may to him appear totally different from the way it appears to us.

A few further examples from different performance fields may illustrate the failures due to impairment of abstract attitude. Just as the patient cannot deal with figures when they do not represent concrete objects, he fails further when he is confronted with ideas, thoughts, and feelings when their handling presupposes abstract attitude. He is unable to shift from reciting one series (for instance, numbers) to another (days of the week), because active shifting is impossible for him. He can follow or even take part in a conversation about a familiar topic or a given situation, but if he has to shift to another topic—even one equally familiar—he is at a complete loss.

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He may be able to read a word and, at another time, spell it, but when asked first to read and immediately afterward to spell, he is unable to do so. The patient's speech in everyday life may not show much deviation from the norm. He may in certain situations have a great number of relevant words at his disposal; this is the case when the words belong concretely to the situation. He will fail concerning the same words, however, when the situation demands that he consider their meaning. His words fit only definite concrete situations. He cannot understand that the same word can have different meanings. In respect to learning, he has the greatest difficulty in rote learning and very quickly forgets what he has learned. The same difficulty exists in the behavior of the patient with regard to practical activities, such as handicraft and labor. (Concerning the symptomatology of such patients, see Ref. 11.)

I would like further to mention two important general points. The first is that loss of abstract capacity cannot be regained by retraining. Only improvement of the brain damage may more or less restore the impaired capacity. The second point is that there are different degrees of abstract behavior, depending on the extent of conceptional complexity which the performance in question involves. Thus the patient may be able to fulfill some performances which need abstract consideration. The highest degree of abstract behavior is required for the conscious and volitional act of forming generalized concepts or for thinking in terms of a principle and its subordinate acts and verbalizing these acts. Similar abstract behavior is the act of consciously and volitionally directing and controlling every phase of a performance and of accounting for it verbally.

A lower degree of abstraction is necessary in volitionally planning an act or series of acts without distinct awareness of or self-accounting for every phase of its further course. In some performance, as in intelligent behavior in everyday life, only the directional act is usually abstract, and the ensuing performance follows a concrete plan. Here the patient may be successful until difficulties arise. He may fail when the required shift demands the abstract, anticipatory deliberation. It is apparent that only careful analysis of each performance in respect to the degree of abstraction required for execution will allow us to decide whether or not the patient is disturbed. The decision is easiest if some tests which have been constructed for this purpose[25] are used.

We are inclined to believe with Jackson that the abstract capacity, the symbol function, being the expression of the most complex function of the brain, suffers first in damage to the brain cortex, while isolated lesions in the motor and sensory areas show only damage of the concrete performance "instrumentalities" (see p. 776). Not infrequently, the symptomatology consists of a mixture of damage to both parts, although the damage may not necessarily be equal in both. Thus we can get very complex clinical pictures.

The opponents to the organismic approach stressed that it took into consideration only symptoms belonging to the higher level, the abstract attitude. This criticism may appear to be justified, since some authors mentioned only these disturbances in aphasic patients, because they considered aphasia an expression of a damage of symbolic function or "intelligence." This holds true, for example, for Pierre Marie, Ludwig Binswanger, and Kronfeld and Sternberg. It is, from the organismic approach, not at all appropriate, however, to omit the symptoms belonging to defects in the lower-level function, the so-called motor and sensory instrumentalities, which are necessary for realization of the symbolic function in the performances of the organism. The very complex picture which aphasia represents, in which motor and sensory disturbances of letters, words, and other features of language not dependent on the defect of the symbolic function are often so completely mixed with those which are dependent on it, gives all the more reason to study carefully the structure of *all* abnormal phenomena. Otherwise, one cannot reach a correct conclusion as to the origin of the clinical symptoms. This is all the more necessary since defects in the instrumentalities *secondarily* influence the use of the symbolic function. Only by analysis of all symptoms can one clarify what is primarily due to the latter. Indeed, even Jackson showed insufficient interest in the effects of disturbances of the "instrumentalities," in the destruction of single

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words and letters, in the disturbances of grammar, of the finding of words, and of sentence formation which are related to dedifferentiation of the function of the motor and sensory apparatuses (see Ref. 15).

The problem of the relationship between the disturbances in damage of the instrumentalities of language (the instrumentalities belonging to the concrete forms of behavior, cf. Goldstein,[11] p. 163) and those due to damage of the symbolic function interests us, particularly, because clarity concerning this relationship is essential for correct evaluation of the symptoms not only in aphasia but in all performance fields.

Jackson did not sufficiently evaluate the disturbances of the instrumentalities, because he considered the separation between the higher and lower functions of the brain cortex to be too absolute. There is no doubt that the processes in the higher and lower levels of the brain are, to some extent, associated; both belong to the "mental apparatus." The organismic approach assumes that any damage which concerns one part of an apparatus changes the function of the rest of the apparatus as well; the "parts" can be considered as only artificially separated "parts" of a whole. This is the case in the connection between the lower- and higher-level functions of the brain cortex. Under normal conditions all performances are determined by a working together of both functions as a unit. Under certain conditions, performances come into the fore which are related to the one level; under other conditions, those which are related to the other level. Such a preponderance of behavior related to one level exists if this level is important for the self-realization of the individual in a particular situation. Thus, for instance, if an individual is thinking with concentration, the concrete world is more or less forgotten; it is, so to speak, in the background (cf. Ref. 19, p. 109). The opposite holds true when an individual is totally involved in concrete behavior. The various abnormal performances correspond to the different ways in which the union of the two functions is impaired.

Jackson speaks of a disintegration from the voluntary to the automatic-emotional level. He goes so far in his separation of the two levels that he assumes, concerning language, that the lower-level activities are related to the "inferior" hemisphere, the right one, while the symbolic function is connected with the "superior" left hemisphere, an assumption which is not in accord with the newer concept of localization.[16] Indeed, Jackson has stressed, in general, the modification of the function of one apparatus owing to damage of another one connected with the first one. On this concept is based his distinction of positive and negative symptoms; the negative ones are an expression of the direct damage of an apparatus, the positive ones the effect of the modification of the function of an apparatus due to another one to which it is related. But he did not come, in my opinion, to a correct conclusion regarding the function of the lower-level apparatus separated from the function of the higher one in disintegration of brain function. He assumed that defects in the higher level did not alter the behavior related to the lower level, in so far as the lower level continues to remain "integrated." We assume, too, that impairment of abstract attitude is an effect of a dedifferentiation of brain function, a reduction of the most complicated function to a simpler one; however, this does not imply that the undamaged lower-level apparatus remains unmodified in its way of functioning. Phenomena belonging to the lower level do *not* remain fully integrated, and the preserved automatic and emotional performances of the patient do *not* simply represent the effect of the lower-level function as it existed before. It is not enough to say that the function of the brain is *reduced* from a level corresponding to the voluntary activities to a lower one corresponding to emotional and automatic performances. The character of this reduction, of this modification of the brain function, has to be considered if one wants to understand behavior on the lower level in all its details. Neither the automatic nor the emotional reactions of patients with impairment of abstract attitude appear, on closer investigation, "normal."

¶ The Automatisms in Damage of the Higher Level of Brain Function

The automatic reactions in damage of the higher level of the brain function show definite deviations from the norm. They do not

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come so easily into action. Conditions in the outer world or within the individual, which usually instigate them, must now be present in a very "adequate" way; in even small deviations from the familiar conditions, the learned automatisms do not occur. So, for instance, it is not enough to ask the patient to utter the (very automatized) series of numbers; the first numbers often have to be presented orally; only then is the patient able to speak the rest of the series correctly. If the patient is interrupted at any point in the procedure, he will not be able to continue, as a normal person would. These and many other phenomena not only show that the automatisms also are functionally modified in damage to the higher level, but also point to the fact that the automatisms are normally closely related to the higher level, more closely than one usually assumes.

The observable modifications of the automatic reactions are not fully explainable by the assumption of a lack of the influence of the higher-level function; only when one considers them as a change in the normal relationship between the figure and ground in the unit they represent can they be understood. Every process in a stimulated area is accompanied by a definite excitation in the part of the organism not directly stimulated. We call the excitation in the stimulated area the *figure* and the excitation in the rest of the organism the *ground*. All performances of the organism, as well as all experiences, are so organized. Figure and ground are intimately interconnected; to every figure belongs a definite ground. The phenomena corresponding to either one can be properly evaluated only by considering the other as well. What is meant by figure and ground is most obvious in visual experiences; however, all other experiences and performances, such as motor reactions, speaking, thinking, feeling, etc., are organized in a similar way. To this organization of the performances correspond equal organizations of the physiological processes in the nervous system.

All damage to the nervous system, especially brain damage, disturbs the figure-ground organization in general or in a part which belongs to a definite performance field. The sharp differentiation of figure from ground suffers, inducing a general leveling or intermingling of the phenomena belonging to figure and background. This can, at times, be carried to the point of inversion, so that what normally is figure becomes ground, and vice versa. We expect a definite figure as reaction to a definite stimulation, but the patient may respond according to the background. This change of the normal figure-ground organization is the basis of a great number of symptoms in damage of the nervous system and in neuroses and psychoses. It is clear that reactions in isolated parts will be deprived of the influences of the normal figure-ground organization which goes on within them, and that they will thus be changed, particularly in respect to their contents. Normal figure-ground organization is, like all performances, dependent upon processes belonging to the higher level as well as to those within the realm of the instrumentalities. It is determined by previous experience, by memory. Furthermore, one has to consider that figure-ground organization in one field is related to the figure-ground organization which the whole organism represents.

In all performances the whole unit is in action. According to the significance of one or the other part for the performance, this part is in the foreground, but the performance is correct only if it occurs in correct relationship to the background which the other part represents—which changes according to the demands of a definite task. If the lower-level function is somewhat separated from the higher-level function, this will come to the fore in modifications of the automatisms, according to the significance of the higher-level function in preserving the relationship of the two levels for definite tasks of the organism—in some tasks more, in others less. Thus the patient's difficulty in starting an automatic series shows that, for the setting in motion of an automatism, some higher-level function (I would say some abstract attitude) is necessary. What has taken place following disintegration of the brain function is a damage of the normal figure-ground relationships between the two levels, which may be observed in variations of the automatic activities under various conditions of the whole organism, by which the figure-ground relationship is determined. Normally, this figure-ground relationship exists which makes possible the

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fulfillment of the task to which the organism is exposed. After damage to the higher-level function, the figure-ground organizations are disturbed—the most complicated ones more than the simpler ones. This shows that the automatisms are, in general, effective, but they are not normal, being modified by the disturbance of the more complicated figure-ground configurations in the disintegration of the brain function involved.

This interpretation of the automatic performances in disintegration of the brain function corresponds to the general explanation of the automatisms and reflexes, to concrete behavior in general, which I have given on another occasion (cf. Ref. 18, Chap. V). I tried to show that these phenomena are not the effect of isolated processes in the organism but represent figures in organizations of the whole organism which differ from those in normal performances only in the special form of the organization.

There is another factor which brings us further understanding of the modification of the behavior in damage of abstraction: the influence of isolation of the lower level in its function. The change of the function of one part of a unit owing to its separation from another part cannot be considered alone as the effect of a lack of influence of one on the other. The effect of isolation itself modifies the function of the separated part. Consideration of this factor has proved to be of the greatest significance for understanding many symptoms in pathology. It has shown that the modification follows definite laws which are equally discernible in each performance field which is in a state of isolation. The modification by isolation concerns particularly the dynamics of the processes. We shall consider them in more detail later, when we take up symptoms which are the effect of direct damage to the instrumentalities (see p. 782).

Emotional Reactions in Disintegration of the Brain Function

For Jackson, the paradigm of the lower-level function was emotional, interjectional speech which is usually fully preserved in damage to the higher level, the symbolic function. Concerning this preservation of emotional, interjectional speech, we are confronted with a more difficult problem than in the automatisms—owing to the uncertainty of opinion about the nature of emotions. Jackson was inclined to consider emotional reactions as belonging to the same category of behavior as the automatisms, and thus to consider the preservation of both in disintegration of brain function as equal phenomena. It is doubtful whether it is justified to put the two groups of phenomena under the same heading. Normally, they show a number of differences, particularly a different relationship to the total personality and to the symbolic function. Automatic phenomena represent part processes of the voluntary activities and are dependent on them. They always occur under the direction of the latter or under the direction of outer-world influences. Emotional reactions are not voluntarily produced, but their connection with the abstract attitude differs essentially from the connection of the automatic activities with the latter. The emotional activities have something in common with the abstract activities in that both represent attempts of the personality to come to terms with the world, that both are emanations of a definite attitude toward the world. The emotional attitude differs from the abstract attitude, however, in that this coming together of personality and world is more immediate, more in relation to the existence of the individual, while the abstract attitude guarantees the organization of an ordered world separated from the individual. Because of this close connection to the existence of the individual, emotions play a particular role in all forms of self-realization and occur in concomitance with, and not in dependence on, the voluntary activities. One has often assumed that emotions are simply disturbing phenomena. This is most certainly wrong. I would like to refer in this respect to newer research published by Leeper[33] and K. Goldstein.[14] Success and failure in all performances are accompanied by definite emotions. Which kind of emotion arises depends on the implications of the situation with regard to the individual's way of realizing his nature in a particular case. The correct emotions—

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that is, those which help to achieve self-realization—are of great significance for executing correct performances.

The emotions are complex phenomena; they consist of inner experiences which are not conscious in the usual sense of the word, but of which we are well *aware* (see in regard to this Goldstein,[19] p. 34). They consist further of activities by which they are "actualized"—movements of the face and body, the so-called expressive movements of different kind; of linguistic utterances such as interjections, sounds, words, and sentences which are brought to the fore in characteristic intonations; and finally of physiological processes in the vegetative nervous system.

What has been called emotional language represents the linguistic part of the motor activities (instrumentalities) belonging to emotions. The activities in emotions—and so also the linguistic phenomena—are based on innate mechanisms acquired in experiences related to the world in general, and most particularly in relation to other human beings. These motor phenomena correspond to the other automatisms in so far as they are concrete activities and come to the fore in emotional situations, as the automatisms do in voluntary activities.

From this aspect it seems incorrect to speak of emotional language; it would at least be less prejudiced to speak of linguistic means, linguistic instrumentalities for realizing the emotional attitude which a situation provokes. They represent special linguistic phenomena, but they are not different in principle from those instrumentalities which are used in abstract attitude. Emotional language is a special, not a more primitive, form of language. The emotional attitude is not a more primitive attitude than the abstract one; it differs from it by another kind of relationship to the total personality, a closer one. It seems appropriate to assume that the greater significance of emotions for the existence of the personality in the world makes the substrata underlying them more resistant to damage of the brain function. It is for this reason that they are better preserved than those substrata underlying the symbolic attitude.

From our discussion it seems that we are not justified in considering that emotional reactions are equal to automatisms. We have mentioned that the automatisms show modifications in impairment of abstraction. Does that impairment not find expression also in differences between the emotional reactions of the patient as compared to those of normal individuals? I think it does. Clarification of this point seems to me important for a better understanding of the abnormally frequent occurrence of emotional reactions and their modifications in patients.

Considering the facts, we must stress the following: Emotional phenomena usually are more predominant in patients with impairment of abstraction than in normal people. Most probably the reason for this is that the world of the patient, owing to impairment of abstract attitude, is not organized normally and so makes many normal reactions impossible. The patient, when urged to react, tries to do what he is able to do, and he is most able to produce emotional reactions, and therefore also emotional language. The emotional activities, however, occur not only more frequently than normally but they are modified as well. They show the characteristics of *isolation* (cf. p. 782); the isolation is due to the lack of the normal relatedness to the reactions in the abstract world, by the impairment of the latter.

Thus we come to the following result: Preservation of the emotional language is an expression of the preservation of emotional reactions; in individuals with disintegration of the brain function, it is *not*—as is the case in preservation of the automatisms—a direct effect of an inferior brain function coming to the fore. Preservation of emotional reaction represents the maintenance of this attitude of man toward the world, which, in normal man, exists alongside the abstract attitude. Because the emotional attitude is more closely related to the personality and more important for its self-realization, it shows greater resistance toward damage of the brain function and thus may remain undisturbed when the abstract attitude is disturbed. The emotional instrumentalities are preserved in the same way as are the instrumentalities in general in impairment of abstract behavior. This shows in the possibility of using them in concrete behavior. The odd preservation of emotional language does not present a

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special problem. Whether a patient is able to produce language or not depends on the attitude under which such language is demanded in a given situation, that is, whether the abstract one or the emotional fits the situation. If the latter is the case, the patient will bring out words; in the former case, he will not. This could be demonstrated by a great number of examples which show that the patient is able to utter a word in an emotional attitude but is not able to do so voluntarily, that is, in the abstract attitude, even immediately afterward. One particularly instructive example concerning a patient of Jackson may illustrate this. The patient responded to the demand to say "no" by saying, "I cannot say 'no.'" He was not able, however, to repeat the word "no." The speaking of the word "no" in the sentence is not a voluntary act but belongs to the patient's concrete reactions. The repetition of the word "no" presupposes the voluntary attitude (cf. Ref. 15, p. 71) which he could not assume, therefore he was unable to say the word on demand. From a superficial aspect this would seem to be a contradiction, since the patient was able to say the word "no" with great emphasis when asked to do something which he could not do, that is, when in an emotional attitude. This seeming contradiction is resolved when we realize that the words appear to be the same but actually are not the same, since they represent totally different reactions of the whole organism. The patient was able to utter the word only when the situation induced him to take an emotional attitude. It is obvious that wrong interpretations of the patient's capacities can easily occur if this difference in attitude is not taken into consideration.

I would like to mention, in the latter respect, another very instructive example: it concerns the difficulty in finding words, particularly names of even the most common objects. This is a very frequent symptom of aphasic patients. No matter how similar, on face value, failures of the patients may appear in respect to the finding of words, the defects can be due to a defect of an entirely different function. In one kind of patient, the inability to name is an expression of an impairment of abstraction; in another, it is a sequela of a defect in the instrumentalities of language, a memory defect. The patients of the first kind have not lost the words but are not able to utter them in naming, because naming, as analysis has revealed, presupposes the abstract attitude. The other kind of patients, with difficulty in finding the name, have no defect in abstract attitude, but their instrumentalities of language are damaged, and therefore they cannot find the words. Only when one considers the whole picture which the patients present does the difference of the origin of the symptom become apparent. As long as one pays attention only to the effective reaction, as has often been done—in this case the difficulty in naming objects—the underlying damage of the brain function may appear the same. This fallacy occurs particularly if one records the results of examination by the plus and minus method and considers the answers only in respect to success or failure. This conclusion from the effective answer, without analysis of the way in which the patient came to the answer, the "fallacy of effect," is the cause of many mistakes in the interpretation of psychopathological phenomena and in the building of theories. It shows up particularly in failures of retraining when the interpretation was wrong.

Similar observations, as we have mentioned, can be made not only concerning the language of the patients but in regard to other motor activities which belong to emotional situations. An example may illustrate this: The patient was asked to behave as he would in a situation in which he became angry with some one and was menacing him. He was not able to do so. When we demonstrated such behavior to him, he began to laugh, apparently perplexed, not quite sure what was meant. He was not able to perform the action on demand. But, observed in a situation in which he actually got angry, he behaved instantaneously like a normal individual as shown by the expression of his face, the action of his fists, etc. This example points to the important difference which often exists between the patient's behavior during special examination and during everyday life. Observation under the latter condition, so often neglected, deserves the greatest attention.

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Symptoms Due to Direct Damage of the Instrumentalities

Up to now, our description of symptoms in damage of the brain cortex was concerned with effects due to disintegration of the brain function from the higher-level function to the lower one. We have discussed symptoms caused by impairment of the higher-level function, the abstract attitude, and have discussed the effect of the impairment of the abstract attitude on the lower-level function, the motor and sensory activities, the so-called instrumentalities, by which the higher-level function is actualized.

At this point we shall consider symptoms which are the effect of direct damage to the instrumentalities. We have to restrict ourselves here to a *survey* of the different ways in which damage of the function of the brain, concentrated in definite regions, is revealed in modifications of normal behavior. From this point of view, we have to classify the symptoms into two main groups.

Symptoms Which Represent Direct Sequelae of Damage to the Substratum of a Definite Region

These sequelae rarely take the form of complete loss of a performance; more commonly, the performances affected undergo modifications. Such modifications can be considered as a result of a systematic disintegration of the concerned function. Structurally, this disintegration invariably exhibits the same features, regardless of the region involved, be it the spinal cord or the subcortical apparatus, and regardless of whether it concerns reflexes, motility, sensation, speech, thinking, or feeling. A particularly important consequence of this dedifferentiation is impairment of abstract attitude and abnormal concreteness of behavior, about which we have spoken before.

All direct damage causes a rise of the threshold and a retardation of excitation. The receptivity of the patient is reduced in the involved sense organ. It takes him much longer to react. This manifests itself in the fact that patients may succeed perfectly in a task when they are given a sufficiently long time of exposure but fail in the same task when given only brief exposure, for example, when examined by the tachistoscope. (The tachistoscope is an instrument which allows exposure in different short lengths of time.) Pathology consists of a slowing down of the physiological process.

The patient may perceive when the stimulus is strong enough and presented long enough, but he may cease to see it after a certain time, in spite of continued stimulation. Later, the sensation may appear again; it seems that the threshold changes during stimulation. This is also true in stimulation of normal individuals, but it is far more apparent in brain damage.

When excitation takes place despite obstacles, it spreads abnormally and remains effective an excessively long time. This is due to disturbance of the process of "equalization" by which the effect of the stimulation is regulated (cf. Goldstein,[19] p. 113). Examples here are phenomena such as tonic innervation, repetition of the same movements, reiteration in reflexes (clonus), etc. A word grasped with great difficulty by an aphasic patient sticks, perseverates, and influences subsequent performances.

Another characteristic effect of the damage is the fact that performances are determined to a much greater extent than normally by stimulating influences, external or internal. We call this abnormal stimulus responsiveness.

Symptoms Due to a Separation of an Undamaged Area from a Damaged One

By such separation or, better, "isolation," the function of the undamaged area, and thus the performance, is modified in a definite way. The pathology can consist in an isolation of parts of the unit which the organism as a whole presents and an isolation of the subunits corresponding to definite performance fields. Isolation can occur in gross anatomical separation or in functional separation; it can also occur in psychological conditions.

It seems useful to give here a brief summary of the functional changes caused by isolation

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(cf. Goldstein,[19] p. 133). The reaction appears modified in the following ways:

1. The effect of an adequate "stimulus" is abnormally strong.

2. The effect of an adequate stimulus is of abnormal duration.

3. The reaction is abnormally influenced by inadequate stimuli, external or internal. It is abnormally "stimulus bound."

4. The individual is forced to react. He appears to be easily fixated when his reaction to the present stimulus is completely successful. If his reaction, however, is not fully successful, he seems to be forced to react to another present stimulus. If, now, the correct reaction takes place, fixation will set in; if the correct reaction does not take place, the patient will again be forced to react to still another stimulus, etc. Thus he may appear very distracted. The patient seems to be driven to achieve an "adequate" reaction by which the entrance of "catastrophe" is eliminated (cf. p. 784). Fixation and distractibility appear so as the two results of the same defect under different conditions.

5. As a result of loss of the normal influence of the rest of the organism on the activity in the isolated part, the reaction appears to be lacking special contents. It appears, or actually is, more "primitive" because it lacks properties belonging to the "nature" of the individual. The degree of primitivity and diminished appropriateness depends on the place and extent of the isolation, on how large a part of the whole organism is excluded from cooperating in the reaction (cf. Ref. 19, p. 148 ff.).

6. Isolation distorts the normal figure-ground organization which is of essential importance for the outcome of any normal reaction.

All the factors mentioned above are responsible for occurrences of abnormal performances, and all of them have to be considered in the evaluation of any one symptom in damage of the brain cortex.

¶ Symptoms Representing the Reaction of the Individual to the Defect

So far, we have discussed symptoms in brain damage only in their relation to defects of structure and function of the brain. Our results were still somewhat unsatisfactory, particularly in regard to *understanding the variability* of the symptoms. We must try, therefore, to go a step further, to regard the phenomena not only in their relation to the damage of structure and function but in their relation to the reaction of the individual and of the whole organism to the defect. Such a step corresponds to the procedure of the organismic approach and often leads to a better understanding of the patient's behavior.

Systematic investigation of the patient's general condition while he is able to fulfill a task and when he is unable to do so reveals another fallacy, which consists of only recording the effect of failure or success in the performance. One observes, particularly in patients with impairment of abstract attitude, that the patient, unable to fulfill a simple, seemingly unimportant task, may be completely changed in his total appearance. The same man who, shortly before, looked animated, calm, in good mood, well poised, collected, and cooperative, while successfully fulfilling a task, appears now to change color, to be agitated; he starts to fumble and becomes unfriendly, evasive, even aggressive. This overt behavior is very reminiscent of that of a person in a state of anxiety. The relationship of this general condition to the capacity of fulfilling a task becomes particularly evident from the fact that such a general condition can be experimentally produced, in some patients, by presenting them with a task which we know they will not be able to perform.

We call the state of the patient, when he is successful, an ordered condition; the state in a situation of failure, a disordered or catastrophic condition. In the latter condition the patient is incapable of performing tasks in which he is usually successful, which he is able to do very well when in the "ordered" condition. Such failure lasts for shorter or longer periods of time. One observes frequent catastrophic conditions, particularly in patients with impairment of abstract capacity. Since an individual with such impairment is unable to account to himself for what he is doing or experiencing (see p. 774), we assume that he is

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not aware of his failure; as a matter of fact, he is unable to say, when questioned about it, whether or not he has been confronted with something frightening. Hence we come to the conclusion that the catastrophic condition is not a conscious reaction to the failure but, rather, belongs intrinsically to the objective situation of the organism in failure.

Even the smallest failure may have this effect on these patients, since they are unable to decide which failure might be dangerous for them and which might not. They are, so to speak, always endangered whenever their reaction is not adequate. Thus any objective failure can bring the organism into disorder, into catastrophe, into anxiety.

I cannot, in this presentation, discuss the consequences of our description of these phenomena for a theory of anxiety (cf. Ref. 18, Chap. VII). Here, we are interested only in the symptoms which these patients show, owing to the occurrence of anxiety, which are not directly related to the damage of the brain. If we do not pay attention to this, we may be deceived about the patient's brain defect and may consider symptoms as being related to it, when actually they are not. Consideration of the phenomenon of catastrophe explains the variability of symptoms under similar conditions.

One factor which is apt to modify the symptomatology considerably is the development of protective mechanisms by which the occurrence of catastrophes is eliminated or at least reduced. It is easy to understand that all patients, when they do not essentially improve, have the greatest desire to get rid of the anxiety, for otherwise they are prevented from using even their preserved capacities and thus from coming, at least partially, to a state of self-realization.

We realize that patients with even severe brain damage and impairment of abstraction show, after a certain time, a diminution of the disordered behavior, of catastrophic conditions and anxiety, and yet, examination reveals no change whatever in the damage to their mental capacities. In such cases this can occur only if the patient is no longer exposed to tasks he cannot cope with, or is able to take the failure without reacting with catastrophe. Concerning the first point, observation of his behavior in everyday life reveals that he lives apparently in a modified environment, an environment from which far fewer tasks arise which might lead to catastrophes. How does such modification of environment take place? Observation shows that the patient is withdrawn from the world around him so that a number of stimuli, including dangerous ones, do not arise. He avoids company. He is as much as possible doing something which he is able to do well. What he is doing may not have any particular significance for him, but concentration on activities which are possible for him makes him relatively impervious to dreaded stimulation. Particularly interesting is his excessive orderliness in all respects. Everything in the surrounding world has a definite place. Similarly, he is very meticulous in his behavior as to time, whereby the determination as to when he should do something is related to events and to activities of his which always occur at the same time, or to a definite position of the hands of a clock. This orderliness enables him to prevent too frequent catastrophes.

Another interesting protective mechanism is unawareness of the defect. We observe this particularly in patients with impairment of abstract attitude, but also in patients who are incapacitated in a special performance field without mental damage, for instance, in severe hemiplegia. This symptom, called Anton's symptom, described first by Anton in 1899,[2] occurs particularly when the incapacitation is total (cf. Ref. 39, p. 38), so severe that the patient is not able to use the disturbed capacity at all. The symptom may not take place if the defect is partial and if the patient is able to use the capacity at least to a certain degree, for example, if he can move his paralyzed leg somewhat. This protective mechanism has been described as denial, a procedure which would demand a somewhat conscious activity. I do not think that such an interpretation is correct. Certainly, it can be rejected as far as it applies to patients with impairment of the abstract attitude, who are, owing to this defect, unable to do anything voluntarily. Whether the phe-

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nomenon becomes more understandable if one ascribes to it unconscious influences is doubtful. I think it is sufficient to consider it as an effect of a new organization of the behavior of the organism, which, though *not directly related to the defect*, occurs from the organism's tendency to realize the capacities which it has, in pathology those which are preserved. Within this new organization the effect of the disturbance does not become apparent. This would make it understandable that the patient is not only unaware of the defect, but that the defect is so arranged in his behavior, without his knowledge, that the disturbance does not show.

It is not the disagreeable experience of the failure itself which produces the new organization. This becomes evident when lack of awareness or other protective mechanisms disappear under the influence of the physician. As transference develops between patient and physician—when, for example, under the influence of the physician the patient learns to bear his disturbances and learns through his own experience that, by bearing them, his general contact with the world is improved—then he is more able to realize himself without the shelter of the protective mechanisms. With this added security, he is able to give up his safeguards. Indeed, the more the abstract capacity which makes such deliberation possible is preserved, the more is this the case.

We consider the organization of protective mechanisms as an expression of the attempt of the organism to come to terms with the demands made on it, in such a way that self-realization is guaranteed as much as possible. I would like to stress that these passively originating, protective mechanisms occur not only when the abstract attitude is impaired but also if it is by circumstances diminished, as, for example, in severe anxiety in normal individuals.

There is another way to eliminate danger to self-realization which is produced more actively by conscious interference. One should distinguish these mechanisms, which occur particularly in neuroses, from the passively originating protective mechanisms by terming them differently—by calling them defense mechanisms.

In view of these facts, we should be very cautious in the interpretation of symptoms; the possibility that some phenomena observed in the patient might not be the effect of a damage but of a protective mechanism always has to be considered. This concerns also the absence of symptoms by "denial," which might be expected in a special damage of the brain.

Somatic symptoms, resulting from defects of the nervous system, can also bring the patient into general disorder. Here also, we observe, after a certain time, a modification of behavior by which, even when the original damage is neither eliminated nor improved it is no longer effective. For instance, a patient may, after damage to one hemisphere of the cerebellum, suffer from disequilibrium, falling, deviations in walking, etc., and from different disturbances in general, subjectively and objectively, and so may be hindered subjectively or objectively in his self-realization. After a certain time the general disturbances improve, without improvement of the pathological condition (which special examination shows existent as before). Concomitantly with the general improvement, however, we see that a deviation of the body has occurred, which seems to bring about a new equilibrium, a better general condition, and thus a better possibility for self-realization. The patient, however, is not aware of his deviation.

That this general improvement is related to the deviation becomes apparent by the fact that improvement disappears immediately when one tries to eliminate the deviation; in other words, such action brings the patient into the previous condition, into catastrophe. We say that the deviation represents the individual's new, preferred condition (cf. Ref. 19, p. 340). The following few remarks may explain what is meant by this. If we consider an organism by the usual atomistic method as composed of parts, members, and organs which can be used in very different ways, and if we then look at the organism in its natural behavior, we find that many kinds of behavior which, on the basis of the first consideration can be conceived of as possible, are actually not realized. Instead, only a definite selective range of behavior can be observed. Normally, each performance is

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executed only in a definite or, as we say, preferred manner. Observation of the whole organism in a situation where one performance field —be it motility, perception, language, etc.— shows preferred behavior reveals that all other performance fields exhibit preferred behavior as well. In the above case we say that the organism is in an ordered condition; it performs all its activities in the best way; it can use all its capacities in coming to terms with the demands of the outer world; it has a definite constant visual acuity, an erect position of the body, is able to speak and to act according to its nature, that is, is able to realize itself in the best way.

The organism always tries to achieve such ordered behavior in spite of its defect. It can be reached only through modification of the behavior in the damaged performance field by finding a new preferred behavior which goes along with a somewhat modified but preferred behavior all over. This must be considered in our evaluation of deviations; we have to distinguish those which are the expression of the defect from those which are an expression of the new, preferred behavior; that is, from those which are means to guarantee the new order. This distinction demands careful study of the influence of the deviation on the behavior of the whole organism, that is, whether or not it is accompanied by order or disorder of the latter. A symptom belonging to a preferred condition is characterized by the fact that any voluntary change of the new preferred behavior brings the organism into general disorder and that it returns involuntarily to that very behavior. So, for instance, should the head be in a tilted position, any attempt to bring it to the normal erect state produces not only general disorder, but the head returns involuntarily to the new preferred condition, in this case a tilted position.

What we have described here concerning the effect of a cerebellar damage can be observed in damage of each performance field in the change of the direction of the performances toward a new preferred order. This new preferred condition can be achieved in two different ways.[22] One way consists of yielding, giving in to the defect; the other, of building a counteracting mechanism by which the effect due to an abnormal condition is compensated. These two ways of eliminating the danger to self-realization do not present equal effects. By the first, the normal functioning is, in principle, unchanged. It is the more "natural" procedure; it occurs more automatically, scarcely demands voluntary activity on the part of the individual, and therefore brings greater security. By the second way the normal form of functioning in the particular apparatus is changed. It is a more volitional type of behavior; it is not as secure, leads more readily to fluctuation, and admits greater possibilities for catastrophic reactions. Whether one or the other way of adapting to the irreparable defect occurs depends on which offers the best possibility for self-realization under the given conditions. If this is guaranteed by the first procedure, it will occur, since it is the more secure procedure; if, however, this is not possible, then the second way of adaptation occurs.

The significance of the preferred condition for the best performance must be considered most carefully in all therapy, even if that condition deviates from the "normal." Any attempt to bring the patient into the "normal" condition may make all treatment meaningless and inane. The similarity of this situation in organically disturbed patients and in neurotics is theoretically of the greatest interest. Unfortunately, we cannot even touch this point here.

We mentioned before that the symptomatology of a patient with brain damage can become more difficult to understand in direct relation to the defect because of a factor other than the protective mechanisms. This factor is the development of the relation between the physician and the patient. If this relationship is good, the patient will no longer become afraid so easily and the occurrence of catastrophes may be diminished; thus, many defects may come to the fore which the patient concealed simply by not reacting because he was afraid to let them appear. The development of a kind of transference between the patient and the physician is of the greatest significance for a correct examination, for finding the defects related to the damage, for evaluation of the symptoms, and, not least, for execution of cor-

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rect therapy. This development of transference in organic patients has not had the attention it deserves. In this respect I would like to refer the reader to my article about organismic therapy in this volume where I also discuss in detail the transference in organic patients (cf. Goldstein[12]).

¶ The Nature of "Distorted" Performances and Their Interpretation as Symbolic Phenomena

The discussion of the protective mechanisms, particularly their consideration as new preferred behavior, has some bearing on the understanding of phenomena which are usually called compensational or distortive. When we observe such phenomena, the question of whether we are actually dealing with pathology always arises. I have in mind particularly some reactions, unusual as to form and content, of aphasic, apraxic, agnostic patients. What does the material which the patient brings to the fore represent? Sometimes it certainly is the expression of disturbances in the field of the instrumentalities. Sometimes, however, one gets the impression that the material corresponds to activities and experiences which have played a particular role in the premorbid life of the personality, and which are now released, so to speak, through pathology. From this point of view such material has been considered as of particular significance for the study of the deeper level of the patient's personality. It seems to me important that we look at these phenomena a little more carefully than is usually done. They deserve attention not only in relation to their interpretative value of symptoms but from a more general point of view as well. They have suggested an interpretation as "symbolic" phenomena, which, in my opinion, is mostly wrong. The error originated because their relationship to the total condition and behavior of the patient was not fully considered.

Some utterances of aphasics, also of such whose symbolic function was generally disturbed, can easily give the impression of symbolic phenomena and often have been interpreted as such. I think they can be understood in various other ways as well which are not in contradiction to the existing basic defect, the defect of the symbolic function. Some are so-called "physiognomic phenomena"[42] and represent normal reactions which occur in a special concrete and not symbolic attitude of the individual. This is easily overlooked because these phenomena are not well known. In our culture particularly, they play a small part in everyday life and are not familiar except in the experience of artists. In normal life they are, so to speak, embedded in our realistic everyday attitude toward the world, and they come to the fore only in special situations. We do not have sufficient studies of the physiognomic behavior of our patients, but I feel justified in assuming, from my experience, that this behavior differs from normal physiognomic experiences which are related somewhat to the symbolic attitude. This relation is lacking in the physiognomic experiences of the patients. They appear particularly when the attitude of abstraction is diminished by pathology, and especially in patients with a premorbid inclination for the physiognomic attitude toward the world. Such utterances should not be considered as symbolic. For these patients, a shifting from the physiognomic attitude to the more usual attitude, which, for normal individuals is easy, becomes almost impossible. Their aspect is, so to say, fixated due to "isolation."

Other utterances are more difficult to evaluate and frequently give rise to symbolic interpretations. They are outstanding in the sense that they consist of poetic, symbolic, or even newly coined words; they may appear to be utterances of particularly intelligent, cultured, and erudite personalities. I have often observed such "quasi-symbolic" phenomena in aphasic patients. In a recent paper, W. Riese[37] has stressed the occurrence of such phenomena. He has considered them as means "evidently to compensate the naming defect of the patients." The patients' neologisms "impress the listener by their descriptive and figurative power." The language of one of his patients, "a highly educated scientist and humanitarian" before his sickness, became "after a brief initial

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period of complete loss of speech, formal, solemn, poetical, dramatic, pathetic and 'Shakespearean,' frequently using quotations." He continues: "What the brain injury brought to the fore was that element in his nature which disease could not destroy, but rather released" and "I reached the conclusion that disease may occasionally reveal though in a distorted fashion what is great and noble in man's nature."[37, p. 11]

It is true that such utterances and behavior may occur in patients with brain defects. I have noted that disease may emphasize the premorbid character of the patient, especially in the way the patient now bears the defect and in what way the untouched part of the personality helps him to overcome his failures. Whether in a patient with impairment of the abstract attitude an interpretation such as W. Riese suggests is justified, I would doubt. In such cases, I think, we are dealing with phenomena of "quasi-high" value, and I assume that the patient Riese describes belonged to that group. Closer consideration may show that the phenomena represent material which previously belonged to the behavior of a high-level personality, which appears now in the form of protective mechanisms and has lost their previous meaning for the particular individual. These utterances represent the undamaged remnants of the instrumentalities of speaking and thinking, which prevail now because the adequate activities due to the impairment of abstraction are impossible. The previous particular way of speaking, the previous rhythm and preference for poetic, dramatic, pathetic expression of the personality are preserved, but this material no longer is an expression of the attitude to which it originally belonged, the attitude which is lost through damage to the brain. Some abnormalities which these utterances show, and which Riese has carefully reported, reveal that we are no longer dealing with utterances prompted by the premorbid personality of the patient. They reveal "no planning, no effort, they occur passively, apparently without intent." In all this, they show the characteristics of isolated automatisms. The rapidity and fluency with which they are uttered (which Riese mentions, and which I have often observed on such occasions) may be even better described as being "thrust out." I think that the patient utters the words in this manner because he wants to get rid as quickly as possible of the distress in which he finds himself when he cannot react correctly but feels forced to do so. As one of my patients said: "If one is asked, one has to answer," and he brought out something which occurred passively in him by *association* of previous knowledge to the task he had to fulfill now. He said definitely that he did not know and could not say how it entered his mind, but that he was forced to utter it.

Such examples definitely point to the fact that these utterances are not related to the present personality. Certainly, their prominence is an indicator that we are confronted with experiences which the individual has had before, and therefore his utterances may reveal the premorbid character of the personality, but we cannot assume that they represent the old personality as released by pathology. In any case, we must be careful to see whether we are justified in so doing or whether these utterances do not belong to "quasi-high" behavior.

I have discussed these phenomena in some detail because I consider it important for the psychiatrist to be fully aware of this problem. We meet the same problem and the same wrong interpretation in the evaluation of utterances of schizophrenics, which have often been considered as symbolic, as expressions of deep insight into the essential things of human life, which disease has revealed. Here too, I do not want to deny that the particular premorbid personality of the schizophrenic patient may become apparent in some of his behavior. This is understandable, because we assume that the patient is not totally modified in the typical schizophrenic manner but is partially normal, or, better, in some respects normal. (Federn has stressed this particularly. Cf., on this point, my chapter, "The Organismic Approach," p. 1342.) Thus he may show normal and even high-level personality behavior under some conditions, but I would deny that this particular high-level behavior is related to the schizophrenic condition. We shall understand the

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behavior of the patient only when we distinguish sharply between high-level behavior and "quasi" reactions which only appear to be of high-level nature. That the latter occur in schizophrenics is to be expected, particularly when we assume that the patient's behavior is frequently abnormally concrete.

We know, since Vigotski's[40] investigation, that thinking in concepts is disturbed in schizophrenic patients, at least in some groups of such patients. This was confirmed by the work of Hanfmann,[27] Kasanin,[31] Bolles and Goldstein,[5] and others. Storch[39] was already doubtful whether one is justified in considering schizophrenic behavior as symbolic. Beck[3] has stressed, on the basis of his Rorschach studies on schizophrenics, that it is an error to assume that the schizophrenic gives the world "a form and outline which the healthier do not see," that he has "a greater power or superior ability to transmute his experience into something richer." The author wonders "whether the general belief in the schizophrenic profuse fantasy life is not due to confusing distortion with fantasy." He adds: "Fantasy actually involves a *creating* of something totally new. . . . The schizophrenics' misconstructions take on fantastic form. But this is still not fantasy. It is inaccuracy. . . . Not having the power to apprehend the presented real world is what chiefly distinguishes the schizophrenic's percepts and his thinking."

I have come to the conclusion that in schizophrenia we are dealing not with an organic defect of abstraction but with a nonuse of abstraction which concerns only a definite part of the world, and that this is an effect of the anxiety which the schizophrenic experienced in early youth in relation to his personal environment. This nonuse of abstraction is a protective mechanism against the danger of catastrophe and anxiety. (Cf. Chap. 65, "The Organismic Approach.")

The fact that the origin of the abnormal concreteness in schizophrenics differs from the origin of such concreteness in organic patients becomes apparent in certain essential differences of the symptomatology. This can be seen, for instance, in the frequent appearances of physiognomic experiences. The schizophrenic's utterances sometimes yield "symbolic" interpretations but are often revealed, by analysis, to be only pseudo-symbolic phenomena. Such phenomena are here particularly suited to appear as symbolic, since the distortion of behavior brings out much of the instrumentalities belonging to the preschizophrenic condition of the patient where the symbolic attitude plays a more or less important role in the thinking of the patient. Further attention must be paid to the fact that schizophrenics often build complex mechanisms to cover their ideas, feelings, etc., which may easily appear to be of a high-level function, owing to their complexity, but which prove to be only complex associations built on a very concrete basis. This is often difficult to unveil, because the schizophrenic has not only passively originating protective mechanisms, like the organic patient, but also has defense mechanisms, which he produces intentionally, that may give the impression of higher-level function and sometimes may be also an expression of it. The picture of schizophrenic behavior is so complex that its origin may be understood only by a very detailed analysis. In this analysis the distinction between real symbolic and "quasi," pseudo-symbolic behavior has to be taken very seriously.

¶ The So-called General Mental Functions as Origin of Definite Symptoms

I stressed, in the beginning of my presentation, that in the interpretation of symptoms a distinction has often been made between defects in a special performance field and defects of so-called general functions, and that this distinction is not justified since the general functions appear changed in the same manner as do the specific performances. There is not enough space here to give detailed proof of the correctness of my statement, but I would like to make a few remarks about the changes in these general functions, particularly those which are related to the personality change of the patient owing to impairment of abstract attitude. I have chosen these because analysis

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of this dependence may be especially useful for psychiatrists.

First, there is the problem of memory. Under certain circumstances the faculty for reproducing facts acquired previously may be about normal in patients with impairment of abstract attitude. Things learned in school, for example, may be recalled very well, but that is the case only in certain situations. The situation must be suited to the reawakening of old impressions. If the required answer demands an abstract attitude on the part of the patient, he may be unable to recollect. Therefore he fails in many intelligence tests which seem very simple to a normal person, and may be amazingly successful in others which appear complicated to us, namely in those which can be executed without the abstract attitude. He is able to learn new facts and to keep them in mind, but he can learn them only in a concrete situation and can reproduce them only in the same situation in which he has learned them. Because intentional recollection of experiences acquired in infancy requires an abstract attitude of the adult in relation to the situation at that time, and the events in infancy were not experienced abstractively, the patient is unable to recall experiences of infancy, but we can observe that aftereffects of such experiences appear passively, at times, in his behavior. He is incapable of recollecting when asked to recall things which have nothing to do with the given situation. He can recall only when he is able to regard the present situation in such a way that facts from the past belong to it. Repeated observation in many different situations demonstrates clearly that such memory failures are not caused by an impairment of memory content. The patient has the material in his memory, but he is not able to use it freely. He can use it only in connection with a definite concrete situation. (Cf. my discussion of the problem in Chap. 65.)

We arrive at the same results in testing attention. At one time the patient appears inattentive and distracted; at other times, he is attentive, even abnormally so. The patient's attention is usually weak in special examinations, particularly so at the beginning, when he has not as yet become aware of the approach to the whole situation, something he can get only through concrete activity. When he has done so, has entered the situation concretely, his attention is usually satisfactory, and he may even appear abnormally attentive, because under such circumstances he might often be totally untouched by other stimuli from the environment to which normal persons would unfailingly react. In other situations he will seem to be very distracted, as, for instance, in those which demand a change of approach. He seems distracted because he is incapable of making a choice. Consequently, it is not correct to speak of a change in attention in such patients in terms of plus or minus. The state of the patient's attention is but part of his total behavior and is to be understood only in connection with it.

Another important problem is judgment as to the patients' emotional experiences. Usually, the patients are considered emotionally dull, and often they appear so, but it would be incorrect simply to say that they are suffering from a diminution of emotions. The same patient can be dull under some conditions and very excited under others. This can be explained when we consider the patient's emotional behavior in relation to his entire behavior in a given situation. When he does not react emotionally in an adequate way, investigation may reveal that he has not grasped the situation in such a way that emotion could arise. The patient may have grasped only one part of the situation—the part which can be grasped concretely—and this part may not give any reason for an emotional reaction. His emotional reaction appears to us inappropriate because we grasp the whole situation to which the emotional character is attached, while he reacts only to a part of it. This connection between emotions and total behavior becomes understandable when we consider that emotions are not simply related to definite experiences but are, as I have stressed before (see p. 778), inherent aspects of all behavior, are part and parcel of behavior. No behavior is without emotion, and what we call lack of emotion is a deviation from normal emotions corresponding to the deviation of behavior in general. From this point of view, the follow-

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ing modifications of reactions, which are of particular interest in respect to the problem of emotions in general, are interesting: We frequently see that a patient reacts either not at all or in an abnormally quick manner. The latter occurs particularly when the patient believes he has the correct answer to a problem. Although this quick behavior might seem to be simply an effect of a change in the time factor of his reactivity, it is actually the effect of an emotional factor. To some extent, the patients are always in danger of coming into catastrophic conditions, and the quick response is an effect of their tension, of which they want to rid themselves by all means. They are forced to release tension because they cannot handle it and cannot bear it. To bear tension presupposes deliberation, considering the future, etc., all of which is related to abstraction. The difference in behavior between these patients and normal people throws light on the nature of the trend to release tension. The patients must, so to speak, follow the "pleasure principle." They must, owing to their abnormal concreteness, react to the stimulus in a way which brings release. The trend to release tension thus appears as an expression of pathology, as an effect of a protective mechanism to prevent catastrophic conditions. The ability to speed up an activity or part of it, when this corresponds to the requirements of the task, belongs to normal behavior, but in the same way as the capacity to bear tension and even to enjoy it at times, when it is necessary to fulfill a particular task. In contrast to this, patients with impairment of abstraction are only able to experience the pleasure of release of tension. They never appear to enjoy anything, a fact which is often clearly revealed by the expression of their faces. This becomes understandable when we are aware of the fact that in any kind of joy immediate reality is transcended, that joy is a phenomenon which presupposes the abstract attitude and especially the category of possibility. Thus brain-injured patients who are impaired in this attitude cannot feel joy. Experience with brain-injured patients teaches us that we have to distinguish between pleasure through release of tension and the active feeling of enjoyment and freedom so characteristic of joy. Pleasure through release of tension is the passive feeling of being freed from distress, and therefore this feeling lasts, in normals, only until a new situation stimulates new activity. Joy, on the other hand, is something we try to extend, something which admits the possibility of infinite continuation.

The two emotions of joy and pleasure play essentially different roles in regard to self-realization. They belong to different performances or different parts of a performance. Pleasure may be a necessary state of respite, but it is a phenomenon of standstill. It is akin to death. It separates us from the world and the other individuals in it; it is equilibrium, quietness. In joy there is disequilibrium. But this disequilibrium is productive, leading toward fruitful activity and a particular kind of self-realization. This difference in the significance of the two emotional states for the normal person and the brain-injured patient is an expression of the essentially different behavior of the latter and of the different world in which he lives.

The drive toward release of tension is one of the causes for the strange behavior of brain-injured patients in friendship and love situations. The lack of the experience of future forces them to look for close relationships to other people and to maintain such relationships at all costs. At the same time, close relationships are terminated suddenly should their maintenance necessitate some bearing of tension, that is, should any difficulties arise in the relationship. The following example is illustrative: One of my patients, Mr. A., was for years a close friend of another patient, Mr. X. One day Mr. X. went to a movie with another man. Mr. X. had invited Mr. A. to go along with them, but the latter did not want to go, since he had seen the picture before. When Mr. X. returned, my patient was in a state of great excitement and refused to speak to Mr. X. He could not be quieted by any explanation. He was told that his friend had not meant to offend him and that his friendship had not changed, but these explanations made no impression at all. From that time on, Mr. A. was the enemy of his old friend, Mr. X. He was aware only of the fact that his friend had been companion to another man, and he felt himself slighted. The experience had produced great tension in him. He regarded his

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friend as the cause of that tension and reacted to him in a way which is readily understandable in terms of his inability to bear tension and to put himself in the place of someone else.

Another patient never seemed to be concerned about his family. He never spoke of his wife or children and was unresponsive when we questioned him about them. When we suggested to him that he should write to his family, he was utterly indifferent. He appeared to lack all feelings in this respect. At times, according to an established practice, he visited his family in another town and stayed there for several days. We learned that while he was at home he conducted himself as any man would in the bosom of his family. He was kind and affectionate to his wife and children, and interested in their affairs in so far as his abilities would permit. Upon his return to the hospital from such a visit, he would, when asked about his family, smile in an embarrassed way and give evasive answers; he seemed utterly estranged from his home situation. Unquestionably, the peculiar behavior of this man was not actually an effect of deterioration of his character on the emotional and moral side; his behavior was the result, rather, of the fact that, owing to his impairment of abstraction, he could not summon up the home situation when he was not actually there, and therefore he could not show adequate feeling and behavior. Lack of active imagination, which is so apparent in this example, makes such patients incapable of experiencing any expectation for the future. Active imagination depends on the abstract capacity.

This lack is apparent, for instance, in the behavior of a male patient toward a woman whom he later married. When he was with her, he seemed to behave in a friendly, affectionate way and to be very fond of the girl. But when he was separated from her, he did not care about her at all; he would not seek her out and certainly did not desire to have a love relationship with her. When he was questioned, his answers indicated that he did not even understand what sexual desire meant. He could not imagine any sexual situation and did not understand pictures which showed such situations. When he met the girl again, however, when she spoke to him, he was immediately able to enter into the previous relationship. He was as affectionate as before. When she induced him to go to bed with her, embraced him and put his penis into her vagina, he performed an apparently normal act of sexual intercourse, with satisfaction for both. She had the feeling that he loved her. She became pregnant, and they married. The above case also reveals the great significance of speech and voice for any relationship, particularly when other possibilities are destroyed by the defect of the brain function, as was the case here.

Some other so-called general factors which are often mentioned as obstacles to examining such patients consist of fatigue and perseveration. Here, also, observation shows that these phenomena are not always present in the same way, that they change according to the situation, as do all performances. Observation of our patients shows that fatigue is not a simple function of the duration of continuous performance but depends to a high degree upon whether or not the performance in question is within or somewhat above the capacity level of the patient. Thus a paradoxical situation may occur, where fatigue decreases as the activity continues. This happens, for instance, when a later task is "easy" to perform while the earlier tasks could be executed only with difficulty. Another point is the fact that fatigue does not express itself simply as a slowing down of performance but, especially at the beginning, as a fluctuation of performance (Goldstein,[20] p. 260). Subjectively, the individual feels not only incapacitation but also discomfort, uncertainty, and distress. The phenomena occurring in fatigue show great similarity to those observed in catastrophic conditions and seem to be closely related to them. Patients with severe brain damage tire easily because many normal tasks represent difficult ones for them, thus producing distress. While fatigue in difficult tasks may thus be understandable, we may ask whether the same point of view is appropriate to explain the fact that fatigue occurs also in continuous work consisting of a task which is within the limits of the individual's capacity. I think that is the case. Continuation means consumption of energy which deteriorates the function of the substratum, so that a task which was previously

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easy to perform may be changed into a difficult one; therefore, mere continuation may produce catastrophe and fatigue. This becomes evident by the fact that fatigue does not set in as early when the task is varied. Boredom and interest influence the fatigue rate. This must be considered particularly in testing situations. If, after we recognize the onset of fatigue, we should change the task, the patient may then perform without fatigue and may do so better, both subjectively and objectively. This is particularly true if the succeeding task is within the capacities of the individual, and if the change does not demand a voluntary shifting on the part of the individual, which, as we have mentioned previously, is an especially difficult problem for many brain-injured patients. Automatized performances may be continued for a long time without the patient showing and experiencing fatigue. We frequently observe, however, severe breakdowns after excellent performances. This suggests that the symptoms of fatigue are not only signs of catastrophe but also indications of imminent catastrophe—warnings, which, thoroughly considered, may help to prevent the latter. Patients with a mental defect which appears in a lack of planning and foresight are particularly prone to fatigue, since they do not recognize the protective danger signals and thus become abnormally tired.

Perseveration is a frequent phenomenon in brain damage. I am inclined to assume that it is a secondary phenomenon due to incapacitation in some performances, and a means to avoid catastrophe occurring under such conditions. Perseveration occurs particularly when the patient is forced to fulfill tasks with which he is unable to cope. For instance, a patient who has difficulty with arithmetic may be able to answer promptly as long as he has to solve problems which are within his capacity. The moment he is given a problem which he is unable to fulfill, he may either be thrown into a catastrophic state and not react at all, or he may repeat the last correct result or a part of it, that is, he perseverates. If he is then given an example, however, which he is able to solve, he may again answer correctly, and all perseveration will disappear. The same patient may show perseveration under some conditions and distractibility under others, so that it becomes evident that we are not dealing with a primary defect of rigidity. As we have explained previously, the sick organism tries to react as well as possible to the task set before him. Confronted with assignments which he cannot fulfill, he tries to react to that part of the task in which he is able to succeed by means of his remaining capacity, and he sticks to that rigidly, because thus he can best avoid catastrophe. But under certain conditions he becomes aware that he has not fulfilled the task correctly. Then he gives up the first reaction, I think, because continuing it does not help in overcoming distress. He tries again and may become attached to another part of the situation to which he is able to react, but again may feel that he is not performing the task demanded. Thus he appears abnormally distractible. Neither rigidity, perseveration, nor distractibility is a defect per se; they are phenomena coming to the fore under special conditions which can be defined. They can be avoided—at least to a certain degree—by the same means by which abnormal fatigue can be avoided, because ultimately they originate from the same cause.

¶ Some Remarks Concerning the Method of Examination

I would like to conclude with some remarks concerning the method of examination which follows the rules prescribed by the organismic approach. From our discussion it is evident that only a method can be successful which takes the relationship of each performance of the patient, each success and each failure, to the whole behavior of the patient and the whole organism into consideration, and which particularly keeps in mind that a performance can be evaluated correctly only in respect to the trend of the organism for self-realization. The organismic approach by no means overlooks the significance of the study of details, correct reactions and failures, of the quantitative deviations from the average and the influence of previous capacities of the individual patient; it uses all available quantitative methods and applies statistics to the evaluation. But one should be aware that statistics can be really helpful only when we are con-

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fronted with quantitatively different material, and that, in the symptomatology of brain cortex damage, particularly those which are of interest for the psychiatrist, we are mostly dealing with qualitative deviations from the norm. Statistically valid results, therefore, are not too important for the increase of our knowledge of what pathology did to the patient and what we can learn from pathological findings for understanding normal behavior.

According to our evaluation of the significance of abstract attitude for all performances, the capacity of abstraction should be tested in the beginning of any examination. Whether the abstract attitude is impaired and how much it is impaired can be evaluated by observing the patient under the conditions of various modes of behavior which can be correctly executed only in this attitude. Some tests have been constructed which allow one to judge the patient's capacity in an easier and more correct way. The tests differ as to whether the material used is language or the execution of some performances—matching, sorting, making choices, etc. The results with the first group of tests are sometimes difficult to establish because of the ambiguity of language and because they are not always simple to apply when the patients are suffering from language defects. The advantage of the other group of tests is not only that they do not use language but also that they are so organized that judgment can be based directly on the results of the behavior of the subject in the test.

As an example of the first group of tests, the Proverb and Phrases tests by Hadlich, John Benjamin[4] may be mentioned; as an example of the other group, the Vigotski test should be mentioned, particularly in the presentation by Hanfmann and Kasanin;[27] further mention should be made of the various performance tests of Goldstein and Gelb,[24] Goldstein and Scheerer,[25] Weigl,[41] and others. (See also the papers by Von Domarus,[9] Beck,[3] Cameron,[7] and Angyal,[1] and the psychological monograph by Goldstein and Scheerer.[25])

The use of various tests in examining the same patient is recommended, since each test differs somewhat as to its applicability and definiteness in determining the impairment of abstraction and as to its ability to characterize the various forms of abnormal concreteness. The technique of the Goldstein-Gelb-Scheerer tests enables one, by the use of various materials and by the application of various specified subtests besides the main test, to determine whether or not a patient can assume the abstract attitude, to measure somewhat the degree of the impairment, and to find out the specific type of concreteness to which the patient is confined. This proved to be particularly helpful in distinguishing between the defect in organic patients and in schizophrenics.

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PART SIX

Childhood and Adolescence

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CHAPTER 40

COMMON NEUROSES OF CHILDHOOD

Joseph B. Cramer

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PERHAPS NO BETTER COMMENT can be made on the history of neurosis in childhood than to point out that there is no mention of children in Kraepelin's classic treatise[66] published in 1904. A few papers on mental illness in childhood were published between 1880 and 1910.[23, 56, 62] They reported and described cases of insanity in children as clinical anachronisms, with a kind of curiosity that exists when any disease ordinarily affecting adults appears unexpectedly in a child. Without a theory of mind, the clinicians could think causally only in such terms as constitutional deviation (degeneracy), heredity, fatigue, and religious obsession. Such "causes" hardly provided a basis for therapeutic action. Diagnosis in phenomenologic, adultomorphic terms was the end of the road. Irreversibility was assumed by these clinicians.

To find something recognizably related to present-day notions of causality, one has to go back to the sixteenth, seventeenth, and eighteenth centuries, when occasional references to feelings and needs and to parent-child relationships appeared in learned clinical treatises on nursing, feeding, and other child-rearing activities.[18]

The term "neuroses" had little meaning, nor was it applied to children until the advent of psychoanalysis. Attention to the individual's development during childhood first came from the attempt to understand the neuroses of adults. Breuer and Freud, studying hysteria, established the relationship between neurotic symptoms and childhood experiences. Freud's aphorism, "No adult neurosis without an infantile neurosis," reflected the fact that he regularly discovered childhood symptoms in the past life of his adult patients. Though the infantile neurosis discovered by Freud is certainly pertinent to the clinical syndromes discussed here, it is not to be considered identical with them.*

* Glover[42] clarifies the distinction between the infantile neurosis of Freud and the clinical syndromes called "the neuroses of childhood" in the following statement: "Freud's aphorism . . . serves to emphasize not only the developmental factors in mental disorders, but

It was only after Freud's work that the term "neurosis" was applied descriptively and conceptually to children. Kraepelin's careful descriptive case studies made it necessary for the thoughtful person to ask questions regarding pathogenesis. For descriptive psychiatrists these questions also led back to the development of the illness and the person. Adolf Meyer, whose work may be viewed as a mid-point between analytic and descriptive psychiatry, very early in his career emphasized the importance of the individual's development. His psychobiology required a biographical study of the patient. These data led to childhood and the study of childhood neuroses. It became obvious that experiences of childhood, parental attitudes, and the social environment were of more basic importance than physical or hereditary influences in causing childhood neuroses.

In accordance with the fact that the first data from psychoanalysis provided evidence of the importance of childhood sexual experiences, the study of childhood neuroses was first aimed at the investigations of like factors, and they were found to be present. Early investigators of childhood neuroses tended to explain the conditions entirely on this basis. This view seems now to be a little distorted but these early studies produced evidence that children did indeed experience, at successive stages in development, erotic excitement in specific body areas—the oral, anal, and genital zones. The oedipal stage, being that in which sexual problems could primarily be located, also was emphasized in early investigations, which, however, did not begin directly with children until several years *after* Freud's formulation of the infantile sexual theory.[39]

The technique of psychoanalytic investigation was modified by Anna Freud,[31, 33] who provided a method suitable for the analytic study of neurosis in childhood itself. At about the same time Klein[65] developed a method based on interpretation of the meaning of child's play without recourse to verbal confirmation.

It was not only the change in attitude toward mental illness but also a change in social attitudes toward children which prompted the passage of laws, first in Australia, soon afterward in the United States, establishing special courts for children. Justice could no longer be dispensed to children on the basis of what was right or wrong for adults. It had to be based on more than a legal concept of criminality. The more the judges learned about psychological causation, the more prevention-minded the courts and the public became. Clifford Beers, who had recovered from mental illness, devoted himself to the prevention of mental illness; a national movement, for which Meyer suggested the name, "mental hygiene," was initiated and became the motive force for much subsequent study.

Thus the psychoanalytic study of neurosis in childhood and the mental-hygiene movement became the joint instruments for the development of the child-guidance clinics in the United States in which much of the study of the neuroses of childhood has been carried on during the last thirty or more years.

Until recently most of what is known about the neuroses of childhood had come from psychoanalytic study by psychoanalytically trained therapists. A few not very systematic efforts to study children and infants were begun soon after the method of child analysis came into use. In the last few years direct observation of infants and children has been carried on systematically in many kinds of child-study laboratories.[9, 15, 41, 42, 57, 68] This method has been more rewarding for having had the data from psychoanalysis as a guide to what to look for and how to look. New data have been added, and concepts derived from reconstructions alone have been reformulated and improved.[36, 84]

From direct observation have come the important clues to those influences from his basic physical make-up and from his social world which determine the manner in which the child adapts to the crises or milestones of his development. The milestones and crises,

the fact that no hard and fast line exists on the one hand between the mental reactions of normal children and of mentally disordered adults, or on the other, between those of abnormal children and of apparently normal adults."

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and the ways in which he learns for good or bad to solve them, become patterned either as the beginnings of his character or, in adverse situations, as the beginnings of his neurosis.

¶ Diagnosis

The criteria for the diagnosis of neurosis in childhood go beyond the specific behavioral derangements of the disturbed child himself. There are certainly characteristic symptoms, common to most cases, but the meaning of the symptomatic behavior is more pertinent to diagnosis than is its form. Strictly speaking, the diagnosis of neurosis, even with a broad use of the term, should exclude those illnesses in which derangements of development or constitution, organic disease of the brain, serious pathology of any specific organ system (for example, colitis), or gross neglect or other adverse social influences constitute the prime determinant. In the neuroses of childhood, mental conflict resulting from psychological trauma is of prime importance, and the evidence for this may not come alone from the behavior of the child.

The list of signs characteristic of neurosis in childhood is a familiar one, but neither a single sign nor any constellation of signs is pathognomonic. Enuresis, for example, is present in many cases of neurosis, but not in all. Also, it occurs in the psychoses of childhood, in the serious derangements of development, and, in fact, in all types of childhood mental illness.[6, 45, 63]

Specifically diagnostic of the neuroses in childhood are:

1. The absence of a steady state of mind. The neurotic child, whether mainly fearful, mainly anorectic, or mainly overactive, fluctuates in his behavior between, on the one hand, states of relative adjustment during which he feels and often appears quite well, behaves in an age-appropriate way, and deals fittingly with reality, and on the other hand, states of distress during which he feels and looks sick and tests reality poorly.

2. Free anxiety. The neurotic child undergoes conscious mental suffering. The presence of a parent whose attitudes or behavior tend to subsidize various alloplastic binding devices may provide relief from subjective suffering much of the time, but some subjective and conscious mental distress exists.

3. Irritability. The neurotic child has little margin of safety in his adaptive resources. They are stretched taut even when working well. Thus a seemingly innocuous stimulus may cause considerable excitation and may initiate a decompensated state.

4. Encapsulability. In the neurotic child the disease is "localized" even when his incomprehensible behavior reflects intense suffering. At no time is there a complete disorganization of mental function. He may look as if he has "gone to pieces," but even if he makes no sense to the puzzled adult, he is not, so to speak, out of contact with himself—only beside himself. (Encapsulation is not central, for example, to the psychoses.)

5. Autoplasticity. The neuroses are characterized by adaptive devices which tend to bind anxiety *within* the mental apparatus. Overactivity, for example, though it may be irritating to the environment, expresses, like pacing the floor, a *self*-orientation, as do most of the common neurotic signs such as daydreaming, masturbation, fears, obsessions, compulsions, bed-wetting, and even the sleeping and eating disturbances. (Autoplasticity is not, for example, central to the antisocial character disturbances.)

The neuroses of childhood have to be differentiated from normal behavior, from transient difficulties of adjustment, from psychosis, and from those disturbances of social adaptation which are secondary to, or significantly determined by, organic disease of the central nervous system. Especially in childhood the diagnosis of neurosis is complicated by a lability of signs and by the multipotentiality which is inherent in an ongoing, not yet fully developed process. One sick child may manifest, in nearly equal quantities, antisocial tendencies, fears, and early signs of somatic disturbance. If his disease is not checked and it becomes chronic or is reactivated intermittently, more

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clear-cut patterns of one particular symptom complex will eventually predominate. Thus distinctions between psychosomatic disease, psychopathic states, and the more circumscribed symptom neuroses become much clearer after childhood.

¶ Etiology and Pathogenesis (Dynamics)

In the neuroses of childhood, disharmony or conflict exists between components of the mind. No childhood illness should be considered neurosis unless evidence for some internal mental conflict can be found.

Neurosis in childhood is caused by social experiences which are traumatic; that is, inappropriate in respect to the capacity of the mental apparatus of *that* child at *that* moment to contain and integrate them in a manner consistent with the maintenance of normal development. Since normal means something different depending on where one is, and especially depending on how old one is, adaptive devices of the child's mind find different responses in different environments and at different ages. Thus, differences in what constitutes a noxious stimulus may depend on various cultural influences.

The mental apparatus of the child may be viewed, for conceptual purposes, as an organ system. Its self-regulatory activity may be likened, then, to that of other organ systems which contribute their shares to the maintenance of life and growth. For the child to remain healthy, each system, in conjunction with all of the others, must maintain its appropriate steady state as a kind of matrix within which its contributory function may operate.

Different points of view with regard to the etiology and pathogenesis (dynamics) of childhood neurosis stem from differences in various theories of mental function. There is general agreement about what the mind does, but many different positions have developed in respect to *how* the mind functions and what its boundaries are, and, especially, what kind of a climate it needs in which to do its work effectively.

The psychoanalytic theory has not been accepted by Adler, Jung, Rank, Horney, Fromm, and Sullivan as an accurate explanation for aberrations of mental function.

Adler[1, 2] indicated that feelings of inferiority are of primary significance in all children. He assumed that such feelings burden every child, regardless of the environment in which development takes place, and that mental function is determined by this burden. He was the first to propose the importance of the striving for power and domination in Western society as a direct determinant of behavior. This was the first departure from the drive-centered etiological position of Freud.

Jung[60] early stressed the emotional interaction between children and parents as the primary determinant of developing mental function. He did not find evidence in his work to confirm the libido theory of Freud.

Rank,[74] with his theory of birth trauma, stressed the separation of the infant from the mother and the deprivation of the pleasurable situation in the womb.

Horney[55] objected to an implication (to her) that psychoanalytic theory included a concept of universal normality. She felt thus that neurosis could be characterized in relative terms. She objected to a biological basis for the object-seeking of the child and denied that child-parent attachments were instinctually determined. Her emphasis on the primacy of cultural determinants went along with her rejection, especially, of Freud's concepts of penis-envy as a central factor in the psychology of women.

Fromm[43] also stressed the cultural determination of the form of expression and satisfaction of man's needs.

Sullivan's[86] hypothesis is perhaps the most complicated of those which have been advanced as basically different theories of mental function. He has attempted to formulate a theory of mind which will diminish the conceptual limitations of a "one-body" system. To Sullivan, the process of human development is absolutely synonymous with the process of socialization. His theory of interpersonal relations is an attempt to show how the patterns

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of the culture determine the mental function of the individual. He sees psychiatry as the study of processes that go on between people rather than as the study of one sick person.

It follows that explanations of cause derived from psychoanalytic investigation are based ultimately on the psychoanalytic theory of instincts. The horse phobia of little Hans can be understood as the end product of a mental conflict between the mental representation of an age-specific biological drive and a mental representation of a life experience (perception) which thwarted the aim of that drive for satisfaction. This theory provides a basis for a conception of mental conflict limited to the unit organism and viewing culture as a factor affecting the adaptive demands. Other theories would explain the phobia as an end product of a mental conflict between culturally determined tendencies on the one hand and either environmental frustration or limitations of genetic endowment on the other.

It seems quite likely that a useful and comprehensive theory of mind will eventually incorporate concepts from psychoanalytic theory and also from the creative efforts of those workers who view the social environment more as a part of mental function itself. Fortunately for child psychiatry, not only psychoanalysis but also new discoveries in other realms of clinical science have helped to gain acceptance for the notion of multiple causation. For, of all illnesses, the neuroses of childhood are among the most difficult to which to assign any single ultimate cause. Is the cause of neurosis the adaptive failure, or is the adaptive failure the neurosis itself? Is the cause the traumatic event, or is the cause the inadequacy of the apparatus to cope with the event which impinges on it? Causal explanations can be made only in terms of the concept by which the disease is defined. It has become customary and useful to refer, therefore, to a variety of causes, to none of which singly can primacy be assigned, but which together result in evidence for disease. At best, one can generalize only in terms of factors regularly present in all cases.

Trauma

Traumatic experiences were thought at first by Breuer and Freud to be *the* cause of neurosis. They considered such experiences to have inherently and categorically noxious values. Traumatic experiences are an essential ingredient without which the disease does not occur, but the trauma is not inherent in the nature of the event. Thus the event, as far as cause is concerned, is reduced to a kind of parity with those qualities of the organism which make the event traumatic to that child at that time. Pearson,[72] after outlining four basic childhood needs* and three corollary fears† to which children are subject, states:

> Anything that prevents the effective satisfaction of the child's psychological needs or that increases the fears . . . will have a deleterious effect on the development of the child's personality and is likely to produce an illness. Such occurrences are known technically as traumatic events. They can be grouped into three classes:
>
> 1. acts of fate
> 2. adverse parental atitudes
> 3. exposure to premature and excessive sexual stimulation.

It is possible that the last of these may be somewhat too narrowly defined, since there is evidence that premature and excessive stimulation of other than a sexual nature may act as a traumatic experience to the child. A traumatic event may be a direct cause of neurosis. It may, moreover, in certain cases have the effect of reviving a symbolically related conflict which is in process of resolution or has been dealt with unsuccessfully at a younger age. There are certain experiences which have an inherent capacity for traumatizing a child. Among the more obvious are: loss of one or

* (1) He needs the security and backing of two present parents. (2) He needs their love and understanding. (3) He needs an optimum period of gratification for his infantile sensual desires. (4) He needs opportunities to express his hostilities, antagonisms, and aggressiveness, so that he may learn what these feelings are like and how to deal with them effectively.

† (1) Fear of being deserted, (2) fear of not being loved, and (3) fear of being mutilated.

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both parents, with inadequate substitution and inadequate resources for mourning; physical illness; injury; starvation; or neglect.

Parental Attitudes

The attitudes and character of the child's immediate family and important human objects may also constitute one of the principal etiological factors. This particular determinant may exert a far more constant pressure toward psychopathology than do traumatic events. Mothers or their substitutes provide a constant influence on the child's attitude toward his impulses and therefore on the choices he has of ways in which to make ever-changing use of those impulses as he matures and develops.

The significance of cultural factors in the determination of parental attitudes and the place of such factors in understanding the child's illness are matters of much clinical and theoretical interest at the present time. Obviously, in dealing with neurotic children, only an accurate evaluation of the antitherapeutic elements in the environment will make appropriate intervention possible.

The data from psychoanalytic study seem to indicate that parental hostility, inconsistency, overprotection, seduction, or dependency mainly reflect instinctual conflict in one or both parents. This is specifically activated in their relations with the neurotic child. Such a construction would indicate that a causal therapy should refer to the parent's "hidden" or "reciprocal" neurosis. Often the most obviously distressed parent is not the primarily neurotigenic one, or the one most basically involved in neurotic interaction with the sick child.

There is, of course, always evidence for cultural determination of parental attitudes and conflict. By and large, these are construed as attitudes so universal and so necessary for survival in a particular culture that they must be adopted even if they place the subject child under an adaptive burden by being inimical to his developmental needs.

The analysis or interpretation to a parent of unconscious conflict with respect to cultural pressures is quite different from the analysis or interpretation of parental conflict in respect to instinctual pressures. To complicate the situation further, there is a strong implication, from recent studies of neonatal behavior and physiology, that specific genetic constellations in the child are important determinants of parental behavior, especially in respect to that particular child. The need for further definition of the determinants of parental attitudes is quite obvious.

Constitution

Possibly even more constant as a determinant of adaptive patterns, good and bad, is the hereditary constitution of the child. In many instances the hierarchy of determinants of neurotic behavior is not clear. An example of this challenging problem is that of the overactive child who presents presumptive, but not gross, evidence of a damaged brain, together with positive evidence of destructive family attitudes. No adequate method with which to allocate primacy of determination yet exists. Some of the factors in the constitution which are generally considered to be inherent are intellectual capacity and physical type. It seems possible also that instinctual drives vary in innate quantity or strength from individual to individual. Recent studies and formulations, especially those of Hartmann,[54] tend to affirm the notion of innate variations as well in the capacity of other psychic institutions, that is, the ego and superego. The shape and form of either the child's character or his neurosis are probably influenced, therefore, by the strength and nature of these innate qualities. They are, however, so difficult to evaluate that their probable role in the development of neurosis in childhood cannot be analyzed in the same way as can those of traumatic and attitudinal determinants.

Some authors view the total constitutional make-up of the child as having been quite implacably determined from birth, and imply that even neurotic developments reflect this "given" make-up.[47, 81]

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¶ Classification

Nosological difficulties have been with us since the development of a dynamic orientation to mental phenomena. Recently Szasz[87] has contributed a critical assessment of the various schemata which have developed. Perhaps the most convenient system is based simply on the relationship between the phenomena of the illness and the stages of personality development at which they occur.* Kanner[51] uses a behavioral system, subdividing the problems of behavior into categories relating to the major kinds of performance: sexual activity, anger, jealousy, fear, anxiety, hypochondriasis, obsessions and compulsions, hysteria, delinquency, hospitalism, and schizophrenia. Psychoanalytic formulations are not used by Kanner in his classification scheme which is, in fact, a carefully complete list of symptom complexes. Nor does his outline refer to a dynamic concept of neurosis as a factor in classification.

Pearson's scheme is dynamic and is based on psychoanalytic theory and the psychoanalytic concept of neurosis.† No distinct and separate classification of the neuroses of childhood exists, and, in fact, it is probably not possible clearly to delineate one.

¶ Neurosis During the First Three Years of Life

Emotional difficulties are strongly colored by the adaptive problems characteristic of the age of the child who has them. Hyperactivity of the newborn and even of the fetus in the late stages of gestation has been construed as evidence of mental distress. Sonntag[82] did, indeed, find some evidence for correlation between hyperactivity, regurgitation, insomnia, and excessive crying in infants, and emotional stress of the mother during pregnancy. Greenacre[50, 51] has also contributed some interesting formulations concerning effect on personality of prenatal and birth experiences. Early in the history of psychoanalytic investigations, Otto Rank[74] found evidence that the experience of birth itself might be regularly viewed as a trauma in respect to its influence on the adaptive process in the mental apparatus and concomitantly on the development of personality or its disorders.

Recent investigations have added to what was known from anamnestic reconstruction and have confirmed the importance of the early months of life in the pathogenesis of mental disease. Direct evidence for a significant relationship between psychopathology and very early trauma is more clearly visible in the more serious disturbances of mental function—the serious character derangements and the psychoses. But even in the more benign conditions, events of early life have important contributory influence. The term "neurotic" may be applied to abnormal mental states occurring even in the first year or two of life. The earliest sign of mental conflict is crying, when it occurs under conditions in which it makes no obvious sense.

Continuous or extensive crying, crying in the absence of evidence of gross physical pathology, or crying that is not relieved by the response of the mother indicates an unresolved state of mental tension. The anxious cry in the immediate postnatal period may be associated with the physical and psychic trauma during birth or the immediately preceding intrauterine period. By the end of the second week, however, assuming an understanding and appropriate response to the infant's needs, this instability usually ends. Should crying persist, it indicates that the ordinary cycle of accumulation of needs and their satisfaction is not being fostered by the mother's response. Crying in the young infant may thus be related to a state of apprehension comparable to the

* Gerard's summary[44] is based on this relationship, as is the one used in this chapter.

† Pearson[72] classifies the emotional disorders of childhood as follows: (1) Direct reaction to present environmental errors; (2) acute and chronic anxiety states; (3) anxiety hysteria; (4) conversion hysteria (a) after the phallic phase of development is attained and (b) pregenital conversions; (5) organ neurosis; (6) compulsion neurosis; (7) perversions; (8) psychosis; and (9) character neurosis.

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free-floating anxiety which occurs at later stages of psychic development.

Recent studies, such as those by Mirsky[69] on the pepsinogen secretion of large population samples, have tended to suggest some modification in concepts of the pathogenesis of derangements in mother-child relations. In the absence of visible evidence for extremes of behavior associated with variations in the requirements of certain infants for adequate need satisfaction, the breakdown of a harmonious relationship between infant and mother was formerly attributed largely or entirely to adverse maternal attitudes. Thus, if an infant had no history of birth trauma, no congenital deformities, and no abnormalities of his vital functions, it was assumed that any normal, that is, not neurotic, mother would understand and respond adequately to his expressed need. The studies of peptic ulcer and the statistics on the incidence of high rates of pepsinogen secretion have pointed to the strong possibility that certain special needs, related to variations in inborn physiological functions, may be expected to call for responses that even a normal mother may be unable to reconcile with her own expectations and with conventions of child rearing applicable to the average child. A mother, therefore, may be normal for one child but neurotigenic or "ulcerogenic" to another. It is obvious that, in addition to the foregoing possibility, the more ordinary deviations in the attitude and behavior of the mother, such as frank rejection, cruelty, impatience, forced feeding, neglect, rigidity, or excessive laxness in routine will provide a climate conducive to neurotic developments in early infancy.[8, 42]

Kris[67] differentiates from true object-relationship an "anaclitic relationship" to mothers or substitutes in early infancy, the aim of which is relief of tension rather than the reassurance and support of a specific person. Often an infant's tension is exacerbated when handled by his own mother, and one can see that the tension is reduced when handling by a more neutral substitute results in the cessation of the anxious cry.

Symptoms which develop to reduce tension in early infancy are quite varied. Head rolling, rocking, thumb-sucking, and even genital stimulation are seen commonly enough. The pattern of turning attention and psychic energy back to the self when confronted with difficult adaptive tasks, or with frustration, is central to neurotic behavior at any age. The potentiality, resident in this pattern, for restriction of activity, of shared pleasure, and of healthy object-relations is obvious. The implications for distrust, loneliness, and anxiety are also quite apparent.

The most common cause of crying is physiological hunger, and eating, itself, is, in earliest infancy, the most regular avenue for relief of the discomfort which is neither physiological alone nor psychological alone, but always both. The feeding experience is among the earliest and most concentrated of those which gradually acquire meaning to the child.[34] Discomfort emanating from an experience for which comfort is needed and anticipated can lead to confusion and conflict, first on a more mechanical, but later on a psychological basis. Food refusal and vomiting are the most common early signs of psychological eating disturbances. Refusal of food indicates a sacrifice of the comfort of satisfying a physiological need in favor of avoiding the intolerable discomfort of the psychologically unsatisfactory feeding experience. The food refusal, at first a rather simple defensive operation on the part of the infant, carries with it meanings which are threatening to the mother and against which she must defend by a frontal attack on the child's behavior. It is, in fact, the mother's unwitting anticipation of a hostile or retaliatory interest on the infant's part which makes her incapable of objective understanding of the infant's needs in the first place. The impasse within which the feeding experience creates in the infant a need to defend himself against the repeated experience of discomfort leads to the state of anxious apprehension, conducive only to a further inability to eat, a further threat, therefore, to the mother, and a repetitive neurotigenic cycle.[11]

Vomiting may be initiated in connection with major or minor organic illnesses from birth onward. Again, the experience of discomfort leads to apprehensiveness in connection

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with food intake, and the development of a symptom is fostered when meaning related to the mother-child relationship is superimposed.

Persistent thumb-sucking is always a sign of some unresolved mental conflict. Yet a marked change in social attitudes toward this symptom has led to a change in the relation of the symptom to later developments of a neurotic nature. Until the time when thumb-sucking was seen to be connected with inadequate sensual satisfaction from feeding, this symptom regularly became an arena for the perpetuation of conflict between mother and child. Forceful repressive measures produced a balance in favor of excessively strict super-ego controls. With a more tolerant attitude toward the symptom, thumb-sucking often persists even until puberty. But the permissive social attitude has not resulted in the prevention of neurotic illness, since the cause is not corrected by overindulgence any more then by a too suppressive attitude. For thumb-sucking, like any other symptom, can only serve as a partial and inadequate solution to an internal psychic conflict.

The last major symptomatic expression of mental conflict in early childhood is sleep disturbance. When no evidence for physical distress is present, the anxiety manifest by sleeplessness, with its attendant irritability, reflects a vigilant attempt at protest against a frightening impression of the environment.[28]

Another group of clinical phenomena which indicate the existence of unresolved mental conflict are those which are prominent from the time of walking and speech development until about the beginning of the fourth year. Symptoms most characteristic of this age group are fecal retention; overactivity; stammering; temper tantrums; rituals, especially of play, ordinary routines, and cleanliness; defiance and disobedience; outspoken jealousy of siblings; aggression, especially toward age-mates; hair pulling; and hair swallowing.

Soiling and wetting beyond the appropriate training age, as well as the persistence of symptoms present in earliest infancy, are signs more characteristic of the diffuse derangements of development (that is, nascent antisocial disturbances and the psychoses) than they are of neurosis in this age group, since implicit in the concept of neurosis are concepts of internalized conflict and of organized defenses.

Until now the term "behavior disorder" has been avoided in describing the various disturbances of the early period of childhood, though it can easily be seen that all of the symptoms mentioned qualify for such descriptive terminology. Because of the incomplete differentiation of the components of the mental structure, one cannot speak of ideas or feelings being expelled by the conscious ego, that is, repressed. Thus one fundamental quality of neurosis is not present. But a behavior disorder in earliest childhood, as in any later stage, does reflect the existence of a state of conflict (antagonistic forces in the broadest sense) within the mind, and thus relates to neurosis or psychically determined deviant behavior at any later age. The character of the symptoms of neurosis during the second and third years gives evidence of an incomplete development of the state of consciousness.[89] The two-year-old who, on the toilet, withholds his stool despite his mother's training efforts, and then soils when she has pulled up his pants and left him, presents a great puzzle with regard to how conscious he is of his behavior and even of the local sensations and general feelings involved. In this instance the soiling represents the regressive behavior or the sign of poor development, while the retention of the stool begins to assume the more complex characteristic of neurotic symptom-formation.[75]

During the second and third years the neuromuscular system ordinarily matures to the point where voluntary control of elimination can be achieved. Purposeful motor activity begins to be put in the service of active, independent mastery of the environment. The first teaching or training of the child by mother and other adults involves prohibitions and encouragements of activities which have, for the child, learning, mastery, and growth values when they are *not* invested with affectively loaded meaning. But when the same behavior modalities need to serve a more urgent purpose of tension relief or of solving painful mental problems, the nonconflictual development of (ego) adaptive skills is complicated

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by defensive operation against the misunderstood drives, and the condition for neurotic development is present.

In this period of training and mastery there can be noted the beginnings of evidence for structuring of the mental apparatus. The postulation of an earlier anticipatory prestructuring by Klein[65] is based on a hypothesis much more difficult to verify by observation.[48]

The dependent child can be seen to attempt a differentiation between right and wrong, good and bad, depending on indications of approval or disapproval by mother of the behavior which expresses his impulse and his problem-solving efforts. This is the age at which children may so often be observed, when unaware of the presence of the adult, to reach for something or to bang something and then to talk to themselves in a prohibitory or warning manner as if the parental injunction were a separate, not-yet integrated institution, a part of, but yet not a part of himself. The open self-criticism indicates the inability of the child to know and feel, as his own, the prohibition of the parents. Internalization of the parental standards as conscience or super-ego can take place successfully only if the disharmony between the impulses and the externally derived restraining forces is kept quantitatively consistent with the state of maturation of any particular child.

Sleep disturbance occurring at this age in a child who has not had these symptoms earlier is not common,[28] but it occurs in those children whose marginal success in maintaining a severe control while awake is threatened by the loss of parental protection and control during sleep. It is in this age period that the questions are often raised as to the judgment of overcompliant or overconforming behavior. Good behavior is not ominous per se, but it may be viewed as neurotic when accompanied by signs of strain or by "leaks" which indicate the excessive degree to which it serves defense and is therefore not ego-syntonic.

¶ Neurosis During the Fourth and Fifth Years (the Oedipal Period)

One might express the achievement of a steady state of equilibrium in children of this age group by the declarative statement "I am a male" or "I am a female." The child who can feel the unconditional verity of this statement by about the end of the fifth year of life is mentally healthy. Comparable statements which may be analogously referred to earlier stages could be similarly formulated. For the anal stage (second and third year) "I am a separate person," and for the first year (oral) simply "I am." In the fourth and fifth years, the development of the mental apparatus has proceeded to the point where the existence of internalized psychic conflict can be clearly demonstrated. There is a sharper definition between conscious and unconscious, and there is evidence of repression and of the "return of the repressed" in the symptoms of the neurotic child.

A brief recapitulation of some specific historical developments may provide a clue to the understanding of this most important area of childhood neurosis. Before the discovery by Breuer and Freud of the infantile neurosis, the fears of a neurotic four-year-old were incomprehensible. What ensued with regard to "treatment" was based on conscious manifest explanations by the child or the parent, often incredible, at best acceptable only by way of considerable rationalization or other sacrifice of reality testing. At this age there is a tendency of the disease to self-limitation of a sort.* Thus, the disappearance or modification of distressing symptoms may have been followed by various possible developments. In some cases the high quality of "sanitation" (from a mental-health standpoint) in the environment must, in fact, have resulted in a complete arrest with subsequently healthy development. More often, constriction of function as a result of character pathology or a later outbreak of psychoneurosis or other sequelae ensued, but its relation to the childhood neurosis was not recognized.

With the discovery of the infantile neurosis and infantile sexuality, a giant step was taken. But the reconstructions of the predisposing childhood illnesses, emphasizing as they did the sexual conflict and the sexual symptoms,

* The work of Breuer and Freud proved that this self-limitation may be only apparent and that a more correct attitude would be to view the disease as having "gone underground."

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and formulating defense largely in terms of fixation and regression (that is, according to libido theory alone) proved, on later direct study, to have only an incomplete resemblance to the actual childhood illnesses. The relationship of characteristic sequelae to current and recurrent neurotic developments had to await first the work of Anna Freud and other investigators of the psychology of the ego and second the more intricate and explicit investigations of Erikson,[25] Greenacre,[52] Hartmann,[53, 54] and others. These provided a more careful evaluation of pre-oedipal development and its relation to oedipal conflict.

With these data at hand, it is possible to make a tentative distinction between two classes or types of childhood neurosis in the oedipal stage. In both there is a conflict regarding sexual identity, and there are characteristic symptoms common to both. Fear of bodily harm (castration fear) exists in all the neurotic children at this age, and penis-envy, either outspoken or masked, can be found in all the neurotic girls.

The two types, A and B, may be contrasted with respect to (1) the character of the symptoms, (2) the dynamics of the disease, (3) the "premorbid personality," and (4) the human-object environment.

Type A may be thought of as a pure type, an excellent example of which is the famous little Hans.[37] Symptomatically, this type is characterized mainly by fears and phobias. Masturbation, nightmares, and enuresis are other frequent symptoms. The personality structure remains relatively intact at an age-appropriate level of function; ego-functions, such as learning and motility, remain quite unimpaired, and there is little tendency to disorganization. Avoidance and displacement are used successfully to insulate or wall off the unconscious conflict. Anxiety appears mainly when these defenses are thwarted. Quite specific, often highly symbolic stimuli are necessary for the activation of the conflict and the break-through of symptoms. In this type of childhood neurosis there is little evidence for psychic conflict during the earlier (pregenital) stages of development. Antecedent problems of feeding, sleeping, or training are rare and minimal.

There is usually a history of psychic trauma. The traumatic event usually consists of a threat of bodily harm. Illnesses and operations occur in the context of attitudes which reflect the parents' unresolved sexual conflicts, and these are especially noxious. One or both parents are often found to be acting out within the family environment in reaction to sexual conflict, with evidence in their behavior of counterphobic or sexually stimulating activities. The parental attitudes which have an adverse effect on the child in his efforts to deal with his sexual-identity problems are confined largely to matters which are phase-specific to the child. That is, they are noxious to his development only in this stage.

Type B is more protean in its manifestations. Although symptoms of Type A do regularly appear, the symptomatology of Type B is by no means so limited. In addition, jealousy, destructiveness, overactivity, tantrums, irritability, and negativism are common. All of these reflect a degree of organizational deficit. Anxiety is bound, in Type B, if at all, much less systematically, and the devices used by the child are more primitive and less effective. Learning, motility, and other developing ego-functions are interfered with. Though this type is classified with the neuroses of childhood, it may be viewed quite properly as a stage in a psychopathological process already developing by the time the oedipal period was entered. Pregenital determinants are much more apparent in the symptoms and in the characteristic, not very effective, defensive operations. The history will give indications of previous feeding, sleeping, and training difficulties and of persistent tension during the earlier years of life, often of a subclinical degree.

There is usually evidence that the parents have had anxiety or unconscious conflict not only in respect to sexual but also in respect to pregenital needs and impulses. In this latter type of child, the environmental stimuli adequate to activate conflict are quite nonspecific as to their meaning and are not necessarily phase-specific for oedipal problems. Secondary developments in dynamics and in symptomatology leading to regressive clinging and loss of control of impulses appear much more quickly in this type of neurotigenic environ-

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ment than in the more encapsulated pure cases of Type A. The implications for a substantial tendency toward character pathology in Type B are quite apparent.

Neurosis from the Sixth to the Ninth Year

As is the case in neurosis appearing at earlier stages in the life of the child, the timing of the appearance of manifest illness in this stage has special significance. When development has proceeded through the oedipal period without incident, there is implied a process of structuring of the mental apparatus and a balance of forces in favor of ego and super-ego controls.

The period roughly between the sixth and ninth years has been called the period of psychosexual latency. As the term implies, this concept stemmed originally from an idea that the sex impulses remained latent during this time. Subsequently, this notion was revised, for the study of neuroses in children of this age group has indicated quite clearly that recession of sex (and other) impulses does not truly occur, but rather an increasing repression and a renunciation of erotic activity of both an active and a fantasy nature.[13, 14, 15, 32, 38]

The ego, supported in its development by a widening of social relationships and an increasing knowledge of both the human and inanimate object worlds, becomes stronger.[19] As this occurs, energy is directed into substitute channels. The intense involvement of the child, in life and in fantasy, with his immediate family lessens, and reduces the demands for coping constantly with large quantities of highly charged emotional stimulation of a very personal nature. This is the stage at which the super-ego becomes increasingly a factor in the growth experiments and the problem-solving efforts of the child. It is concomitantly the age at which socialization, according to rules beyond those of the family itself, have to be respected and obeyed.

Adaptive failure and the outbreak of a neurosis are more common in connection with starting school or failing to adjust to school than at any other one time in the life of the child. The unconscious involvement of the total family in reciprocal systems of neurotic adaptation frequently provides a climate, before the child has to go to school, in which the tolerance of his defenses forestalls the break-through of symptoms. His attempts to deal similarly with exacerbations of anxiety in the school environment cannot be so easily tolerated. In general, he may respond with a breakdown at school, or, even if able to contain himself at increasing cost *while* at school, he may decompensate at home. Eventually, if the strain continues, he will be unable to sustain an age-appropriate, nonsymptomatic behavior in either environment. Often, the breakdown of defenses is hastened by the failure of either teachers or parents to understand the reactive nature of the child's inappropriate adaptive efforts and the nature of the reciprocal economic and dynamic relationship between home and school.[64]

When school represents a threat to the vulnerable child and he responds with behavior which tends to displace his unresolved conflicts into the child-teacher unit, the resultant tension often produces a climate within which learning cannot proceed. The educational process becames the arena for further symptomatic developments, and a typical vicious circle is initiated in which fear, shame, negativism, and all the other scattered components of the child's behavioral pattern become focused in an inability to learn. This may have the disastrous effect of forcing more desperate and ineffective adaptive efforts, while reducing opportunities for constructive relationships with teacher and peers.[73]

Phobias, compulsions, conversion phenomena, learning inhibitions, and, indeed, any of the more discrete and circumscribed symptoms of the psychoneuroses may appear during the latency period. When these symptoms appear at this stage for the first time after an earlier symptom-free childhood, they are likely to be more persistent and stubborn than similar, more transient, and limited symptoms appearing during the phallic or oedipal stage. A stormy oedipal phase may quiet down with little intervention. It seems to be, like a stormy

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adolescence, "more normal" than a stormy latency period.

Tics are a frequent sign of neurosis appearing first in the latency period.[46] They are fleeting spasms of groups of muscles which result in blinking, grimacing, or jerking of the arms, legs, or head. They may be shown to represent, in a partial or distorted manner, a defensive movement—at first actually and later symbolically—reactive to a trauma which occurred earlier in the childhood of children whose super-ego development was influenced by severity and inconsistency on the part of the parents. Peter, aged seven, for example, blinked, gasped, and threw his arm in front of his face, at the same time flexing his thigh and bending at the waist. The entire, painfully bizarre constellation was a habitual, uncontrollable partial re-enactment of a shocked and panicky recoil from the anesthetic applied before a tonsillectomy at age three during which a circumcision, which he had not been told about, was also performed. Following the double operation he was symptom-free for a year until the birth of a younger brother, when his severe tic appeared.

Stammering is also a frequent symptom of neurosis in the latency period, often appearing in children whose speech up to that time was normal.[22] Stammering, especially common in boys, frequently follows immediately on a physical trauma such as a broken leg or arm. The injury acts as a precipitant of castration conflict, expressed in speech pathology in those children whose oedipal conflict is superimposed on a personality constricted by an early need for suppressive control of impulses.

Disturbances in conduct are among the most common signs of childhood neurosis in latency. These include all the many derangements of behavior which interfere with social adjustment at school, at home, or on the street. There is a spectrum of conduct disturbances ranging all the way from daydreaming and problem solving in fantasy, through restlessness and overactivity, to disobedience, stubbornness, and aggressive antisocial acts. In general, the impairment of ego control in the outwardly directed conduct disturbances is associated with a corruptible conscience, and there is a concurrent tendency to avoid punishment.[58, 59] In some cases punishment is sought over and over in order to pacify an overstrict conscience toward which is directed both the protest and the need for retaliation.[3, 40]

Stealing in neurotic children usually contains a highly symbolic, predominantly sexual aspect referring to unresolved castration problems. In children with "deeper" character problems, stealing often reflects, besides, a repetitive search for satisfaction of unrequited oral-dependency needs.

Exhibitionism, peeping, and fetishism also appear in the latency period, most frequently together with other symptoms of a more diffuse nature which may be more disturbing to the parents and more prominent.[20] Occasionally, however, a perverse sexual symptom may be well defined and may be the principle reflection of the child's central conflict. In all such instances the appearance of perverse symptoms reflects a serious unconscious fear of bodily harm and an environment in which symptom-formation of a more circumscribed and highly developed defensive nature has not been possible.

Vegetative disturbances also occur during this age period.[5, 26, 35, 79, 80] Though they should perhaps not be classified together with the common neuroses, the dynamics are often similar. Recent investigations tend to suggest that children whose psychic conflicts are reflected in manifest chronic organ-system derangements may have specific predispositions of a physiological nature.[69]

While the relationship between the signs and symptoms of illness and the existence of mental conflict is quite distinct in latency children with the patterns described, there are partial evidences for neurotic components, either contributory to or reactive to more serious and pervasive deviations of development and of character, which are common in this period. In the more grossly disorganized cases, the influences of neglect, deprivation, cruelty, and other environmental factors, active from the beginning of the child's life, play a more prominent role. The resulting constriction of ego-function and the inability of such

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children to trust adults have important prognostic and therapeutic significance.

¶ Management, Treatment, and Prevention

In order for a child to be mentally healthy and to develop normally, he must live in an emotional climate with adequate tolerance and adequate resources for age- and phase-appropriate adaptive functioning.

If one assumes that anxiety and temporary conflict are inevitable and wholesome concomitants of adaptive experimentation throughout childhood, one may see the behavior of a child at each stage of development as a gambit which "feels right" to him at that moment in order to master provocative stimuli and to reduce unpleasant tension. The feedback which he gets from his human-object environment defines in large degree his feeling of optimism or pessimism about the potential success and satisfaction of his intuitive or maturationally determined problem-solving behavior. Let us take, for example, the rejection of food in the first or second year of life. This behavior may be viewed as adaptive and experimental, determined as well by his internal biochemical state as by distractions and "threats" implicit momentarily in the environment. The persistence of such behavior to the point of weight loss and malnutrition would be obviously maladaptive. An environment, however, which can await the outcome of the infant's experiments, in response to feelings and homeostatic tendencies which follow his first move, will permit for a full development of his adaptive potential by responding only to objective signs of inadequacy. But a food refusal may easily stir up immediate unconscious maternal fears. These have the quality of premature pessimism: "He is already starved (sick) enough to need help." or, "If I do not intervene, things will turn out bad." The food-forcing mother, responding with action determined by her pessimistic fantasies, becomes an immediate party to a confusing environmental reaction to the child's experiment in adaptation. The failure of his experiment forces a repetition which can only heighten the tension in the mother-child system. Similarly an experimental stool withholding at three or four years of age may activate neutral maternal fantasies, in which case the experiments of the child toward homeostatis receives support. It may at worst, however, activate unconsciously fearful or pessimistic fantasies in the mother, for example, "He will burst," or, "He will be sick," which drive her to action that restricts her child's experimentation and prevents his autonomous resolution of a mastery problem.

The mother of a four-year-old boy, with a symptom of severe stool withholdings, indicated that bowel movements had been a problem to her child since he was six weeks old. At that age she began to notice that his face became red when he was having a movement. She became distressed. She had the idea that he was having pain at stool and conjectured that his anus was too small. Three pediatricians reported normal physical findings. She still felt that his anus must be too small, or his face would not be red at stool. A fourth pediatrician indicated to the mother that the child's anus needed enlarging, and a program of dilatation with mechanical dilators was instituted.

The understanding of a childhood neurosis comes from a synthesis of anamnestic and derivative data. From the history comes a serial picture report of adaptive efforts and failures and the climate in which these took place. From the examination of the child and the interview with the mother, come expressions of the current ways in which communication and understanding are blocked by the mutual activation of problems in fantasy, to which wholesome and age-appropriate solutions have not been learned. The failure to adapt results when the anxiety associated with the "loaded" fantasies prevents adequate environmental support of a reasonable experimental use of age-appropriate mental resources. An illustration from the case of a four-year-old phobic boy is pertinent. One of his "antineurotic" experiments consisted of dealing with his fear of bodily harm by provoking mild pummelings by a slightly bigger playmate. When he began to get too anxious, he would

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come home to play by himself. Then later he would go back to repeat the experiment. His mother began to force him to "fight it out" when she became anxious that to let him come home "would make him a sissy or a fairy." The child then began to develop somatic complaints and "war fears," which kept him in the house altogether.

It is increasingly evident that, in the neuroses of childhood, management and therapy should consist primarily of providing a climate in which the adaptive experiments of an adequate ego are not hampered. "Nourishment," in the sense of combating the effects of deprivation, is secondary. Neurosis implies an inherent capacity for self-limitation and healing—thus the rationale for collaborative psychotherapy. Tendencies of the environment (represented by the mother) to react irrationally to the child's seemingly inappropriate adaptive efforts are attacked, together with those distressing mental confusions of the child which determine those same experiments. Any procedure which either lessens the repetitively reinforcing or "unhealthy" response of the parents or substitutes, or which diverts and confines the adaptive experiments of the child to an environment in which a constructive response is forthcoming, or both, is therapeutic.

Child analysis is one reliable treatment method.[31, 65] Its reliability and appropriateness in neurosis stems from two factors. It is a method by which the cause of the illness (the mental confusion with its attendant symptomatic expression, suffering, and frustration) can be made understandable to the child. His anxiety is relieved by a gradually developing, shared understanding of why he feels bad. At the same time, he is under no pressure, because of the absence of "toxicity" in the analytic situation, to resort to inappropriate and ineffective adaptive patterns. The analysis provides a setting in which the inappropriateness of existing symptomatic patterns is made manifest, and there is also a person at hand who can offer suggestions for alternative, more constructive coping procedures in a context in which they make sense and are not threatening.

The effectiveness of analysis in the neuroses of childhood stems from the fact that the method gives the therapist the control he needs to manage the child's illness. It is a procedure in which the type and quantity of healthy experiences during treatment tend to insulate the child against a neurotigenic environment which may be difficult to modify. It goes without saying that child analysis, though it may be effective even with little improvement in the sanitation of the environment is more likely to restore the neurotic child to health if the responsible adults undergo concomitant changes in control, in attitudes, and even in values. To this end, psychoanalysis for one or both parents is often recommended.

The technical aspects of child analysis are beyond the scope of this chapter. Verbal free association depends on the adult patient's ability to use his sophistication and logic to overcome distrust. Children, especially neurotic children, cannot so easily convince themselves that it is logical to assume reliability and restraint on the part of an adult regardless of his training and diplomas, so that until their verbal development is quite advanced, or until they have overcome initial distrust, verbal free association cannot be counted on as a central resource toward uncovering conflict. The analyst has to be more active and do more of the "translating." The material out of which reconstructions and interpretations can be made may come from play or from nonverbal behavior, and interpretation refers relatively more to life events and relatively less to transference events and fantasies.

The use of this treatment method is, unfortunately, determined often by availability of resources rather than by the clinical indications. Many children whose neuroses could be appropriately treated analytically cannot be analyzed for lack of resources or for lack of money.

Analytic treatment of children, even when modified according to necessity or convenience, may be distinguished from all other management plans in that significant alienation of the child from the parents and teachers is inevitable during the treatment. In all other treatment plans the relationship between the treatment and the life situation is more complementary, less substitutive.

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Analytic principles may apply to some extent to any plan in which the child plays with or talks with the therapist. When the conditions for a child-therapist relationship which can stand on its own feet cannot be arranged, the outcome of the illness must depend heavily on alteration in the environment.

Efforts in the direction of creating a more sanitary environment for the neurotic child comprise the rest of the spectrum of therapy for the neuroses of childhood. "Therapy" of the environment may be attempted by support, by interpretation, or by direction to any or all of the important adults in appropriate settings. Character change in the parents usually takes an amount of therapeutic investment which is hard to arrange. Often the direction and guidance which can be formulated from a knowledge of the child's needs and from the derivative conflict situations of life at home can be used by the parents, especially if they have support, to control and correct repetitively noxious behavior, and to give the child and the family a respite during which the natural "healing powers" of the child may be re-established and a downhill course be reversed.

The popularity of parent- and teacher-education programs in schools and in the community at large, and the avidity with which pediatricians, social workers, and others working with children and families seek understanding indicate the wide acceptance of responsibility for improving the climate in which the neurotic child may be helped.

Most neuroses encountered in practice are chronic by the time they are brought to the attention of the psychiatrist. Perhaps in no other field of medicine does the specialist so rarely see really acute illness. Nor is the child psychiatrist in his practice often afforded opportunities for complete prophylaxis. These opportunities fall rather to the pediatrician in the well-baby clinic or in his intimate contact with families, or to the psychoanalyst of the parent-to-be. It is mainly as consultant and teacher that the psychiatrist can help others to *prevent* the common neuroses of childhood. What prevention there is, which is most pertinent to child-psychiatry practice, may be compared with that important aspect of medical practice which concerns itself with the prevention of complications, chronicity, and deterioration so that self-limitation may be permitted and healing subsidized.

Definitions of the neuroses of childhood are tentatively formulated only in closing, since it is an illness so complicated and one about which so little is known: The neuroses of childhood are diseases of the mind characterized primarily by partial decompensation (maladaptation) in social (human-object) relations. There exists mental conflict of a degree and kind incompatible with health. The derangement of mental function is expressed in a variety of ways. The mode of expression (the form taken by the neurosis) is determined by hereditary and constitutional factors, by developmental patterns, by the stage of development at which the mind is disturbed, or by the response of the social environment to the homeostatic tendencies of the child's disturbed mental apparatus. (Previous conditioning may add a predilection for certain organ systems or for specific constellations in the human-object world of the child.)

In the neuroses of childhood, age-appropriate reality testing is in large part preserved, being lost or distorted only in partial and circumscribed aspects of mental activity.

Neuroses in childhood may be acute (and self-limited). This occurs when the primary cause is removed before the developmental pattern is specifically altered by the inclusion of nonconstructive, aggravating mental reactions to the noxious stimuli or events. A chronic state of the illness may develop rapidly. Nevertheless, if the cause is removed, the potentiality for healing or "self-limitation" of the disease may be present for some time. Under such circumstances, some "scars," not necessarily "crippling or deforming" are likely to remain.

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CHAPTER 41

SEVERE EMOTIONAL DISTURBANCES IN CHILDHOOD: PSYCHOSIS

Margaret S. Mahler, Manuel Furer, Calvin F. Settlage

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THE SEVERE EMOTIONAL DISTURBANCES in childhood consist of a heterogeneous group of syndromes which include, besides child psychoses, the sequelae of hospitalism and anaclitic depression,[91] certain delinquencies, tic disease, grave psychosomatic conditions, and organic syndromes. They are distinguished from the neurotic disturbances in childhood by their greater irreversibility and by the fact that their psychopathology is based on a defect in the system ego (whether inborn or acquired), a defect in the adaptive, inhibitory, and steering agency of the personality.

We have chosen from among these groups of severe emotional disturbances to describe psychotic syndromes in children, because the psychoanalytic investigation of these has led to our conceptualization of ego-pathology and reconstruction of the early stages of ego development. Hence our psychoanalytic point of view seemed best suited to throw some additional light on this particular area of psychopathology of childhood.

¶ Summary of the Literature

The serious disturbances in childhood that result from emotional deprivation have long been studied by various workers.[10]

From a psychoanalytic point of view, in 1941 Margaret Ribble[86] emphasized the disorganizing and relatively irreversible effects that such deprivation through deficiency of mothering has on the development of the body and psyche of the infant.

In a series of papers initiated in 1945, René A. Spitz[91, 92, 93] has reported on careful studies

of emotionally deprived infants which have led him to delimit two clinical pictures in infancy which he calls hospitalism and anaclitic depression.

"The term hospitalism designates a vitiated condition of the body due to long confinement in a hospital (or institution such as a foundling home), or the morbid condition of the atmosphere of the hospital."

Spitz studied 164 children in two institutions, as compared to 34 children reared at home, with Hetzer and Wolf baby tests and extensive use of films. The outstanding result of his study was that the developmental quotient of the infants in one of the institutions (foundling home) dropped almost in half during the first year of life, and half of that at the end of the second year. These babies were also very susceptible to illness and showed a relatively high mortality rate.

At 18 months to 2½ years of life, the survivors could not eat alone, were not trained for cleanliness, and spoke only a few words. At 8 to 12 months in the other institution (nursery) the infants were active, agile, and vocal. The background of the children of both the foundling home and the nursery is similar. Both institutions provide good housing, food, and medical care. The "visual radius" of the nursery is much greater, owing to the activity of the mothers present who take care of their own children, as well as the fact that their vision out of their cots is not blocked. In the foundling home the crib sides are covered, and stimulation from adults comes only from the nurses present at feeding time. Locomotion was restricted in the foundling home so much that, as a result of this lack of motion in the early months, hollows have formed in the babies' mattresses.

In the nursery, located in a penal institution for delinquent girls, the babies are the mothers' only source of pride and pleasure, and consequently they receive a good deal of care and attention from their mothers. On the other hand, in the foundling home each baby has "one eighth of a nurse" only.

Spitz concludes that the deterioration and lack of development of these latter infants is due essentially to the lack of mothering.

A follow-up study[93] of the two groups of children 2 years later showed that the foundling-home children progressively deteriorated in body development, in handling of materials, in speech, and in adaptation to the environment (such as toilet training). They were underweight and undersized. On the other hand, the children in the nursery had continued to develop well individually (bodily) and socially.

In 1946, Spitz described another severe disturbance of infancy which he called anaclitic depression.[94] This is a condition in which infants who have just established a constant cathexis of a need-satisfying object (the mother) lose this object and develop a mourning reaction which can progress to a state of depressive withdrawal and debilitation. Spitz found 19 severe and 26 mild cases of this syndrome out of a total of 123 infants observed in an institution. In each case the mother had the full care of her infant until between 6 and 8 months of age, when she was removed from her child for a period of 2 to 3 months. The syndrome did not develop in infants who did not have this particular history, but, on the other hand, not all of those whose mothers were removed developed symptoms. Substitute maternal figures were available to some of these infants, but these women, who were delinquents, were often unloving. It is noteworthy that the syndrome developed more frequently if the previous mother-child relationship was a good one.

The syndrome develops in the second half of the first year and first shows itself by a consistently sad expression on the infant's face. If an observer approaches at this time, the infant tends to cling. However, after a short period of time, the reaction to the observer is one of apprehension, and an attempt to make contact provokes crying. The observer may be accepted after a long period of attempting to interest the infant, but the sad expression does not disappear. Finally, a complete withdrawal and dejection develop, with a frozen rigidity of expression. An attempt to engage the infant's interest at this stage occasionally gives rise to screaming.

When the mothers are restored to these

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infants, there appears to be a complete recovery and they become friendly and gay. If the mother is not restored, the process continues, and there is a picture of stuporous, deteriorated catatonia or agitated idiocy which appears to be irreversible. It is further noted that 34 out of 91 children in the institution where the mothers were not restored died over a 1-year period. During the episodes of milder depression, the infants appeared to be more susceptible to colds, they lost weight, and were unable to sleep.

Spitz considers this syndrome the equivalent of the "primal parathymia" which was described by Abraham (1924) as the infantile prototype of a later depressive psychosis. Spitz also states that he considers this syndrome to be a psychosis, the signs and symptoms of which differ from those of later life because of the immaturity of the psychic apparatus. He states that, in the second half of the first year of life, the ego is organized enough for the control of motility and of the expression of negative and positive affects, disturbances of which can be called psychotic. The cardinal symptoms that are present in the infants observed are the dejected expression and posture and the distaste for locomotion. He explains that an infant, after 6 months of age, can seek an adult, and that the infants do attempt to regain the lost object world as do adult psychotics, but in infancy it takes the form of finding a substitute object. In the particular situation of the institution under study, this was limited by the fact that there were few substitute love-objects to be found, and also by the fact that the infants' locomotion was prevented.

He explains further that there is a parallel with melancholia in adulthood, in which the aggression of the super-ego is turned on the ego, by pointing out that this super-ego was originally the external love-object and that one could consider that in anaclitic depression the sadism of this external love-object is directed against the ego of the infant. The connection between anaclitic depression in infancy and other psychotic states is, as yet, not clarified. We have the impression that the main difference might be in the fact that anaclitic depression, with or without its sequelae, is inflicted upon an infant with per se normal ego anlage.

The important common feature in an infant who later develops child psychoses and those who have anaclitic depression is an interference with the libidinization of its own body (particularly its boundaries) as well as a disturbance of the progress toward "object-constancy," that is, toward libidinal cathexis of the surrounding world. Parallel with this developmental lag, neutralization of the drives, especially of aggression (or amalgamation of aggression by libido), and the directing of aggression away from its own body becomes thwarted.

It is our impression that in anaclitic depression, even though the ego anlage is normal, the lack of mothering results in an investment of the primitive ego with unneutralized aggression. However, this ego will be able to seek out and utilize whatever it can find of what it needs to repair the damaged mother-child unity and to restore the same.*

In anaclitic depression there is not a defect either in the child or in the mothering partner but a loss of the real object in the outside world, at the crucial stage of the normal mother-infant symbiotic relationship.[91] On the other hand, in autistic and symbiotic child psychoses, it is the mother-child unit which is deficient (as will be described in what follows). This deficiency results in a confused orientation between the self and the outside world, and, whether the mother (the first love-object) is actually available or not, sustained cathexis of the whole object is more or less irreversibly disturbed. In other words, there is an intrinsic defect of the sociobiological adaptation in the latter cases, whereas there is an inflicted, rather than intrinsic, damage in the anaclitically depressed infants of Spitz.

At the present time, further understanding of the relationship between anaclitic depression and similar conditions and the syndromes of child psychoses is not available. The missing parts of the theoretical framework, for com-

* Compare A. Freud and Sophie Dann's study of concentration-camp children who seemed to be able to build object-relationships on extremely scanty opportunities. They also utilized every bit of that which they could find in each other.[32]

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parison of the two afore-mentioned groups, will have to be provided by further investigation and data about the infancy of those children who later develop child psychoses, and by follow-up studies of the later childhood of those who had been anaclitically severely depressed in infancy. The meaning of this statement will become clearer after we have reviewed the literature pertaining to and have discussed the schizophrenialike pictures in children, which we intend to do in the following.

Different authors use many different names for children with various psychotic disturbances. Some call them atypical children, others, schizophrenic children; workers in the field readily apply the term "autistic," while still others hesitate to call the psychotic child schizophrenic and prefer the term "schizophrenoid." Each author has his own reasons for his choice of the name by which he designates these conditions. While the term "atypical" is perhaps both too cautious and too broad, the designation "autistic child" is a generalization from only one type and is one of the frequently found features of the many other types of childhood psychoses.

In the forties Kanner[56,57] described a special syndrome among the varied pictures of child psychosis—a syndrome which he called "early infantile autism." This condition is characterized by profound withdrawal and lack of contact from the very first years of life, an obsessive demand for sameness in the environment, a lack of communication in the use of language, and a preference for relationship with inanimate objects. Kanner's view, which is elaborated by Rank,[84] is that it is the mother's and/or parents' inability to create a warm emotional climate ("the frigidaire atmosphere") which prevents the child's ego from developing its capacities for the externalization and taming of the drives. The result, in Rank's terms, is the "fragmented ego." Rank and her co-workers state that the personality structure of these children represents "fragments of various stages of development showing high achievement of some of the executive functions of the ego, while other manifestations of the ego or instinctual drives remain crippled or are on a much lower level."

Lauretta Bender[4] defines child schizophrenia in terms of a "clinical entity occurring in childhood before the age of eleven years which reveals pathology of behavior at every level and in every area of integration or patterning within the functioning of the central nervous system, be it vegetative, motor, perceptual, intellectual, emotional or social." The schizophrenic process is conceived of by her as a form of encephalopathy which interferes with the normal biological developmental patterns. Some of the observable disturbances in the child, such as the disorders of temperature regulation and sleep rhythm, are considered direct evidence of inadequate patterning, while the presence of "neurotic defense mechanisms" are felt to be the particular responses of the child to the anxiety engendered by the basic defect in homeostasis. To explain the wide variability in psychopathology, Bender introduced the concept of plasticity. For example, some of these children are withdrawn and blocked, while others are brilliantly articulate and apparently gifted; in the same child there are simultaneously present both early and more advanced patterns of maturation and development. Finally, Bender was impressed with the similarity of the failures in adaptation of the schizophrenic child and those described by Gesell for the fetal infant. She concluded that childhood schizophrenia is a "developmental lag of *the biological processes* from which subsequent behavior evolves by maturation at an embryological level." She emphasized that the very primitive nature of the child's functioning is the source both for the defects and for an unusual capacity for development. The psychological problems of the schizophrenic child, she states, concern the overwhelming anxiety about body-image, object-relationships, orientation in time and space, and meaning of language. According to her, "The disturbance in identification processes, that is, difficulties in identifying one's self and thereby relating to the rest of the world, is the essential psychological problem." She does not distinguish autism from the large group of schizophrenias in children but groups them rather according to the age at which the disturbance became manifest.

Annemarie F. Weil,[99,100] in her studies, con-

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tinues this emphasis upon the "failure in balancing homeostatic patterns." She points out that these children do not acquire latency characteristics and that, in contrast to neurotic children, their developmental deviations are more abundant, varied, and especially interchangeable. There is a history of either overintensity or underintensity of reaction from earliest infancy. She differentiates a special group of severe disturbances of ego development "characterized by lack of progression as contrasted with even more serious narcissistic disturbances of a regressive type," and she considers that their behavior cannot be distinctly related to a specific level of development (Mahler's Group III).[76] Weil defines the faulty ego as consisting of a deficiency in the development of object-relationship with its consequences, lack of acceptance of the reality principle, a deficiency in reality testing, and failures of the synthetic function of the ego and of the proper use of age-adequate defenses. The cases described are more like those Bender considers invasive in interpersonal behavior rather than withdrawn, and are not autistic as described by Kanner. These children, she states, do not overcome the stage of primary narcissism, the drives are relatively untamed by the ego, and only primitive defenses, such as "as if" imitation, almost delusional denial, and introjection and projection are at the disposal of their egos.

Despert[15-18] was one of the first to describe the clinical picture and therapeutic process in childhood schizophrenia and to define differential diagnostic criteria between neurotic and psychotic pictures in children. She emphasized the affective withdrawal and, especially, the "dissociation between language sign and language function," that is, between the accumulation of words and the paucity of their use for social communication.

Geleerd[41] observed the pathological significance of temper tantrums, later editions of the small infant's affectomotor panic, in children with "arrested ego development." She described how they could be soothed only by supplying a mother-substitute on the level of what we would call a symbiotic partner. She described the difference between ordinary temper tantrums of small children and those met in these patients, during which they were out of contact with reality and acted delusionally as if they were warding off an attacker. She concluded that these children have not set up an image of the mother within themselves, so that they are dependent on the actual presence of their mother; they cannot separate from the actual mother figure without withdrawing into a world of fantasy of omnipotence. Geleerd's[39] recent concept of identification with the omnipotent attacker and alternately with the impotent victim promises to be quite fruitful in research in child psychosis.

Bergman and Escalona,* in a study of unusual sensitivities among very young children who also fall into this general group, offer another explanation for the unevenness of ego-functioning. They postulate an insufficiency of the stimulus barrier which results in premature and fragile ego formation. Bergman and Escalona emphasize that protection from traumatic overstimulation in the normally developing infant is supplied both by this protective stimulus barrier (Reizschutz) and by maternal care.

Bradley's, Potter's, and many others' pioneering work should be referred to as well.*

¶ Differential Diagnosis

In terms of psychoanalytic concepts, the psychoses of childhood are due to inadequate differentiation and inadequate functioning of the ego, and, as in adult psychoses, represent a conflict between the ego and reality. Neurotic childhood disturbances, on the other hand, which have a much greater reversibility potential, are due to traumata and fixation in the area of psychosexual development and represent a conflict between the ego (super-ego) and the id.

We should like to emphasize that we believe the group of child psychoses is not a distinct and well-defined disease entity. We are dealing with certain constellations, groupings, or pat-

* An excellent and exhaustive review of the literature has recently been done by Ekstein, Bryant, and Friedman in the new edition of Bellak's book, *Schizophrenia: A Review of the Syndrome.*

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terns of symptoms—that is to say, we are dealing with *syndromes*. Two syndromes of early infantile psychosis seem rather clearly distinguishable: one is "early infantile autism" and the other, described by Mahler, the "symbiotic infantile psychotic syndrome." These syndromes are related to each other. They often overlap, and they have at least two basic features in common: (1) alienation, or withdrawal from reality, and (2) severe disturbance of the individual child's feeling of self-identity. If these two cardinal features are not evident, we would not designate a child's disturbance as psychotic. A third group of child psychosis is the more benign group described by Mahler, Ross, and DeFries[76] as well as Gelcerd,[40] in whom autistic, symbiotic, and neurotic mechanisms are used simultaneously or alternately by the ego. In all these children the disturbances of reality testing and of the sense of entity and boundaries of the body-image are evident.

Among the various severe psychiatric disorders in children, the so-called organic cases are most likely to present a problem in differential diagnosis. Their prominent clinical feature also is a defect of the ego. Their main symptoms are in the nature of disturbances of intelligence, motility, visual motor coordination, etc., but in the pure cases the two afore-mentioned cardinal symptoms of psychosis are absent or not prominent. In contrast to the psychotic child, the organically damaged child, within his own limitations, orients or adjusts himself relatively well to reality. These children cope with their social environment to the best of their ability, in spite of their reduced cognitive function. We might formulate the differential diagnostic criteria in an oversimplified manner as follows: The organically damaged child tries, to the limit of his ability, to utilize his reduced endowment for adaptation to reality, particularly social reality; the psychotic, in contrast, with an uneven but often extraordinary endowment in certain dissociated areas, is particularly unable to use his endowments for social adaptation. The clinical diagnosis is complicated, however, by the fact that there often are admixtures of organic disturbance and psychosis.

¶ Psychoanalytic Concepts

Our hypothesis of infantile psychosis is based upon two of Freud's fundamental concepts. It is a quasi-sociobiological proposition. Freud[33] emphasized that, whereas the animal has an instinctual faculty for sensing danger in the outside world which enables it to take appropriate action to cope with such danger, this faculty has atrophied in the human being. In the human being the ego has to take over the reality testing which the id neglects. The predicament of the human young is immensely complicated by still another biological circumstance—namely, by the fact that he is born at an earlier, less matured stage of physical development than any other mammal. These two interrelated circumstances—namely, the atrophy of the instinct of self-preservation and the immaturity of apparatuses at birth—result in the human infant's absolute dependency for his very survival on the nursing care of a mother or a mother-substitute for a long period. Long after the child has been born, a species-characteristic social symbiosis between the infant and mother is necessary.

Within that twilight stage of early life, which Freud designated as primary narcissism, the infant shows no sign of perceiving anything beyond his own body. He seems to live in a world of inner stimuli. The first weeks of extrauterine life are characterized by what (according to Ferenczi) we call the stage of hallucinatory wish-fulfillment. Whereas the enteroceptive system functions from birth, the perceptual-conscious system, the sensorium, is not yet cathected. This lack of peripheral sensory cathexis only gradually seems to give way to sensory perception, particularly to distance perception of the outside world. However, the functioning of the undifferentiated ego apparatuses of the infant, that is, the affecto-motor reactions, such as crying, enables him from the beginning of life to signal and summon the mother to minister to his needs. The mother thus serves as an external executive ego. This is the first phase of the mother-infant unity, and it has been termed the presymbiotic or normal-autistic phase.[65]

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Under normal conditions the presymbiotic, normal-autistic phase of the mother-infant unity gives way to the symbiotic phase beginning at about the age of 3 months. Through the periodic, rhythmically recurring experiences of painful accumulation of tension inside his own body, followed by the regularly repeated experiences of gratification which he cannot provide for himself, the infant eventually becomes dimly aware of the fact that satisfaction *is* dependent on a source *outside* of his bodily self. Thus he gradually comes to recognize an orbit beyond his own body. During his wakeful periods the 3- to 4-month-old baby seems to perceive, temporarily at least, that small part of external reality which is represented by the mother's breast, face, and hands, and (in a gestalt kind of perception) her ministrations as such. When this occurs—usually by the end of the third or in the fourth month—the baby's reactions gradually become less diffuse, and his activities seem more goal-directed toward the above-described need-satisfying part-object in the external world. A certain degree of ego development is indicated by our observation that by then (at 3 months of age) the baby can wait. He follows his mother's now-familiar preparations with his eyes. We have no evidence, though, that even at this stage the mother is perceived as a specific whole person. The practical fact that the mother or the nurse can still be replaced by any equally gentle nursing and mothering substitute seems to indicate that the 3- to 4-month-old baby is aware of the mother only as a need-satisfying quasi-extension of his own self. This phase of dim awareness of the object marks the beginning of the phase of symbiosis in which the infant's own and the mother's body-ego boundaries seem fused, confluent, and confused. The infant and his mother are an omnipotent symbiotic dual unity.

Toward the end of the last third of the first year, a tentative experimentation at separation-individuation sets in, at least as far as his body is concerned. This can be observed in such experimenting as his pulling alternately his own and his mother's hair, ears, nose, etc., and the familiar putting of food into the mother's mouth which often is mistaken for the beginnings of altruistic behavior. This primitive initial phase of individuation, occurring at the height of the symbiotic phase, advances toward the separation-individuation phase proper. This occurs parallel with the maturation and consolidation of such autonomous functions of the ego as locomotion, the beginning of language, and ideation.

The steps of separation are taken while in search for the need-satisfying object. This separation-individuation depends to an unusually great extent upon interaction between the child and the mother, upon stimulus and response between the two partners of the dual unity. The mother is both the external ego and the one who triggers separation. Erikson,[26] Spitz, Sylvester, and many others rightly stress the circular nature of this early mother-infant somatopsychic relationship. This emphasis on its circular nature is important. In addition to or instead of the baby's lack of sending power, there may be grave deficiencies and incompatibilities on the mother's part of the symbiotic unit. The mother either may be lacking in empathy or may so completely anticipate her infant's needs as to stifle any initiative from him.* In the latter case we find that the mother continues to regard that particular infant as part of her own self. These deficiencies then interfere with the growing infant's normal individuation.

Physicians and others who work with children's problems lean toward either of two extremes: They either believe that it is the mother in the symbiotic dual unity who is responsible for schizophrenia—known as the "schizophrenogenic mother"—or else they assume that early infantile psychoses are wholly due to the infant's hereditary or constitutional deficiency. In order to understand the pathogenesis of severe emotional disturbances in children, we must think in terms of a circular process. According to Spitz, there is an absence of an "inner organizer" in the human infant. Therefore, the symbiotic partner must be able to serve as a buffer against inner and outer stimuli, gradually organizing them for the in-

* According to Hartmann, Kris, Loewenstein, and Anna Freud, the gratification-frustration sequences are necessary for the development of psychic structure.

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fant in orienting it to the inner versus the outer world. The infant, in turn, must be able to utilize the mother to this end.

The second 18-month period of life is the one in which—after quasi-bodily experimentation (from the end of the first year)—firmer delimitation (cathexis) of the boundaries of the self seems to occur, which is prerequisite to separation-individuation. Ever since birth there have been gradual normal shifts of distribution of libido from the inside of the body (the viscera) to the periphery of the body, particularly the libidinal zones. As we said before, of particular importance in the separation-individuation phase is the advent of locomotion; this faculty seems to add tremendously to the autonomy of the child's ego. The child now has the capacity to experiment with physical separateness from the mother in an active way, rather than to experience separation passively as he hitherto did. Freud stated that "absolute mastery of motility is one of the basic characteristics of the mature ego." This control of motility, when adequately and comfortably established, provides the pattern for the subsequent development of control of emotions. Parenthetically, we may state that in tic disease and in certain acting-out problems, the continual experience of the ego of being overwhelmed by inner, uncontrolled forces has a disorganizing effect which interferes with its further development. Taking place concurrently with self-differentiation in the second year of life, the child gets acquainted with and tests a much broader segment of reality. The reality-testing function depends upon perception, motility, and memory, as well as other functions of the ego. Through these functions the child eventually achieves a clear distinction between the self and the object world.[53]

Cathexis of the perceptual-conscious system permits recognition of stimuli and provides the possibility for differential evaluation of stimuli. At birth the infant presumably can receive stimuli through all of the senses, but the inherent stimulus barrier and the maternal executive ego function together to protect from excessive stimulation. We are familiar with the early beginning of visual contact with the external world as is indicated by the manner in which the eyes will track a moving object. We also have evidence of early auditory reception. However, the sensory capacities of the mouth (oral cavity)[91] and the mouth-hand coordination[92] seem to contribute more dynamically to body-image formation and thus to the beginning of the reality-testing function of the ego. Involved in this are the senses of proprioception, kinesthesia, touch, taste, and smell. The ability to distinguish between the self and the nonself, to separate inner reality from outer reality, is necessary for the ego to localize and evaluate correctly and to integrate within the memory-traces the increasing amount of stimuli received by the senses. At a later time, a stable image of the self, especially of the body, and then a stable concept of the self are the most important anchors and frames of reference for ideational processes.

Just as growth of certain so-called autonomous ego-functions is biologically predetermined, psychosexual maturation is also biologically predestined, both of these proceeding, even though object-relationship and reality testing may not.* Psychosexual maturation implies progressive libidinization of the so-called erotogenic zones (oral, anal, and phallic). It seems that the most consequential maturational happening occurs with the phallic phase. The massive concentration of libido in the genital zone causes, per se, important shifts of cathexis in terms of body-image. This proceeds via the pregenital libidinal phases, resulting in bisexual identifications and eventually in firm establishment of sexual identity. The distinct feeling of sexual self-identity receives decisive experiences along the line of the solution of the oedipal conflict—beyond the more or less marked bisexual identifications. During latency, more complex and qualitatively distinct images of self and object world are formed. If integration of these contributories—concept of the self and object world—has been disturbed, representation of one's self as belonging to one sex integrated within the cohe-

* According to Hartmann, Kris, and Loewenstein, maturation indicates the processes of growth that occur relatively independently of environmental influences; development indicates the processes of growth in which environment and maturation interact more closely.

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sive cathexis of the ego becomes jeopardized by the hormonal upheaval of puberty. (See case of George, described below.)

¶ Types of Child Psychoses

It is our hypothesis that the various types of psychoses in children can be understood as psychopathological distortions of these normal phases of development of the ego and its functions within the early mother-child relationship.

The Syndrome of Infantile Autism (Kanner)

From our sociobiological point of view, early infantile autism represents fixation at, or regression to, that first, most primitive phase of extrauterine life which we have described above as the normal autistic phase. The most conspicuous symptom is that the mother, as representative of the outside world, seems not to be perceived at all by the child. She does not seem to exist as a living beacon of orientation in the world of reality. The self, even the bodily self, seems not to be distinguished from the inanimate objects of the environment. There seems to be an innate, primary lack, or a loss of that primordial discrimination between living and lifeless matter which Monakow called protodiakrisis. It may be argued whether this negative hallucinatory behavior, this turning a deaf ear toward mother and to the entire world, is or is not an acquired, specific, and active warding off of the mother. If it is an acquired somatopsychic defense, it is so archaic and develops so soon, at or after birth, that its psychic content and meaning cannot be discerned. These children's anamnesis contains descriptions of the earliest behavior, which reveals that there was no anticipatory posture at nursing, no reaching-out gestures, and no specific smiling response.[96] It is characteristic of them to become attached to a high chair, a toy, or some other lifeless object. Mothers describe the infants' behavior in the following ways: "I never could reach my baby." "He never smiled at me." "The minute she could walk, she ran away from me." "It hurt me so when I saw other babies glad to be in their mothers' arms; my boy always tried to creep away from my lap as soon as he could." "He never greeted me when I entered, he never cried or even noticed when I left the room." "She never was a cuddly baby, she never liked to be caressed, she did not want anybody to embrace or to kiss her." "She never made any personal appeal for help at any time." This last remark, by the very observant mother of an autistic child, describes most succinctly the disturbance as seen in terms of social behavior.

The entire symptomatology and behavior pattern of the infantile autistic syndrome is formed around the fact that the autistic infant or child is unable to utilize the auxiliary executive ego-functions of the (symbiotic) partner, the mother, to orient himself in the outside or the inner world. The most basic modalities of matter are thus unintelligible to him. He has to create substitutive modalities of orientation in order to cope with stimuli from within and from without. To begin with, he must and does create and tries to enclose himself in a small, utterly restricted world of his own. His most conspicuous and characteristic behavior patterns are the classical features described by Kanner—the obsessive desire for the preservation of sameness, a stereotyped preoccupation with a few inanimate objects or action patterns about which he shows the only signs of emotional attachment. Correspondingly, he shows utter intolerance of any change in his inanimate surroundings. These features, then, may serve as differential diagnostic criteria to distinguish infantile autism from organic syndromes. Other characteristics of the primarily autistic child's appearance and behavior are his intelligent, even pensive facial expression, in spite of the fact that he does not focus but seems to look through you. In his behavior the primarily autistic child differs from the organic as well as from the primarily symbiotic-psychotic child by his seemingly self-sufficient contentedness if only he is left alone. These autistic children behave like omnipotent magicians if they are permitted to live in, and

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thus to command, their static and greatly constricted segment of inanimate environment. Either they are completely mute (talking to their inanimate fetish companions or imaginary objects by gestures), or, if they do speak, their language is not used for functional communication. Instead, their language serves as quasi signals, such as are seen in earliest infancy. These autistic children, with signals and gestures, command the adult to serve as an executive extension of a semianimate or inanimate mechanical kind, like a switch or a lever of a machine. But they use the same gestures, sounds, or words, trying to coerce—to conjure, as it were—the living part-object as the thing they covet.

What is the meaning, what is the function of this autism? It would seem that autism is the basic defense attitude of these children by whom the beacon of emotional orientation, the living primary love-object, the mother, cannot be utilized, that is to say, is functionally nonexistent as such. The child devoid of emotional ties is unable to cope with the complexities of external stimuli and inner excitations that simultaneously threaten his very existence as an individual entity. Autism is an attempt at dedifferentiation and deanimation. It may be looked upon as the mechanism by which such patients try to shut out, to hallucinate away, the potential sources of sensory perception, particularly the infinitely variable ones of the living world, which demand emotional social response. One of the first signs for which parents seek help and guidance frequently is these children's failure to heed or even to hear the parents' communications. The parents prefer to believe (notwithstanding other symptoms of autism) that their child is deaf or hard of hearing. Some form of massive cathectic withdrawal from the distance-perceptive sensorium seems to be at work. This seems to be borne out by the following diagnostic examination:

In order to establish a first tentative diagnosis, we may drop some metal object near the child to make a loud noise. The autistic child behaves as if he heard nothing. One is reminded of the normal autistic phase in which the distance receptors are not yet functionally tuned or, as we say in psychoanalysis, not cathected. That this lack of response (there is no startle reaction) is a kind of negative hallucinatory denial of perception rather than real deafness is proved by the fact that if you now turn on a victrola and play a familiar tune the child will turn and listen with rapt attention and may also move rhythmically, beat time to the record, or at least look at the revolving disk with fascination—having been made aware of it by the sound alone. From these observations we may then draw conclusions regarding the therapy and management of these cases.

When we observe this type of psychotic child clinically, the most striking feature is his spectacular struggle against any demand of human—of social—contact. It would seem that these children's capacity to master their inner feelings, their own thought processes, their motility, their highly selective and restricted sensory awareness all but overtax their undifferentiated, defective, and rudimentary egos. They cannot cope with unsolicited and unexpected stimulation from the external world. They cannot mediate between external and internal stimuli. In short, it seems as though these patients experience outer reality, beyond their own stereotyped constricted one, as an intolerable source of irritation, without specific or further qualification. Therefore, these children seem to have managed to build up, or maintain and solidify, their original massive, negative-hallucinatory stimulus barrier against the impingement of the outside world. Their psychotic defense mechanisms aim at dedifferentiation and deanimation of inner and outer reality.

Psychoanalytic concepts help us to understand still other features of infantile autism and to differentiate it from organic syndromes and symbiotic child psychosis as well. These children are, more often than not, toilet trained at the age of normal children. This relative ease of toilet training seems to stem from two factors: One of these seems to be an insufficient erotization of the body surfaces and orifices; the second, the paradoxical situation that it is precisely the lack of emotional involve-

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ment which makes toilet training an uncharged *conditioning* process for these children. The autistic child neither eats nor defecates to please the parent, nor does he refuse food or withhold his stools to spite the mother.

Most autistic children have a relatively low cathexis of their body surface, which accounts for their grossly deficient pain sensitivity. With this cathectic deficiency of the sensorium goes a lack of hierarchic stratification of zonal libidinization and sequence. This is evident from the relative paucity of autoerotic activities, and a facility for substituting one for the other. Instead of autoerotic activities, they show autoaggressive habits such as head knocking, self-biting, or other self-hurting, mutilating activities, and a mixing up of oral, anal, and phallic contents. In fact, these autoaggressive activities seem to serve the purpose of boundary cathexis of a distorted and deranged libido economy, constituting a pathological attempt *to feel alive* and whole. Autoaggressive manipulations seem to help these children to feel their bodies, to attain a sense of identity. These autoaggressive activities serve to sharpen the awareness of the body-self boundaries and the feeling of entity, if not identity.

The Symbiotic Psychosis Syndrome (Mahler)

The symbiotic psychotic child's primitive ego, unlike that of the autistic child's, seems to have progressed in development to the symbiotic phase and, more often than not, shows beginnings of differentiation in terms of separation-individuation. The symbiotic syndrome represents fixation at, or regression to, a more differentiated stage of personality development than the autistic, namely, to the stage of the need-satisfying part-object. Therefore, the clinical pictures are infinitely more complex, mottled, and variable in children with this syndrome than is the case in early infantile autism. We found it most helpful, in trying to understand the clinical symptomatology and dynamics of the primary symbiotic psychotic syndrome, to visualize the accelerated rate of maturational growth of ego apparatuses in the second and third years of life. The maturational spurt in the second year puts the normal toddler in the position of relatively advanced physical autonomy. His emotional and developmental growth and independence must catch up, must keep pace, as it were, with this somatic maturational spurt. Maturational growth of the central nervous system and of apparatuses is preordained and rather independent of environmental and emotional influences. However, some children's emotional development in this age period seems to lag far behind. Babies who, for intrinsic or environmental reasons, cannot separate, whose ego cannot differentiate from the mother, are unable to cope with this maturational spurt and thus cannot proceed from the symbiotic phase of normal development. They cannot separate from the mother when their maturational growth inadvertently enables them to do so. With age, the discrepancy between maturational and developmental growth increases. When the rate of growth of autonomous ego-functions and psychosexual maturation surpasses the emotional differentiation from the mother, these children's brittle ego-structure tends to fragment. Perhaps the function of independent locomotion is one of the autonomous ego-functions the maturation of which is the most disconcerting to this type of patient, since it enables him to move away from the mother physically before he is emotionally prepared to do so. The child who could not achieve emotional differentiation from the mother is thereby unprepared now to be functionally separate from her. Despite his own matured independence of functioning, he appears emotionally utterly bewildered and panicky; the same is true of his coping with the sexual and aggressive impulses which inadvertently proceed toward zonal maturation. Therefore, it takes only a slight additional frustration or trauma to set off an ego fragmentation in these children. This, however, may not become apparent before the age of 3, 4, or 5 years.

A close scrutiny of the developmental history of the symbiotic psychotic child often shows unusual sensitivities which Bergman and Escalona described—an unevenness of growth and striking vulnerability of the budding ego to any minor frustration. In the anamnesis of

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these children, you will find evidence of extreme reactions to the small failures which normally occur in the exercising, practicing period of partial ego-functions. For instance, such children will give up locomotion for months because they fell or sat down with a bump. There usually is a complementary environmental trauma such as abrupt, though probably unconscious, change of attitude on the part of one or both parents which occurs at the onset of the separation-individuation period. These changing attitudes of parents at different ages of their children was particularly emphasized by Coleman, Kris, and Provence.[14] The acute break with reality is ushered in by what essentially proves to be a separation and annihilation panic, such as enrollment in the nursery school, hospitalization with separation from the mother, the birth of a sibling —all events which may serve in effect as a trigger.

The symbiotic psychotic syndrome is aimed at restoring the symbiotic-parasitic delusion of oneness with the mother and thus serves a function diametrically opposite to that of the autistic mechanism. Clinical symptoms may and often do become manifest between the ages of 2 and 5, with a peak in the fourth year, which is in the phase of psychosexual development designated as phallic. This phase coincides with that developmental level of sociobiological growth which we know as the oedipal constellation. The regression may be insidious, so that the prolonged prepsychotic phase of schizophrenia remains undiagnosed until school age, or it may be acute and fulminant. The clinical picture is dominated by agitated catatoniclike temper tantrums and panic-stricken behavior. These are followed by bizarrely distorted and often feverishly increased reality testing and hallucinatory attempts at restitution. They seem to be attempts to restore and to perpetuate the delusional omnipotence phase of the mother-infant fusion of the first year—a period in which the mother was an ever-ready extension of the self, always at the service and command of "His Majesty the Baby." The stereotyped speech productions show a predominance of hallucinatory soliloquy with the introjected object. The child's actions symbolically dramatize introjective reunion, as we shall illustrate below. Since constant panic is unbearable, the primarily symbiotic syndrome may and often does give way to a regressive yet stabilizing secondary retreat into autism. This is the result of the very break with outside reality and loss of identity which are the cardinal symptoms of psychosis. When we see these children clinically, their originally symbiotic anaclitic behavior has been replaced by secondary autistic features. "The mother in the flesh" and outside reality have by then slipped away. Their objects are introjected.

Only on rare occasions can we observe the slipping away of the object world, the actual process of loss of identity, and the fragmentation of the ego. It was possible to reconstruct some of the processes involved in George's case. (Compare also Kubie's case described in his paper, "Say You're Sorry."[62])

George was 6½ years old when admitted to the Children's Ward with fulminant symptoms of symbiotic psychosis. We will omit details of his early developmental history except for the few most pertinent data. Immediately after George's birth, the father left for the Navy. Mother and infant saw practically nobody but one another. When George was age 2, the father returned, and George's first conspicuously abnormal behavior dated from this time. His father was disinterested and morose. George had had no opportunity to experience and eventually overcome at the appropriate age the normal uneasiness of the infant and toddler about strangers. No wonder, then, that in his third year of life he seemed utterly to misunderstand the affective meaning of social situations, because of projection of his unneutralized aggression. For example, he would cry if greeted by an unfamiliar person with a friendly hello, "as if the word were a serious threat." If friends or relatives patted him on the shoulder or the head, he would become terrified, state that they hit him, and seemed frightened that they would harm him. His speech, which characteristically was not needed during George's prolonged symbiotic relationship with his mother—because symbiotic partners communicate in a preverbal or nonverbal atmosphere—all of a sudden became overcathected. At the age of about 2½ to 3, George's

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mutism abruptly changed to flighty and panic-stricken language, which his mother described and aptly called "talking tantrums." Whenever frustrated, or even without apparent cause, he would pace around the room, talking angrily to himself about something which seemed entirely irrelevant to his environment. At the end of George's third year of life, the mother became pregnant. George began to have night terrors. When George was past 3, his baby sister was born, and George became acutely disturbed. During the last months of his mother's pregnancy he developed an absorbing, exclusive interest in examining his inanimate environment by touching the objects. He became conspicuous by his strange compulsive interest in barrels, beer barrels in particular (they lived near a brewery). He would stop and touch each barrel and examine it with care. Following this preoccupation with barrels, he became fascinated by pipes of all sorts, which again he would have to stop and touch, commenting on their size, shape, or other characteristics. Since his father was a plumber, he could play with the pipes in his shop for long periods. After a few months he developed a similar preoccupation with electrical appliances. He would endlessly pretend to be plugging a cord into a socket. Later George developed an intense interest in fires, and this was predominant at the time of his hospitalization.

George's case is only one example in which the slipping away of reality is ushered in by the loss of the innate human faculty of discrimination between the animate and the inanimate, the living and the dead. To this primal discrimination Monakow has given the name "protodiakrisis." It seems to depend on and consists of impressions of warmth, resiliency, turgor, deep tactile sensations between two living higher organisms in contact with one another. In his third year George demonstrated his utter confusion of the workings of living bodies and inanimate systems. For example, George was panic-stricken when he had to pass a certain picket fence for fear of the holes in it; and he became frantic and later obsessed with the workings of electrical appliances. The nature of the sexual difference of bodies was confusing to George.

Shortly after the baby sister came, George wanted to wear her clothes, and often also his mother's dresses. He insisted that he wanted to be a girl, preferred female animals, and asked his mother perseveratively why he should not be a girl. When George entered kindergarten, he had no contact with and was terrified by the other children, and could be kept in school at least for a while only because of the great appeal he had for his teacher. He spoke to her of his sister and again and again of his pet kitten: "I have a cat at home. It's a girl cat. I like my cat. I am a girl cat." His behavior in school became so bizarre that the teacher referred him for hospitalization.

After a far too exclusive and morbid symbiotic parasitic two-year period with his mother, George was suddenly faced in a hostile, extended environment with separateness from his mother in the functional-maturational sense, without being emotionally at all prepared to give up the delusion of omnipotent fusion with her. George seemed to have tried frantically to adopt countercathectic devices against fragmentation of his brittle ego. He tried to counteract the threatening loss of the libidinal object world by attempting to recapture it in a concrete sense using the contact-perceptive faculties of his ego. We see this kind of frantic reality testing very frequently in this type of psychotic child. George compulsively and feverishly tried to finger, "to feel" things. He obviously tried to distinguish between—to compare—beer barrels with his pregnant mother's body. Later, after his baby sister's birth, George compared, in this tactile way, concrete symbols of male and female anatomy.

The bisexual problem augmented to a spectacular degree this boy's struggle to regain his symbiotic completeness with the "lost mother." Castration fear and envy of the intimate relationship of the girl baby and the mother seemed to drive George into intense body hallucinations which were characterized by psychotically destructive contents.

The outstanding hallucination during hospitalization was his seeing a fire destroying his little sister. At first George verbalized during these fire hallucinations, and hence we knew how to read his agitated behavior when it betrayed these visions.

It seemed that his hallucinatory and delusional restitution attempts consisted of incorporative and destructive tendencies toward his

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sister and mother. In his clearer periods he would state: "I'm afraid of killing my mother. I have ideas of wanting to kill her. Yes, I think of killing her, and these thoughts upset me so. That gives me bad feelings in my head. It makes me so upset when I am home. Doctor, you are supposed to take that out." He showed all kinds of self-mutilating and self-destructive tendencies. At the same time, George's hallucinations served restitution as well, which the following example will illustrate: While sitting next to the nurse whom George loved and also hated most, he appeared to hallucinate the big fire. During the conflagration George unzipped his overalls and began pulling at the nurse's skirt as though gathering up the ashes. He then put his hands in his overalls as if pouring in what he had gathered. This went on for a short time, then he zipped up his overalls and sat there smiling. "I've got a Hollinger (name of the nurse) in there . . . that's what I've got in there."

George was hilariously elated for the rest of the day and sat off in a corner, communicating with the introjected beloved.[61]

By this behavior and the resulting affect, we saw that George introjected the loved object and by so doing succeeded in restoring his former symbiotic unity with the mother.

Patients like George, who began with an insoluble symbiotic problem, thus sever the ties with unbearable reality, submerge into their self-created autistic inner reality, and erect their own object world represented by the introjects. These patients thus secondarily regress into autism to maintain their lives and entity in some dedifferentiated, deanimated form. In other words, continual separation-annihilation panic being unbearable, children who begin with a symbiotic psychosis will use autistic mechanisms as defensive measures. This is a means of warding off the danger of losing whatever minimal individual entity they may have succeeded in attaining, either through development or through treatment. They try to preserve whatever autonomy they may have attained by the mechanism of autism. To repeat, these autistic reactions are secondary attempts to ward off the threatened re-engulfment into a symbiotic relationship since such fusion would destroy the individual entity the child has barely attained.

More Benign Child Psychosis

In 1948 (published in 1949) Mahler, Ross, and DeFries[76] described a third group of "more benign" cases of child psychosis. In these cases there was also a low tolerance to frustration and lack of emotional differentiation. However, owing to better structural development of the ego, these children remained in better contact with reality and functioned more efficiently.

The symptoms in these children develop more insidiously. They employ, besides psychotic projection and introjection, denial and condensation as well as abundant neurotic defense mechanisms. These children may never break down completely, or they may become frankly psychotic during latency and particularly with the upheaval of puberty. This third group of Mahler *et al.* resembles to a great extent some of the cases whom Elisabeth Geleerd described in 1946[40] and, recently, in 1957.[39] In the latter paper she classifies some of her cases between Mahler's third group of benign schizophrenia and A. Weil's[100] cases. The difference between Weil's and Geleerd's cases seems to be that the former's cases did not present frankly psychotic pictures during adolescence, whereas many of the latter's cases did.

We found in these cases, as did Geleerd and Weil, low tolerance to frustration, emotional immaturity, unevenness of development, uncontrollable impulsivity, mood swings, tenuous relationships, and poor judgment, plus all kinds of neurotic traits such as phobias, compulsions, and hysterical and hypochondriacal traits and symptoms. These children are in contact with reality and are not delusional, but at the slightest frustration they are apt to withdraw into their own fantasy world. They coerce their environment, especially their immediate family, and are prone to severe temper tantrums, as described by Elisabeth Geleerd. Some of these pseudoneurotic or borderline cases of benign schizophrenia, according to careful longitudinal studies, especially during long psychoanalytic treatment, may show marked improvement and

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may weather adolescence better than anticipated. Some, however, become frankly psychotic (cf. Geleerd, Hawkins). Many more careful follow-up studies will be necessary to clarify this question.

Treatment

Treatment of the psychotic child aims at the restoration of, or establishment of (1) greater body-image integrity, which should convey a better sense of entity and identity, (2) with simultaneous development of object relationships, and (3) restoration of missing or distorted maturational and developmental ego-functions. In achieving this the child must progress through the previously missed or unsatisfactory phases of development (presymbiotic, symbiotic, and separation individuation), the therapist serving a substitutive function by providing a more readily utilizable auxiliary ego. It is quite common, for example, for psychotic children to have been toilet trained before they reach the anal phase of psychosexual development. As a result, they not only fail to experience the libidinal gratification associated with the normal erotization of the anal area, but they were deprived of the feeling of control and mastery which accompanies toilet training achieved after the myelinization of the central-nervous-system pathways involved in conscious control (at about 18 months of age). The libidinal gratification has importance not only in balancing and neutralizing the aggressive drives resulting from the inevitable frustrations and overstimulations experienced by any child, but also for a more adequate development of the body-image. The deficiency of the body-image is due to the lack of libidinal cathexis of certain important areas of the body periphery, especially the erotogenic zones.

The therapist then (at the appropriate time) will encourage a "living through" of this phase of development, providing suitable substitutive anal expressive material such as clay and finger paints, and also permitting and even encouraging a *temporary* regression to actual soiling or defecation in the treatment situation, if this be the child's need. In so doing, the therapist usually is placing himself in opposition to the mother. If symbiotic fusion with the mother is still the only way of adaptation the child knows or can accept, the psychotic child, even more than the neurotic child in a similar situation, will perceive the therapist as "the devil's advocate," and panic may ensue. Extreme caution, therefore, is necessary, particularly if the child is being treated as an outpatient while continuing to live with mother.

Barbara, age 6, was diagnosed as suffering from a symbiotic type of childhood psychosis and was treated in a residential institution. Prior to placement she manifested acutely psychotic behavior in which she had no relationship to anyone, she ate ravenously with her fingers in an animal-like way, she stayed up most of the night for several nights wandering aimlessly about the house singing and talking to herself, she repeatedly took off all of her clothes, either attempting to climb into the toilet bowl or running down the street in the nude, entering any door of any house. Barbara's mother had been diagnosed as an ambulatory schizophrenic. The history revealed generally severe emotional deprivation and a particularly harsh and much too early toilet training. As an example of this child's early experience, it was reported that much of her first two years of life was spent in a crib which was completely covered by a blanket except for one small corner through which the child would peer out at her surroundings. In treatment with a woman therapist, Barbara's first activity consisted of soiling herself, defecating in the corner of the playroom, and playing with her feces. This behavior was repeated almost daily over a period of several weeks. The therapist was accepting of this behavior, offering no rebuke or criticism while continuing to reach out emotionally to the child. Finally, having been permitted to have this experience, Barbara stopped the actual defecation and smearing of feces and turned to the use of clay as substitute means of expression. She continued to live through and work through this phase of development for a good many months thereafter. This and similar remedial regressive experiences made Barbara slowly and gradually ready for object-relationship by simultaneously helping her to feel and accept her

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own body as a separate entity and particularly her femininity, first on the body-image basis and later on the basis of the idea of being a girl.[71]

We found in several instances that recognition, enjoyment, and acceptance of the own stool coincided with giving up the pronominal reversal, as if the recognition of the scybalum which had been within and actively was pressed out, helped to establish body-self-identity. This is "I." I made this, but it is not me. More observation and research, however, are necessary to ascertain this connection.

James was first seen at age 3½. The outstanding presenting symptoms were failure to develop intelligible language, failure of adequate relationship to other people, and a general hypertonicity or muscular tension which caused awkwardness in movement. The history revealed that speech had begun to develop seemingly normally until age 14 months. At that time father went into the service and the family life was disrupted. Mother, who prior to this time had been living with her own mother, was forced to move completely across the country to a strange city. She was very upset by this and frankly stated that her own anxieties and needs claimed all of her attention. Simultaneously with the above, James developed a very severe case of diarrhea which persisted for several months, causing him great bowel distress and considerable pain and irritation of the anal area, and causing mother an even greater amount of anxiety. Also in the history was the fact of a sudden weaning from the bottle at age 9 months. Mother, a generally insecure person, did this upon the advice of a friend. James reacted to the weaning by becoming a thumb sucker, immediately and avidly. Observation of James showed that his tongue in his attempted speech was curled concavely and was in the position of the tongue of a sucking infant. In treatment the therapist provided candy for James to suck on and demonstrated that sucking was all right by sucking candy himself and encouraged thumb sucking. Initially James refused the offer of candy. Again, we see that the maternal tabu was operative in this child, whose ego was so rudimentary and psychotically fragmented. This evidence of conflict (probably with mother) should be a warning to the therapist to use caution in permitting or even encouraging this necessary reliving of missed infantile experiences without adequately preparing the mother and also the child for it.

Seymour, an autistic child, at 5 showed readiness to relive some of the missed or hurriedly passed libidinal experiences. His asking for his fetish pillow was taken as an indication that he would be ready to relive the phase and overcome some of his oral frustration. However, the mother's unconscious fear of regression and the boy's by that time strong symbiotic need for the mother made him completely refuse the bottle of milk which unobtrusively was made available to him. He withdrew from the analyst for a while and became quite suspicious.

Hence in Seymour's case the therapist refrained from introducing milk or other foods which would perhaps cause even more anxiety about loss of fusion with mother. Gradually, as Seymour permitted himself oral gratification, and as he became very active and eager in this process, improvement in speech with clearer enunciation became evident.

In addition to permitting and aiding the living and working through of early developmental phases, the therapist provides particularly those ego-functions lacking in the child which are necessary to the development of a concept of self. The therapist may have to serve as a substitute stimulus barrier, protecting the child from excessive stimulation from the environment. At the same time the therapist draws the child's attention away from the threatening inner stimuli by engaging him in their common pursuits.

Because of such ego deficiencies as faulty reality testing, primary-process type of thinking, and poor orientation as to time, place, and person, the communication of the psychotic child is often so obscure as to be incomprehensible. Accordingly, the therapist must be able to delve into the primary-process type of symbolic behavior of the patient with great empathy and without anxiety (cf. Sechehaye).[88] At the same time he must be able to translate the patient's primary-process material which leads eventually to assimilation, integration, and synthesis. This type of activity on the part of the therapist aids in the gradual establishment of the boundaries between the self and the rest of the world and accordingly allows

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for reality testing in distinguishing between the inner and outer environments. In time, the patient's ego becomes better structured and differentiated, and he can begin to take over these functions for himself.

Another seemingly contradictory task of the therapist is to set limits, particularly to the overwhelming self-destructive and aggressive impulses, to protect both the child and himself from harm and to prevent unnecessary or panic-creating destruction of the physical environment. He must try to establish sufficient contact with the psychotic child so as to convey to him that the therapist cannot let him harm himself and others and that he will protect him against his rage reactions. In general, there needs to be a firm definition of limits and boundaries in both the play situation and the interpersonal relationship. The therapist needs to function in such a way as to reflect adequate responses back to the child's soundings, thus helping the child explore and gain some judgmental ability concerning himself and his environment. It may be necessary to help the child maintain coherence in the play, which is all too inclined to become scattered and meaningless. The therapeutic endeavor ever so often, if not always, is and has to be started through the cognitive function, as emotional adjustment can only be attempted after a measure of control—often purely intellectual or conscious habitual control—has been established.*

The case of Danny, age 4, illustrates the need for this type of substitutive ego-function by the therapist. Danny was brought to the child psychiatry clinic with two major complaints: (1) He was an extremely fearful child, laden with what, at first glance, appeared to be phobias—for example, fear of the dark, fear of wild animals, fear of witches, fear of dogs; and (2) he was a management problem tending to get wild and uncontrollable; various forms of parental threat and physical discipline either had no effect or provided only a temporary control. It was learned that both parents were quite anxious and quite immature people. Mother had had a stillborn child prior to the pregnancy with Danny, and this had greatly increased the already existing feelings of inadequacy and inferiority. When Danny was born, he had a congenital atresia of the bowel which required surgery on the second day of his life, and which resulted in a colostomy. The colostomy was surgically closed at age 4 months. At age 8 months Danny had a surgical repair of bilateral inguinal hernia under general anesthesia. At age 10 months he was again taken to surgery for circumcision. Mother recalled that Danny seemed to suffer a good deal with each of these experiences, and felt that he had a "conscious reaction" to the circumcision and to the separation from mother at age 10 months.

In a play situation Danny characteristically would begin to play in a seemingly reasonable fashion with a fairly good rapport with the therapist. Shortly, however, the therapist could perceive that Danny's fantasies were stimulating him increasingly. He would have the therapist make witches or wolves out of clay and would then use these in fantasies where people were threatened by them. Very soon Danny would be screaming wildly while running about the playroom or running in and out of the playroom and generally throwing play materials about the room. The same sequence would occur if he chose to paint; what would begin as a fairly orderly process of applying paint to paper would end up with an impulsive dumping of the paint jar on the floor. Meanwhile Danny would be alert to every new sound or stimulus in the environment. If a door slammed, a dog barked outside, the steam radiator hissed, Danny would stop his play, listen attentively, and insist that the noise be identified and explained. Whereas with a neurotic child we would try to learn about the fantasies connected with this preoccupation with noises and work on the probability of frightening primal-scene observations to which this frightened fascination perhaps referred, in this case the ego had to be strengthened and controlled regression facilitated rather than undone.

The therapist not only attempted to reduce outside stimuli to a minimum, but he gradually insisted that Danny not divert from his play to identify every extraneous noise. When Danny began to get excited in his fantasy play, the therapist would actively intervene and quietly but firmly stop the play for the time being. At the

* This is in marked contradistinction to the therapeutic process with neurotic patients.

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same time the therapist would state in simple terms that Danny, in effect, was scaring himself with these play stories. As the play stories became established in pattern and their meaning could be understood, the therapist verbalized their meaning in terms of Danny's fears of not only what could happen to him but what his anger would do to others. Eventually witches and wolves were translated into Danny's fears about himself and his mother. As these various things were accomplished, Danny began to develop a feeling of control of his fantasies and his impulses. Simultaneously with the work with Danny, mother was treated to relieve her of her guilt about Danny's "defectiveness" at birth and to make her able to be firm with him in setting limits in controlling him.

Because of the primary-process character and therefore incomprehensibility of the psychotic child's behavior and communication which is difficult to understand, it is absolutely essential to have a close and effective informative alliance with the mother, if the child lives at home, or the substitute parent-figures if the child is in an institution. The communication of the psychotic child often can be understood only if the therapist has prior knowledge concerning the events of the child's life which took place in the twenty-four or more hours preceding the therapy session. This is even more important than with a neurotic child, since the cause-and-effect relationship between stimulus and behavior needs to be almost immediate or current in the psychotic child's experience for him to perceive and understand it.

The psychotic child often needs considerable verbal reassurance as to his basic worth and as to his basic integrity as an organism. There usually is much distortion and defect in the body-image concept, this being reflected in the fear of body-disintegration, in castration anxiety, and in panic reactions.

At one stage in treatment Barbara (see p. 830) was working out her concern and her questions about her female self. She began by putting her slacks on backwards, calling attention to the seam which was now over her genital area. Similarly, she approached this subject by putting her jacket on backwards, then viewing herself in the mirror from the rear—the jacket had a seam which normally ran down the middle of the back. Eventually she exposed her genital area and examined it in front of the mirror. As she did so she asked questions of the therapist concerning the difference between boys and girls. It became obvious that Barbara felt her mother had taken her little boy genital away from her. The therapist reassured Barbara with the explanation that little girls were born to be as they were and that there was nothing wrong with her. Eventually this subject led to a full discussion and explanation concerning the female function of bearing children.

At another time Barbara was engaging in play in which she had clearly established a large girl doll as a representation of herself. She had the doll engage in some "naughty" behavior and then proceeded to beat the doll unmercifully. The therapist intervened, preventing Barbara from beating the doll (herself), insisting that we would not allow that her doll-child be beaten. For a while Barbara persisted in her attempts to beat the doll, but when she saw that the therapist would not permit this she gave up and instead became very tender to the doll. The therapist then began to explore with Barbara the meaning of the play. Although it was important to determine the meaning of the play, it was equally important to Barbara's developing identity and self-esteem to prevent the "beating."

With psychotic children it often is necessary for the therapist to serve an educational type of function. Specific examples are to teach the child about relationships in time, about the functioning of the body, and about the realities of various social relationships, when the child is ready for such knowledge. Because of the early and pervasive ego disorganization, most psychotic children fail to acquire these important and basic concepts at the appropriate age. The problem differs from that with neurotic children in that it is not so much a matter of distortion out of a neurotic need as it is distortion out of failure of structuralization.

Danny (see p. 832), when he first came for treatment, had no concept whatsoever of the sequence of the days of the week. Some vague awareness of this time relationship began to

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emerge around the regularity of his visits to the therapist on Monday, Wednesday, and Friday. When Danny showed a desire to anticipate or predict the visits, the therapist attempted to concretize the time concept by representing days of the week by pieces of clay. After doing this the pieces representing Monday, Wednesday, and Friday were arranged in a row separate from the row representing the full seven days. Danny repeated this activity on his own and inside of two weeks he could correctly state the sequence of the days of the week and indicate particular days both past, present, and future.

While engaging in fantasy play Barbara had a herd of cows go out in the pasture and defecate before they ate their feed. When the therapist expressed interest in this she revealed the fantasy that the cows would die if they ate food without first moving their bowels. This fantasy, of course, had much meaning in terms of Barbara's psychopathology. On the other hand, it was felt to be important that Barbara have a clear understanding of what happens to food in the body and of the relationship between ingestion and elimination. Actually, with further exploration of the fantasy and with a realistic explanation of the eating and eliminating functions, Barbara revealed that she had visualized the abdomen as an empty space. This had to do with her concept of the baby in the mother's body, which in turn, led to another fantasy to the effect that she somehow must have harmed her mother in order for her mother to have been so rejecting of her.

Thus far we have been discussing treatment technique as it applies to psychotic children in general. There are specific differences, however, in the treatment approach to the basically autistic psychotic child as compared with that to the symbiotic psychotic child.

It seems apparent that, at the outset, the autistic child is best suited for individual psychotherapy, since he needs the one-to-one relationship to lure him from his withdrawn state. He cannot profit fully from the specialized educational techniques and other environmental supplementation of special residential schools until he has begun to accept the symbiotic type of relationship. On the other hand, the symbiotic psychotic child can profit from the special environment as soon as his panic reaction subsides, since he needs diversified substitute relationships in place of his former parasitic fusion with the mother. The fact that the parents are very much emotionally involved in the child's illness, whether primarily or secondarily, requires extrafamilial environmental supplementation for both types. By this means, adults who are not pathologically emotionally involved with the child can provide properly timed and gradually introduced reality values and opportunities for development of the ego while generally fostering age-adequate individuation.

The autistic child is most intolerant of direct human contact. He indulges in reality testing by smelling and tasting (licking or biting the objects). Hence he must be lured out of his autistic shell with all kinds of devices such as music, rhythmic activities, and gentle pleasurable stimulation to induce him to use, eventually, his higher sense organs.* Such children must be gradually approached with the help of inanimate objects, always keeping in mind that gross bodily contact, even stroking, cuddling—which one might want to use therapeutically in an attempt to reassure a deeply disturbed child—is of no avail and often a deterrent with primarily autistic children. Cases of the autistic type, if forced too rapidly into social contact and into facing the demands of the social environment, may be thrown into as fulminant a psychotic process as we see in some of the symbiotic child-psychosis cases.[67]

Bobby was treated in a residential institution, treatment beginning when he was 6 years of age. The family had known Bobby to be a quiet, reserved child who seemed content to play by himself and who made few demands upon the rest of the family. They did not recognize him as having a problem until he went to school. Here he was found completely unable to learn because he made no attempt to relate to the teacher or to the other children in his class. When studied diagnostically he was found to be quite uncommunicative, but nevertheless there was evidence in his isolated play behavior that he had a good

* When autistic children begin to contact the object and test reality, they first use the primitive sensory modalities of touch, smell, and taste. They may lick or bite the therapist.

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intelligence potential. He was quite skilled in making complicated objects out of clay. He showed a great interest in the record player and would watch it for hours, seemingly being as fascinated by the mechanical repetitious movement as by its sound. As long as he was left to his own devices he was relatively contented. As soon as demands were made upon him he would become irritable and ultimately would have violent "temper tantrums" in which he would bite himself on the hand, slap himself in the face, and hit his head against the floor or wall. (Cf. Ref. 41.)

In the beginning period of treatment, Bobby was quite happy to go to the playroom and he engaged in activity of a seemingly creative sort in an active and persistent way. He particularly enjoyed making miniature victrolas out of clay, and also building castles out of blocks which he would knock down with great glee. In all of this activity the therapist was ignored or treated as an inanimate part of the environment. There was no attempt at communication of experience. Bobby would use the therapist as an extension of himself, for example, to reach an object which was on a shelf beyond Bobby's reach. Any attempt to establish either verbal or physical contact with Bobby was shrugged off. If the therapist persisted in trying to get Bobby's attention, for example, by turning Bobby's face to the therapist and holding it there, Bobby would appear as if he was annoyed, then would appear as if he would cry, although he never had tears, would become red in the face, seemingly with rage, and finally would scream out and bite himself repeatedly on the back of the hand. The same type of pattern would occur if the therapist frustrated Bobby's omnipotent gestures for help in securing a particular play object.

Very gradually, over a period of many months during which the therapist did not force himself upon Bobby, Bobby began to pay increasing amounts of genuine attention to the therapist. He would be waiting for his appointments and would be upset if they were not kept promptly. He would ask for things verbally and in particular became quite well related during the routine of going to the store for candy. The relationship continued to be quite tenuous, however, and Bobby was always withdrawn and autistic again after interruptions due to illness or vacation.

In the primarily symbiotic type of psychosis it is important to let the child test reality very gradually at his own pace. As he cautiously begins this testing of himself as a separate entity, he constantly needs to feel supported by emotionally "uncontaminated" (Dr. Ernst Kris's expression) auxiliary egos of a team of adults who represent diversified substitutes for the pathological symbiotic fusion. Continual infusions of borrowed ego-strength may have to be given for a long, long time.

Barbara (see p. 830), early in the treatment situation, acted out her symbiotic defense by relating immediately and quite unselectively to almost any adult in her environment, particularly women. Barbara was a quite verbal child and would use her verbal facility to establish and maintain contact for as long a time as was possible. She asked a great many questions and apparently kept some control over her inner impulses and fantasies by actively directing her attention to tangible objects in the environment. Once she realized that she had a steady relationship with the therapist, she would come directly and immediately to the therapist's office when she was brought to the Treatment Building. For a long time she would burst directly into the office, opening the closed door, and was quite unable to understand that she had to wait until her appointment time was due. She would not leave the office except in the company of the therapist, and it was necessary for the therapist to go with her to the car when she was returned to her own building. She would go to the toilet with the bathroom door open, partly because of the lack of awareness of social convention, but primarily in order to avoid having a closed door between her and the substitute symbiotic partner.

It was felt to be definite evidence of progress in her individuation when she could wait for her appointment, or when she could actually make the therapist wait for her. Ultimately, she gave up her unselective clinging attachment to people and began to show a more judicious and normally reticent way of relating. Needless to say, these changes occurred only after a good deal of treatment in which the therapist was functioning much of the time as a synthesizing and integrating agent structuring Barbara's ego-functions and her concept of herself as an individual.

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In the secondary autistic type of a primarily symbiotic psychotic child, one needs carefully to evaluate the child's ability to relate, considering each child as an individual case. The initial aproach is much the same as with the primarily autistic child. The fact that the autism is a defense against a previously established symbiotic relationship makes the defense no less intense. Once the symbiotic relationship is re-established, however, progress tends to be comparable to that of the primarily symbiotic psychotic child, and the prognosis, therefore is better than with the primarily autistic child.

A fundamental principle of this mode of treatment is that the therapist works toward becoming a substitute mother figure. He offers himself as a symbiotic partner and allows and aids the child to *relive—re-experience*—in a different way the early phases of psychic life so important to separation-individuation and independent functioning.

It is apparent from this statement that, in contrast to the less severely disturbed child, the psychotic child has been from the beginning of treatment and continues afterward to be more dependent upon his mother. During the treatment there may be times when the child needs to be separated from the mother because institutional care is indicated. Despite this separation, the mother or a substitute for her must be regarded as an essential part of the treatment program at all times. Even though the child may be able to function on a higher level, he will continue to require a certain degree of anaclitic relationship and infusion of ego-strength, perhaps throughout his life. It is vital, consequently, that the actual mother or person who will substitute for her be simultaneously guided as to the special needs of the psychotic child or, if necessary, simultaneously receive treatment. The goal is to re-establish a relationship that offers promise for the child's growth and development.

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CHAPTER 42

JUVENILE DELINQUENCY

Adelaide M. Johnson

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DELINQUENCY HAS BEEN with us from the time man began trying to civilize himself by establishing certain social codes of behavior. John Locke,[20] the great English educator, three hundred years ago deplored delinquency in the same vein as we do today. Six thousand years ago an Egyptian priest carved on a stone, "Our earth is degenerate. . . . Children no longer obey their parents." What do we mean by the term "delinquency"? We refer to that behavior which is opposed to those tenets held by society and the law in our particular culture. The major offenses are stealing, truancy, fire setting, vandalism, and cruelty of all degrees up to murder. Even though the jurist calls delinquent that behavior which deviates from society's code, today, increasingly, such antisocial children and people are not considered capable of responsibility for such behavior. Just as the individual's responsibility for neurotic or psychotic symptoms has been repudiated by most modern psychiatrists, so has the delinquent's responsibility for his acts been considered. Although the super-ego, the conscience, the moral part of his personality is affected, still, as we proceed with a consideration of the etiologic factors in all forms of delinquency, we shall see that the patient is involved in experiences beyond his capacity to make choices and which obstruct his normal development.

"From many sources comes the cry that the Juvenile Court is coddling young criminals and that children should be punished for their offenses," says Judge Winnet[31] in a recent address to the American Medical Association. The Judge sees no evidence that punishment has ever ameliorated the situation and believes that "punishment does not reach the causes of delinquency . . . public punishment . . . can only increase resentment and rebellion and the sense of being outcast." Similarly, Judge Winnet feels that evidence shows that punishment of the parents has been so impracticable as to be worthless.

In the young child we are prone to speak of his having a behavior problem when he defies law and order. When the child reaches preadolescence and adolescence and opposes society's tenets, we call his misbehavior "delinquency." When authority is circumvented by the older age groups, the term "psychopathic personality" is assigned.

Since the first juvenile court was established in 1899, in Illinois, over 3,000 such courts have emerged. Why has this growth been so

vast? The answer is found in the previous irrationality of following a criminal procedure as applied to children.

That delinquency is increasing steadily seems undeniable, if the observer considers a statewide area and not some special locality. Many authorities think there is a national trend toward increased delinquency above what we might expect from increased population. This is said to be particularly true among girls. In some fairly representative cities authorities state that, considering the increase in population, there has been no increase in delinquency over the past years. In some cities, and especially in suburbs, the figures are rising, but many investigators correlate such a rise with better police work and record keeping. More delinquency or not, no one can doubt that it is on the increase as a practical problem that we encounter, and one that must be met. With the exception of specific circumscribed areas, few contend that delinquency is on the decrease. The juvenile courts fail in approximately 50 per cent of their cases. Such problems lead to certain conclusions: One is that our agencies and resources for helping children are inadequate in number, or that we do not offer the right kind of psychiatric and community service in dealing with the problem. Both factors, of course, may be operating. To offer the appropriate kind of service, we must first arrive at an understanding of causes.

¶ Causation of Delinquency and the Differentiation of Groups

In discussing causation of delinquency, there are two common pitfalls. Either a discussant sees causes as too complex and manifold to unravel, and one feels hopelessly discouraged listening to him, or another discussant creates uneasiness by oversimplification of the entire issue. There have emerged, however, some fairly clear concepts of causes related to this challenging problem. The central thesis of causation, as viewed by many students today, leads us to see two large categories of antisocial behavior—the unconsciously driven individual delinquent from the so-called "good or normal" family, and the gang or sociologic group operating at any economic level. It may be well, for the moment, to forget about overlapping of these two large groups. What operates causally in the individual delinquent is, to a large extent, different from what propels the gang or sociologic form of delinquency, and this, in turn, dictates different treatment measures for the two groups. Fifteen years ago—and even widely today—many investigators telescoped all delinquents into one category. This has led to vast confusion in understanding etiology and personality structure and in prescribing treatment. Some years ago many psychiatrists talked as if all delinquents had problems that only the psychiatrist should treat. Sociologists maintained a similar position for themselves as the therapeutic agents. As research progressed, it became clear that certain cases could only be relieved in the psychiatrist's office, while large numbers of other delinquents would be helped only by the sociologic-community approach. Everyone will not agree with the author, but many students of the problem today see the validity of the concept, etiologically, of the two great categories of delinquency.

Let us consider the individual delinquent about whom we know far more today and about whom many are more in agreement as to etiology. Vast areas are still to be explored with regard to personality structure and treatment.

¶ The Individual Delinquent

For treatment to be rational, etiology must be explicit. Arrival at our understanding of clinical evidence for etiology has necessitated drastic changes in our previous understanding of traditional psychoanalytic theory. The psychoanalysts' first interest was in the neuroses, and for years, with few exceptions, research was concerned largely with this aspect of psychopathology. In understanding the neuroses, one conceives of a too-punitive super-ego. Until recently, pathology of the super-ego was viewed only in terms of its being too punishing to patients. For many years any antisocial acting

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out was explained in terms of a patient's being excessively guilty about conflicts or being driven by constitutionally unmanageable instinctual drives. Alexander[2] conceived of the need for self-punishment as a motive for acting out. It is granted that the individual delinquent frequently suffers from neurotic guilt, yet the question that Alexander did not answer was why the resolution of guilt was sought specifically in acting out. The reflected preventive attitude for all patients had been, "Do not repress the child so drastically or he will become guilty, neurotic, or act out." Therapists, as well as parents, have become greatly confused, thinking that prohibitions in all forms lead to too much guilt and thus, neurosis. Some therapists unwittingly permitted and fostered acting out in, especially, the sexual sphere. Prohibitions of a culture in themselves do not lead to unhealthy guilt; rather, they are an important aspect of security. As far as the prevention of neurosis is concerned, the prohibition of antisocial activity merely requires the presence of a parent sufficiently well integrated to accept in legitimate ways the hostility expressed by the child over the limit-setting that society demands.

It has become increasingly clear that many parents, particularly those with poorly integrated impulses, have become uneasy about setting limits, even concerning matters which are specifically destructive to society, such as stealing, pathologic sexuality, or even murderous intent. Yet it is evident that certain specific things, such as stealing, fire setting, murder, and sexual destructiveness, cannot be countenanced in our society if the child is to develop comfortably in that society. Freud[8] himself said:

Let us get a clear idea of what the primary business of education is. The child has to learn to control its instincts. To grant it complete freedom, so that it obeys all its impulses without any restriction, is impossible. It would be a very instructive experiment for child-psychologists, but it would make life impossible for the parents and would do serious damage to the children themselves, as would be seen partly at the time, and partly during subsequent years. The function of education, therefore, is to inhibit, forbid and suppress, and it has at all times carried out this function to admiration. But we have learnt from analysis that it is this very suppression of instincts that involves the danger of neurotic illness. You will remember that we have gone into the question of how this comes about in some detail. Education has therefore to steer its way between the Scylla of giving the instincts free play and the Charybdis of frustrating them. Unless the problem is altogether insoluble, an optimum of education must be discovered, which will do the most good and the least harm. It is a matter of finding out how much one may forbid, at which times and by what methods.

As most of us clearly recognize, there is, then, specific behavior, the expression of which should arouse guilt in everyone. The guilt alone is not unhealthy. Neurosis need be feared only if rage has been harshly repressed, along with the prohibition of such antisocial activity.

Concern in more recent works is with the development of that form of pathologic superego which permits antisocial behavior. Clinical evidence[19] shows it to be lacunar, weak in some respects, punitive in some, and normal in still other areas. Many people have strong latent antisocial impulses, yet never act out such fantasies. In recent years students have been concerned with defining the specific stimulus, if any, to the acting-out behavior with lucid definition of possible secondary causes. We wish to consider the problems of the direct acting out of forbidden antisocial impulses: namely, stealing, truancy, fire setting, and direct sexual acting out in the individual delinquent.

¶ Historical Contributions and Etiology

The provocative contributions of Reich,[21] Alexander,[2] Alexander and Healy,[3] Healy and Bronner,[18] Schmideberg,[22] and many others have long been known to the student of delinquency. It was Aichhorn[1] whose contributions first unquestionably moved delinquency out of the nihilistic depths of constitutional inheritance, into the realm of dynamic understanding.

August Aichhorn, friend and associate of

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Freud, published the first real milestone on the road to an understanding of the problem of delinquency. *Wayward Youth*[1] has been a stimulus to students of the problem since the publication of this readable and challenging approach. Actually this was almost the first attempt to study the baffling problem of antisocial behavior in a manner that stimulated a fundamental treatment approach. Although today we see more clearly etiologic specific stimuli, know more of the pathology of the super-ego and ego in these children, still any student must concede that Aichhorn raised this baffling problem from the gates of the reformatory to a level of dynamic understanding and challenge. Not only did Aichhorn open up a new field for psychoanalytic inquiry, but the warmth, optimism, and imagination of this man have for decades stimulated the personal growth of many students in the field. *Searchlights on Delinquency*, edited by K. R. Eissler[5] and published by International Universities Press in 1949, was dedicated to Professor Aichhorn on his seventieth birthday. Any student of delinquency will refer to the brilliant introductory chapter, "General Problems of Delinquency," by Eissler. Although there have been notable advances on many fronts relative to understanding and treatment since the publication of this work, reference to it will suggest a storehouse of provocative concepts as well as known facts. In fact, this work is the only reference to date in which so much can be learned. Aichhorn did not, however, make any differentiation between the individual and sociologic delinquents—a distinction which many students believe is necessary to more basic understanding.

Any student of delinquency will find himself indebted to Healy and Bronner[13] for their fundamental contributions. Although, like Aichhorn[1] and Alexander,[2] they made no distinction etiologically between the individual delinquent and the sociologic form, they contributed much to our understanding of secondary causes in the individual delinquent and much that is primary in sociologic delinquency. These workers noted clearly such gross pathologic distortions as forging in the parent and stealing in the child. They did not note the subtle unconscious etiologic correlations to be described by later research workers. Healy and Bronner attributed to coldness and rejection by the parents the child's inability to develop a normal inhibiting super-ego, so that one child in a family may steal and another will not, depending upon the one being unloved and the other loved. This is a part of the truth. Even granting that unloved children do not develop a healthy super-ego, it does not follow that coldness of parents alone can lead to the super-ego lacunae we observe. Some very cold parents can create such great guilt or need to make restitution to a needed object that a very punitive super-ego is developed in a child. This is one of the settings from which stems the masochistic child.[18] It is equally true that there are also relatively warm parents whose child may act out antisocially—especially in some of the sociologic delinquents.

Schmideberg[22] takes us back to a more nihilistic view in that she suggested that people who act out their conflicts have a greater constitutional inability to tolerate frustration than do the more inhibited persons.

There is frequently confusion regarding the use of the phrase "acting out." The expression "acting in the transference" was first used recurrently by Freud to refer to the phenomenon which was seen during psychoanalytic therapy in which the neurotic patient repeated in the tranference, without insight, certain salient episodes in his earlier life.

Eduardo Weiss[30] aptly described it in the following way:

> By acting-out is meant the behavior of a person who repeats without insight an unconscious psychic situation out of his past in terms of current reality. A man, for instance, repeats intense feelings of hostility towards his brothers and sisters by quarreling with his fellow workers. . . . Freud considered transference as a form of acting-out. According to Freud one acts-out instead of remembering. However, psychoanalytic experience teaches us that patients in analysis often act-out emotional situations which they have already remembered. . . . Freud's formulation can be modified by saying that one acts-out instead of remembering fully with the appropriate attending emotions. . . . While acting-out is a substitute

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for recall, it does not have the therapeutic effect of the latter. The patient who acts out has still to acknowledge that *his present behavior is a reproduction of past experiences*. . . . I fully agree with Anna Freud who says that the patient who acts-out *exclusively* cannot be analyzed.

In most recent years the phrase "acting out" has come to be used almost exclusively in referring to that behavior against authority which is specifically forbidden by our society. Actually, except for the moral issue, there is no sharp line of demarcation between the acting in the transference and the kind of phenomenon expressed by the unconscious acting-out problems with which we are dealing. This is in keeping with the view commonly held today: that ego and super-ego are not separate entities, but merge imperceptibly on the spectrum of reality testing. At one end are observed highly moral aspects of the ego—that there can be no alternatives to conforming morally. Proceeding to the opposite end of the spectrum, increasingly complicated alternatives and choices become obviously permissible, since ethics is not involved; it is more in this latter area that acting out during analysis occurs.

Since the early work of Johnson and Szurek,[19] collaborative studies by other students on antisocial acting out have continued. From the initial studies emerged the thesis that antisocial acting out in a child is unconsciously fostered and sanctioned by the parents, who vicariously achieve gratification of their own poorly integrated forbidden impulses through a child's acting out. In turn, the child's behavior stimulates the parents to added need for this gratification. One or both parents, in addition, unconsciously experience gratification for their own hostile and destructive wishes toward the child, who is repeatedly destroyed by his behavior. It is possible, in every case adequately studied, to trace the specific conscience defect in the child to a mirror image of similar type and emotional charge in the parent. The focus of these observations has been not on the activities of the kind seen among deprived and other sociologically determined gang groups but rather among individual children of poor or of privileged class, frequently from families of "good" reputation and high social standing.

The super-ego defects in these children are frequently in only one or two areas and are rarely widespread. A child may steal but never be truant. Another may set fires and do nothing else that is antisocial. In another, only the sexual sphere will be implicated through the acting out. To be sure, like other people, these patients have neuroses with conflict and guilt, but they have also the super-ego weakness in one or more areas, permitting discharge of tension.

As early as 1942 Szurek[24] described the psychopathic personality as being only a delinquent grown older, as an individual defective in personality organization, specifically in the individual's conscience. Szurek distinguished those individuals from the sociologically stimulated gang lawbreakers, and presented one of the earliest contributions to the dynamic understanding of these problems. He wrote:

> Clinical experience leaves the impression that the definition of psychopathic personality is no greater mystery than other syndromes in psychopathology. Almost literally, in no instance in which adequate psychiatric therapeutic study of both parent and child has been possible has it been difficult to obtain sufficient evidence to reconstruct the chief dynamics of the situation. Regularly, the more important parent, usually the mother, although the father is always in some way involved, has been seen unconsciously to encourage the amoral or anti-social behavior of the child.

As time has elapsed, we have observed that fathers are probably as frequently implicated as mothers.

Conscience

It is impossible to understand the dynamic concepts behind the behavior of these individuals unless one has clearly in mind the development of the normal super-ego. One must understand the reaction of the well-integrated parent, and the subtle conscious and unconscious ways in which this behavior directs the development of the child's super-ego. Identification with the parent consists of more than

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incorporation of the *manifest* behavior of the parent; it necessarily involves inclusion of the subtleties of the parent's conscious and unconscious image of the child. The healthy parent fantasies his child as capable of becoming law abiding. The well-integrated, mature mother does *not* immediately check on a child following an order or request; she unconsciously assumes that the order will be carried out. The neurotic mother, who immediately checks or warns that if the job is not done dire consequences will follow, merely conveys to the child that an unstated alternative exists in the mother's mind. It is frequently with this alternative image in the mother's thoughts that the child more strongly identifies. This is true because the child senses the peculiar parental emotional need conveyed in the anxious, vacillating tone of the parent's expression.

The child internalizes, then, not only the positive, socially consistent attitudes of the parent but also the frequently unexpressed, ambivalent, antisocial feelings. We cannot agree with those who state that the child identifies only with idealized aspects of the parent. The child identifies with all facets of the parent, repressing those parental characteristics which cause conscious confusion, anxiety, and shame.

Individual Delinquency

An Etiologic Theory of Unconscious Individual Delinquency

The patients with whom we are specifically concerned in this section are those manifesting what are frequently called "super-ego lacunae." The apparent "punched-out" aspect of this kind of super-ego is misleading except from the point of view of society.[10, 13] From the point of view of the patient, there is a positive, undeniable drive toward acting in the manner in which the parent unconsciously wishes, even though it is antisocial in direction. The conception of a deficit within the super-ego structure must be elaborated to include the overwhelming parentally determined dynamic push toward antisocial behavior which the child senses, and with which he necessarily complies. Although we are not here concerned with sociologically delinquent gang members, there is frequently overlapping of the individuals who act out antisocially, these latter often moving into gangs.

If the thesis is correct that parents unconsciously initiate and foster antisocial behavior in order to experience gratification for themselves, accurate documentary evidence must be defined in answer to two basic questions: (1) How is sanctioning communicated to the child? and (2) Why is one child implicated in a family in which all of the other children are quite conforming?

Not only is it possible by careful questioning and observation to define the process by which a specific child is chosen and the dynamic factors behind the choice of a particular form of socially disapproved behavior, but it is also possible to detect the highly personal technique by which the parent transmits the double talk, interest, permissive tone, or structured situation by which the activity is fostered.

During the process of definitive treatment, it is clearly seen why one child becomes emotionally chosen to be the outlet of expression for those forbidden impulses. An adopted child, whose behavior can be blamed on heredity, becomes a natural victim through whom to express antisocial trends, with simultaneous expression of hostile feelings in the parent toward this child. Sometimes the only son of a woman who is disturbed by unresolved, hostile, dependent problems with her own father, and permitted by her own mother to carry on petty stealing, may become the means of expressing both her unconscious anger and her poorly integrated stealing impulses through her fostering such socially destructive activities in her child. Ruth Eissler[6] has lucidly written of the scapegoat child in *Searchlights on Delinquency*.

Proper understanding of case material is impossible unless one is aware of the many innuendoes of communication which occur without conscious awareness between parents and child. Such communications take place by all conceivable means of approach—sometimes errors of omission, frequently ones of frank commission. Knowing *what* to listen for, and how, the diagnostician, listening to the spontaneous communications of the parents, de-

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fines these operations from direct quotations, double talk, facial expressions, and often through histrionic portrayal by some parents who dramatize the actual interchange between themselves and the child. In the more subtle cases the casuistic, disingenuous rationalizations of these parents can reduce the whole spirit of an ethical principle to a quibbling absurdity.

The specific manner in which, for instance, the truancy from home was handled on a particular day must be obtained; frequently, when this is done, one finds that the mother met the girl with the comment, "If you don't like us and our house, find another; we can get along without you."

The entranced parental facial expression apparent to the child describing a stealing episode, a sexual misdemeanor, or a hostile attitude toward a teacher conveys to the child that the parent is achieving some pleasurable gratification. No amount of subsequent punishment will act as a deterrent against the recurrences of the acting out. A child wishes to do the thing which he senses gives the parent pleasure, even though he may be punished. We frequently see parents who describe the child's delinquent behavior with obvious pleasure. Plainly, the child's antisocial behavior is stimulating that parent. Suspicious questioning often conveys the parents' unconscious wish that the child comply by doing the thing *verbally* warned against.

Frequently, parents verbalize evasions and deceptions such as, "Here is an extra quarter, but don't tell your father"; "You can get into the movie for half price, since you certainly don't look twelve years old"; "Fires are dangerous, but if you must get it out of your system, then we'll set some in the sink."

A mother can make such a suggestion, yet she would never recommend that her child take a trial run in front of cars on the street. The mother of a fourteen-year-old girl was not genuinely interested in prohibiting her child's stealing; she said to her daughter, "Why did you take the money from your *aunt's* purse instead of from mine?"

Children hear their parents gloating about shortchanging the grocer; naturally, they sense the parental pleasure. We cannot cheat a child or anyone else and expect the child to overlook it. Some parents do not follow through when the facts of stealing are perfectly clear. For instance, they hesitate to go with the child to the dime store to make proper restitution for a stolen trinket.

Paralyzed consternation may overtake a parent whose seven-year-old has just taken a dollar from the dresser or displayed a trinket pilfered from the dime store. Why this anxiety, confusion, or even undue hostility? Why not manage the matter firmly and directly? There is a reason. An impulse in the parent, alternative to complete honesty, compels vacillation and hedging rather than the establishment of a clear limit. That impulse may explode into a rage, with threats of the reformatory. Such a parental reaction suggests to the child that his impulses to steal really may get out of hand. In his unsophistication and dependency, he is inclined to accept the painting of Dorian Gray as a true image of himself.

The mature, normal parent neither anticipates impending disaster nor dismisses monetary transgression as trivial. Instead, the problem is resolved promptly without anxiety or guilt. The mother says, "Susie, you took the dollar from the dresser; please get it for me at once. No one may take another's money without asking permission." She insists that the money be returned promptly. Of the dime store trinket, she tells Johnnie firmly and without anxiety that it is wrong to take things without paying for them. She accompanies Johnnie to the dime store to return or pay for the article. Storekeepers are accustomed to parents coming on such errands and usually accept the proper restitution. Such a parent is neither the nagging, checking detective nor the permissive, lax condoner. She does not dismiss recurrent minor thefts with the rationalization "Oh, he will outgrow it," only to bring the child for treatment when the school complains of theft.

Many parents, whose own poorly integrated prohibitions permit them to overlook recurrent slight offenses, suddenly react with guilt and

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alarm at the first suggestion of criticism from outside the home. They respond with righteous accusations and punishment. The child is confused and angry at what now appears to be parental betrayal. If the child is not too ashamed or frightened, he may give voice to his recollections of similar parental deceptions, initiating a vicious cycle of hostile blackmail and mutual corruption. A mother who has poorly integrated prohibitions concerning her own hostile sexual impulses may fantasy that her eight-year-old daughter will "get into sexual difficulties" as adolescence approaches. With her provocative warning accompanied by anxiety, she is a predictable stimulus to vacillating sexual behavior in such a child.

Truancy concerns everyone. How does truancy originate? Parental coldness and rejection are insufficient causes, contrary to some authors; these are nonspecific stimuli. The child of six, sensing coldness and rejection, may say angrily: "You don't love me—nobody loves me—I hate you all." Then, and not infrequently, the specific stimulus may be applied by the parent: "Very well! Why don't you just pack your bag and go live some place else if you think we are so awful?" We have observed some parents who even went so far as to pack the child's suitcase—a terrifying experience for the child. The suggestion to run away comes more frequently from inside the home than outside, for rarely do small children tell their friends that their parents are "mean," or get suggestions from other children to leave home.

How an adult can initiate running away is found in the illuminating account of Aichhorn[1] who deliberately resorted to such provocation as a technique of treatment. In managing the transference, he purposely used a simple suggestive device to provoke a boy to run away from the institution. His aim was to establish a positive contact with the adolescent, in which he had been unsuccessful. This very narcissistic boy, with no positive feeling for Aichhorn, constantly complained about the institution. Aichhorn made subtle suggestions about the attractiveness of the outside world, and an hour later the boy ran away, as Aichhorn had anticipated. In keeping with the therapist's predictions, some days later the boy returned, having found the outside world uninviting. He entered at once into a positive relationship with Aichhorn.

We frequently have patients whose parents tell the child to ask the physician for permission to do something they already well understand to be forbidden. Parents complain of *children's* breaking family rules when the parents themselves, consciously or unconsciously, break rule after rule and promise after promise without apology or comment.

The process of vicarious gratification now becomes clearer. The antisocial behavior of the implicated child becomes a means of parental expression by which poorly integrated antisocial impulses of the parent are expressed through the child. As Emch[7] lucidly stated it, the child is "acting out the caricatured reproduction of past parental behavior." In addition to this use as a mode of expression for parental impulses, such a child is the recipient of a hostile destructive drive in the parent; in close relationship lie vicarious gratification through the child and the wish to destroy this same child. Such family behavior, in the end, is destructive to both the child's ego organization and that of the parent, who is constantly being stimulated by the acting-out child. It is a mutually adaptive transaction.

In so complex a setting as family life, a multiplicity of variables operates, so that no single secondary cause for delinquent behavior can be isolated. As already mentioned, it is the contention of Johnson and Szurek[19] that unwitting permissive sanctioning by parents is a major and specific cause for children to live out antisocial impulses. Scientific proof of causation is not satisfied by demonstration of the invariable presence of the suspected cause (parental sanction) whenever the effect (antisocial behavior of children) is observed. It must be demonstrated also that the suspected cause does not occur unless the effect is also seen. This has been the experience of many students today. Johnson and Szurek[19] have never observed these parental permissions without antisocial behavior in at least one child

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who had been chosen as a scapegoat. The thesis is not merely reasoning based on *post hoc, ergo propter hoc*; the enmeshing interplay of parent and child in the affected area bespeaks more than a fortuitous time sequence.

Phenomenology and Treatment of the Individual Delinquent

Many authors feel that they were never able to grasp etiologic factors in individual delinquency until they had treated and thereby studied the parents as carefully as the child. Similar collaborative treatment makes it more readily possible to understand what is going on phenomenologically. Because of research in the last fifteen years, much is known of the normal development of, as well as the pathology of, the super-ego in children.

One of the most lucid accounts of the normal child's moral development is that of M. Woolf.[32] Carefully developed are such matters as truth and lying, the sense of property, and sexuality in the young child in a normal family. However, there is a remarkable lack, so far, of research concerning the ego distortions in these children other than those facts well known to cause neurotic distortions. What is less frequently described are the ego distortions and adaptations closely related to the specific super-ego pathology and the hostility of the parents. Almost nowhere in the literature is there a *detailed* account of the psychoanalysis and treatment of an individual delinquent. The author has heard two recent papers of this nature, but they have not yet been published. Szurek[25] and Johnson[17] have published very briefly how some of these cases resolved their problems in treatment, but most of these were rather simple cases and not published in sufficient detail.

Confusion arises immediately when studying ego distortions in delinquents, for in early papers no distinction was made between the individual delinquent and the sociologic delinquent. Be that as it may, a few concepts seem current since the work of Aichhorn.[1] He always maintained that the first step in understanding and treatment of delinquent personalities was the establishment of an object-relationship, and he drew attention to the difficulty of doing so because of the delinquent's inherent inability to form relationships that can endure frustrations. Van Ophuijzen,[29] Friedlander,[9] and Szurek[25] held the view that in cases of antisocial behavior the treatment plan consisted in the establishment of a relationship with a child. Some workers speak of a process of re-educating the child by means of an emotional relationship to an adult who represents a parent substitute. All agree that treatment is more effective before or at the beginning of the latency period, regardless of whether treatment involves parents or child or both, or whether it is done with the child in residency outside of the home.

Pertinent questions arise relative to the above statements. Many of the delinquent children, individual or sociologic, can and have formed strong object-relationships. This too often, however, involves relationships with an object whose super-ego ideals consciously or unconsciously differ from those of society at large. The author cannot emphasize too strongly that great confusion exists from the telescoping of all delinquents together in one category. If we are dealing with the individual delinquent unconsciously sanctioned by permissive destructive parents, the phenomenology is special for that disorder, and treatment must be psychiatric and quite different from that child who is a sociologic delinquent.

Kate Friedlander[9] says, "We are familiar with the picture of the anti-social child during late latency period and puberty, with his narcissistic self-evaluation, his impulsiveness and his inability to establish object relationships which endure frustrations." This description cannot be accepted as evaluating vast numbers of delinquents. Many of them have established strong object-relationships with parents and other adults, but these are relationships which do not conform with society's codes. Many delinquents can endure frustrations having to do with those prohibitions long consistently demanded by the family, but they cannot endure frustration associated with what has been permitted by the family. We know count-

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less individual delinquents who do not have the narcissistic self-evaluation observable in others. We must be discriminating in describing the character structure of delinquents as a total group. In each individual case a careful evaluation must be made of the healthy personality structure, conflicts, and defenses. Sometimes limit-setting has been excellent and effective in many areas but defective in another. To be sure, in certain cases, vast areas of limit-setting have been overlooked, and then we see the generally impulse-ridden child.

Much research is being done on the so-called predelinquent personality. There seems little doubt that, with careful study of the family, such forerunners in behavior should be detectable early, particularly in the individual delinquent. In sociologic or gang delinquency, the manifestations of impending difficulty may appear at a later age in the child. The soil for such sociologic outburst, however, is often well known in certain city areas. The child, neglected, mistreated, or subjected to overt misbehavior on the part of parents, may well move into a subculture group to resolve his insecurity, degraded self-esteem, and anger.

Once the diagnosis of individual unconsciously sanctioned delinquency has been clearly made, in *general*, treatment needs are now rather well known. If the child remains in the home, not only the child but the significant parent or parents must be treated by the psychiatrist as much or even more intensively than the child. Residency treatment for the child with little or no work done with the parents demands a long therapy if, when the child returns home, his treatment is to remain a stable integration. The availability of residency treatment of a dynamic nature is sadly lacking in America as well as elsewhere in the world. Depending upon the age of the child and the severity of the pathology at home, such residency therapy can be expected to run into years. Many times, parents are so disturbed and so destructive toward the child that they resist help for themselves in the dilemma. It has been the experience of the author and many others that treatment of the child in the home, without the parents in therapy, usually leads to greater acting out in the child. It appears that, with the child only in treatment, the unconsciously sanctioning parent feels he can shift the responsibility for the outcome onto the psychiatrist and is unconsciously motivated to act out his poorly integrated impulses even more so through the child. Ruth Eissler[6] has written brilliantly of the threatening of a family equilibrium by any therapeutic success with the acting-out member. This, therefore, necessitates concurrent help for parents.

Almost no intensive residency therapeutic cases of individual delinquency have been published. Rudolf Ekstein, then at the Menninger Clinic, gave, at a national meeting, a detailed partial treatment of such an adolescent boy, and it is to be hoped that this document will be published in great detail. In his paper on character synthesis in adolescents in general, Gitelson[11] deals with many valuable ideas on the therapeutic task and technique in treating the delinquent.

Many therapists have found that analysis of unconscious neurotic conflicts before the fairly good establishment of a solid super-ego led to disaster. As long as the child has no guilt about acting out in some area, such as stealing, anxiety aroused by uncovering an unconscious guilt about sibling rivalry, for instance, only leads to further acting out.

There are many valuable pointers on treatment of the individual delinquents by several authors in *Searchlights on Delinquency* that should be carefully scrutinized by all therapists in the field.

Hacker and Geleerd,[12] treating aggressive acting-out delinquents in a residency setting, found that there was a need for definite limit-setting in successful treatment. They showed that, lacking internalized controls, the children became victims of unbuffered drives: "His demand for freedom thus becomes a denial of vulnerability which he feels consciously or unconsciously."

Treatment of parents and child outside the residency setting, to be most effective, must be of a collaborative nature. Intensive analysis and close collaboration of all parties concerned

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must be conducted in order for all participants to gain insight into the unconscious pathology and its genesis. This kind of therapy was the means through which Johnson and Szurek[19] arrived at their understanding of the genesis of unconscious, individual, antisocial acting out. In conjunction with an understanding of the genesis of the problems went, hand in hand, the necessary therapeutic changes. Parents are appalled as they gradually become aware that they are instruments in their child's misbehavior, and the greatest sensitivity and wisdom are necessary to help them analyze their role and conflicts. The author has treated many parents of very young delinquents (stealers, truants, fire setters, misbehavior in school) where the child was not treated at all. In such young cases it is often amazing to see the change in the child as the parents work through, in the transference, the problems associated with their poorly integrated impulses. Again we see parents whose destructiveness toward the child is so grave that it is easily apparent, from dreams and fantasies, that they can never be satisfied until the child arrives in reform school or prison.

There is not space in this chapter to discuss the multiple factors inherent in refined collaborative therapy. Szurek, Johnson and Falstein,[26] Johnson,[16] and others have written extensively of this elsewhere. Certainly, to see an adolescent five times a week and parents only once a week, the latter only in a supportive therapy, will never be effective. An analytic uncovering therapy for all concerned is mandatory. The parents who have poorly integrated antisocial impulses arrived at this level of operation with their child because of similar difficulties with their parents, albeit less blatant oftentimes. Necessarily then, their super-ego code and ego distortions must be meticulously analyzed in the transference. The author, with Szurek and other associates, has conducted such collaborative treatment over long years and knows that it is effective. Let us consider, however, the vast numbers of individual delinquents and the paucity of well-trained dynamic therapists. The only answer seems to rest with the earliest detection of difficulty, and we shall owe our gratitude to those research workers now engaged in such studies.

¶ Sociologic Delinquency

What differentiates the individual delinquency just discussed from that great mass of sociologic or gang delinquency? In the individual delinquency from "acceptable" families, we emphasized that there developed a conscience defect *unconsciously* fostered by the parents. This fostering is the specific stimulus, with a great variety of secondary stimuli. So far, there has been no evidence of such a one-to-one specificity of stimulus in the gang or sociologic delinquency. It is the author's impression that arrival at telling etiologic factors in sociologic delinquency is a much more complex and difficult problem than has been true with the unconsciously fostered individual delinquency. Time and great open-minded collaboration between all research groups will be necessary to solve this formidably baffling problem. Fortunately, men and women with such characteristics have been working for years toward a greater lucidity of understanding. This author, having studied the individual delinquent with collaborators for twenty years, feels on fairly familiar ground there. It is difficult, however, for me to do full justice with clarity to the problem of sociologic delinquency.

Etiology of Sociologic Delinquency

Much has been written by way of explaining sociologic delinquents. It is safer at this time to suggest that only partial answers have been given, as most workers themselves would agree. A survey of some of the major views held to explain subculture sociologic or gang delinquency are the following: Some have asserted that the disorder is "traditional" and handed down from generation to generation. There is a hard core of truth in this, but additional factors seem to be involved, as will be reviewed. The so-called "social disorganization theories" maintain that sociologic delinquency flourishes in "interstitial areas" of

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our great cities, where not only is the area economically depressed but the population is mobile and never achieves a solidarity of community spirit or social organization. Observers with differing data in such areas maintain, however, that the social organization of the area as a whole may not be chaotic and without cohesiveness. As Cohen[4] says, "the social organization of the slum may lack the spirit and the objectives of organization in the 'better' neighborhoods, but the slum is not necessarily a jungle. . . . The qualities and defects of organization are not to be confused with the absence of organization."

The so-called theory of "cultural origin," which has enjoyed considerable vogue, is supported by a great deal of challenging data. A classic statement of the cultural-transmission theory of sociologic juvenile delinquency is that of Shaw and McKay.[23] Certain well-known delinquency areas in Chicago were described, with the persistence of the delinquency attributed to the persistence of a delinquent tradition. The principal conclusion of a monumental storehouse of research by Shaw, McKay, and their associates was that sociologic delinquency was a subcultural tradition in the areas of the city inhabited by the lower socioeconomic classes. Such delinquent groups were not correlated with any national group. Thus, regardless of whether Poles, Norwegians, or Italians had taken over the area, the rate of delinquency would continue. At no time did Shaw and McKay maintain, however, that economic factors were the whole answer to the problem. Hewitt and Jenkins'[14] studies found, like Shaw and McKay, that sociologic delinquents were likely to come from lower-standard homes. Many statistical studies tend to confirm the popular impression that gang delinquency is primarily a working-class phenomenon. This is not to say that gang delinquency does not arise in upper-class areas. It is, however, far less common, and, where it exists, as yet has not been subjected to careful study. Tannenbaum[27] and Ruth Topping[28] have also been serious exponents of the cultural-transmission theory.

Any areas of high mobility and conglomerate composition lack a unity of culture, or certainly one consistent with the codes of those representatives of the larger society. Some authors maintain that the adult world presents no clear-cut authoritative models to the child, and he is confused and lacking in respect for any code. Others maintain there is in his group a subcultural unity with codes, but that it is incongruent with the larger society. It is "their" world against our world. Their subculture avows it is all right to steal or betray the other world. In war our culture says it is acceptable to fight and kill the enemy. The gangs and subcultural groups from which they stem may have little guilt about stealing or manhandling those outside their culture.

Hirschberg,[15] speaking from much the same point of view, has said:

> In certain city areas, "the blighted areas," delinquent groups are a significant part of the social organization. Many of the people who live in these areas, regardless of their personal morality, have a strong subgroup sense of rejection by the larger and wealthier society on whose outskirts they live. Tremendous feelings of frustration and resentment ensue, and group attitudes condoning hostility, rebellion and destructiveness come into being. As a result, a mother and father in such a society may raise their child with the conventional emphasis on honesty, respect for property, etc., while they simultaneously express their bitterness, criticism and hatred of the larger society with which they struggle. As an individual the child *may* have no serious internal emotional problems. Again he may be deeply disturbed by personality conflicts. He then becomes a member of a subculture and freely joins with others into an aggressive group with whom he can identify and which is capable of anti-social activity. Nor is this problem confined exclusively to the poor. Many people who have struggled hard for years to accumulate a large fortune have powerful wishes for a hedonic way of life which they verbalize to the child but do not act out themselves, but which their children proceed to realize. Wanton indulgence of sexual impulses, of desires for "high living," or of "madcap" activity, may all be acceptable values in the parental culture, although as individuals these same parents may at times be reasonably conventional people. Their group anti-social ideal, however, achieves concrete form in

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the behavior of their children when the latter come together and form a clique, a set, a club, or whatever. Fundamentally the subgroup phenomenon is the same and the outcome in either case, rich society or poor, is a delinquent group. From the point of view of our society, however, the major problems arise with the groups and gangs that come from the more marginal economic societies.

What makes the sociologic delinquent group is that it is largely moulded by community and home forces more or less *consciously* in opposition to the whole other social world. For example, a youngster growing up in a gypsy society might have certain values and standards about stealing which would be very different from those of the villagers among whom he wanders. He would have incorporated a conscience which was "defective" in at least one area, in that it held stealing to be an acceptable way of obtaining money. This would be both his family's teaching and the way of the group. Once having incorporated the values and images of his parents and his culture, this gypsy youngster would then not only be able to steal without conflict, but would steal as an activity of his sociological group. There would be no *conscious* pressure brought to bear on him when he stole. Nor would he have guilt about what he did. Stealing would be an easy and natural act. On the other hand he might have a great deal of fear of reprisal and he might experience much reality-based anxiety in connection with his act. But it is important to realize that the conflict he experienced would be a conflict between himself and external reality, not between him and his own conscience.

Albert Cohen[4] says of the culturist view that the delinquent is said to develop

> . . . no respect for the legal order because it represents a culture which finds no support in his social world. He becomes delinquent. . . . From the recognition that there exists a certain measure of cultural diversity it is a large step to the conclusion that the boy is confronted by such a hodge-podge of definitions that he can form no clear conception of what is "right" and "wrong." It is true that some ethnic groups look more tolerantly on certain kinds of delinquency than others do; that some even encourage certain minor forms of delinquency such as picking up coal off railroad tracks; that respect for the courts and the police is less well established among some groups and that other cultural differences exist. Nonetheless, it is questionable that there is any ethnic or racial group which positively encourages or even condones stealing, vandalism, habitual truancy and the general negativism which characterizes the delinquent subculture. The existence of culture conflict must not be allowed to obscure the important measure of consensus which exists on the essential "wrongness" of these activities, except under special circumstances which are considered mitigating by this or that ethnic subculture. Furthermore, if we should grant that conflicting definitions leave important sectors of conduct morally undefined for the boy in that delinquency area, we must still explain why he fills the gap in the particular way he does. Like the social disorganization theory, the culture conflict theory is at best incomplete. The delinquent subculture is not a fund of blind, amoral "natural" impulses which inevitably well up in the absence of a code of socially acquired inhibitions. It is itself a positive code with a definite if unconventional moral flavor, and it demands a positive explanation in its own right.

Cohen[4] attempts a new view of accounting for the delinquent subculture—why it is there in the first place, why it is located where it is, and why it has a peculiar content. In his theory of any subculture's genesis he maintains that people with similar problems tend to draw together in a community. Depending upon the problems, collective solutions are elaborated with mutual support and identification. He believes that being reared in social worlds quite different from the middle-class standards of schools which he must attend leads to status frustration and loss of self-esteem in the child. Sharing such conflicts, children tend to draw together in little groups or gangs. Depending upon their private needs and tailored accordingly, the delinquent subculture represents a rewarding of any who attack or assault the middle-class status system. In other words, the delinquent subculture is thus seen to be the logical response to the frustration inherent between their early rearing and the middle-class standards they encounter in school and elsewhere.

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Many students accept such views only in part. For instance, in severely delinquent areas, we find many children who are well-behaved and stable citizens even though poor economically, because they are being reared in families where the parents are truly normal, setting limits effectively, guiding their children consistently and affectionately. A famous educator in this country told the author that he was reared in a highly delinquent slum area. Six of his early friends had already been sent to the gas chamber. The educator, however, had been reared by economically poor but affectionate, consistent parents who emphatically set limits about all behavior that tended to get out of line. Cohen himself says that the explanation he has offered assumed that the delinquent subculture stems from conditions of the working class. He suggests that, could such delinquency flourish independently of those conditions as found in the middle class, "it would strongly suggest that those conditions are not necessary even in the working class. It would suggest we may have overlooked some other constellation of circumstances." As with the works of Shaw and McKay, there is not the space here to do justice to the distinguished contribution that Cohen has made to the study of sociologic delinquency. Their theoretical formulations and data should be considered carefully by any student open to challenging inquiry and suggestion.

Many students feel that in sociologic delinquency a multiplicity of variables enter the picture, with no single one asserting itself as the specific stimulus. In sociologic delinquency, not only do clashes of class and poverty enter in, but there are child neglect, lack of consistent supervision, adult antisocial example, and all degrees of cruelty and rejection; they all create their own personality problems, the solution of which may be sought in identification with common problems of the gang. Fortunately, no one seriously concerned with such delinquency is satisfied with any answer, and excellent research continues on many fronts.

As has been said, many psychiatrists and sociologists have long confused the issues of etiology and treatment of delinquents by condensing them all into one group. The unconsciously fostered individual delinquent scapegoat child is seen by many students as being different etiologically and often phenomenologically from the sociologic subculture gang delinquent. There are students, however, who today do not agree on such a distinction, so further research, education, and clarification seem necessary. Long ago, Shaw and McKay,[23] in Chicago, recognized that the gang delinquents, in large part, could not be helped in the psychiatrist's office. Albert Cohen was careful to make the distinction as suggested above. He said, "Although the 'delinquent subculture' is not a category of delinquency statistics, there are a number of studies which distinguish group or gang delinquency from other delinquency." Cohen goes on, "These studies furnish us with an important kind of evidence about the distribution of the delinquent subculture, for it is a hallmark of subcultural delinquency that it is acquired and practiced in groups rather than independently contrived by the individual as a solution to his private problems." It is this latter group who can only be treated by the psychiatrist.

Because of the confusing condensing of all delinquencies as if belonging to the same category, there are no reliable statistics of the ratio of the individual unconsciously sanctioned delinquent to the sociologic group. Except for a particularly blatant or vicious individual delinquent case, we more frequently read in the press of the sociologic delinquents. Because of this confusion also, it is impossible to talk of the ratio of girls to boys in either group. Taken as a whole, however, practically all published figures from many sources conclude that male delinquency is at least four times as common as female delinquency. Authorities seem fairly well agreed that female delinquency is more likely to be sex delinquency than other forms. Although girls at times may be involved, as Cohen says, " 'stealing,' 'other property offenses,' 'orneriness' and 'hell-raising' in general are primarily practices of the male." As one observes in a large diagnostic clinic, probably in individual unconscious delinquency, girls steal almost as much as boys. This is certainly not true of the sociologic group.

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We come now to the overlapping of the two large groups of delinquency. Oftentimes, the lone individual scapegoat delinquent of the first group, with his deeply personal conflicts, gravitates to a gang in the sociologic areas. When such an individual, internally driven by antisocial impulses and the hostility of the parents, enters such a gang, he is often far more of a problem than are the others. He may be driven unconsciously to steal, destroy, or kill in a manner far more vicious than do other members of the gang that emerged in a culturally antisocial area. This is because of the generated hostility in the unconsciously aroused delinquent.

Treatment of Sociologic Delinquency

To set about a rational treatment, certainly first we must settle whether we are dealing with individual delinquency, initiated as previously described, or sociologic delinquency. The individual delinquent and his parents, as discussed above, are problems for the psychiatrist. Treatment of sociologic delinquents demands a broader and frequently entirely different approach. To be sure, such children, in part, may have internal conflicts demanding psychiatric treatment, but the acting out, often in large measure, is the product of the subculture into which they have drifted and often of living with direct adult examples or lack of any guiding supervision.

In the years of the late thirties and forties at the Institute for Juvenile Research in Chicago, recurrently, social agencies and the courts referred children to us psychiatrists for treatment—children who were not the personally involved individual delinquent but rather the sociologic delinquent. These were not cases appropriate for psychiatric treatment. The sociologist, with his appreciation of group mores, of presence or lack of community leadership, of traditions of delinquency in an area, of economic imbalances and pressures, of community resources that lead to cohesiveness or its lack, is fitted for leadership in directing a therapeutic attack. Long ago, in Chicago, Shaw and McKay[23] and others gave impetus and direction to the multiple community approach that seemed pertinent to a basic modification of the pressures in a delinquent area. Not alone was economic improvement significant, but leadership that would bridge the chasm between the ego-ideal of the delinquent area and that of larger society was necessary. Individual leaders, religious resources, recreational opportunities, police and court cooperation, social agencies—all must contribute to a broad-base community therapeutic attack. All sociologists and psychiatrists interested in this problem should study the truly pioneering work of Shaw and his colleagues. This work not only portrays their data and theories of the inception of "area" delinquency, but it includes the therapeutic measures.

The sociologist, in his enthusiasm for a therapeutic attack on a gang area, should not overlook those delinquents who have internal conflicts not susceptible to the techniques of therapy drawn upon from the community. It is necessary, therefore, diagnostically and therapeutically, that the sociologist and psychiatrist work together very closely. Too often, one gets the impression that psychiatrists maintain that what we need are more psychiatric clinics and residencies—that this will solve the problem. Again too often, newspaper reporters at least get the impression from sociologists that their approach will resolve all delinquency. Both kinds of therapeutic treatment are necessary, depending upon the correct diagnostic evaluation. Many times, careful diagnostic procedures will indicate that, for an individual child or family, both approaches are necessary, possibly not concurrently but in time, to resolve the problem.

¶ Education

We cannot leave the problem of treatment of either category of delinquency without some reference to the possible efficacy of education. Many of us are often inclined toward pessimism on this score, but only time will show how much can be achieved through the avenue of bringing pertinent data to parents and adolescents involved in delinquency.

Whether parental sanction of antisocial be-

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havior is conscious or unconscious, it is legitimate to question whether widespread lay knowledge of the role of parents and other adults in delinquency promises to limit the phenomenon. Nothing can be lost by such an approach, and the thesis might be defensible that the mischief perpetrated by the poorly integrated parents under consideration might well be curbed if it were generally conceded that delinquent behavior should not, without searching scrutiny, be ascribed to heredity, bad companions, poor schools, or divorce. The poorly inhibited antisocial impulses of adults may not then so readily find expression in the encouragement of scapegoats. It is true that such adults might then become neurotic, evidencing emotional conflicts in which conscience has prohibited direct expression of an urge to antisocial action. Troublesome as such neuroses may be—in the form of phobias, compulsions, conversions, or a hundred other neurotic expressions—they are preferable to antisocial behavior, with its threat of perpetuation through generations. In most instances, a neurosis, with conscience holding the fort, is more amenable to therapy than is delinquency, in which the conscience is too weak or is in abeyance. The psychiatrist and sociologist apportion no blame but prefer to interpose a barrier of understanding that might divert conflicts of neglect or cruelty of parents toward their own individual neuroses rather than toward the misbehavior of children.

Educationally, we must consider the meaning of the juvenile court to parents and children. Both the general public and children continue to be unable to divorce the juvenile court from the criminal court and delay use of the juvenile court when it could be most profitably employed. Judge Nochem S. Winnet of Philadelphia points out that continental countries have tried to offset the criminal odium by placing the delinquency problems in the Department of Welfare, as in Sweden, or in the Department of Education, as in Russia. Judge Winnet[81] suggests that we use the designation "family court," which removes the emphasis from the child.

There is no doubt but that widespread knowledge among healthy citizens is the fundamental lever through which to enlist their aid and support for clinics, courts, civic therapeutic work, and an attack on a broad front for the amelioration of both categories of delinquency.

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CHAPTER 43

READING AND LEARNING DISABILITIES

Ralph D. Rabinovitch

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CHILDREN'S LEARNING has long been a major concern of psychology and of child psychiatry, evoking the interest of both theorist and clinician. Theories of learning are numerous, divergent, and still growing in both number and complexity. They range through Thorndike's[44] early stress on stimulus response; Hull's[19] addition of intermediate mechanisms; Gestalt psychology's general principle of "pragnanz,"[49] elaborated in Lewin's[26] field-theory and life-space definition; the motivational approach of psychoanalysis;[33] Mowrer's[30] two-factor drive-induction and drive-reduction theory; and Hebb's[17] intriguing neuropsychological postulates. Psychiatry, faced with pressing service demands, has tended, in its training programs, to devote minimal attention to these background studies. While they often are more philosophical than experimental and are, at times, only tangentially related to the child's experiences, one can find in them numerous suggestions for clinical application. Among the critical review volumes on learning theory, Hilgard's[18] is particularly helpful to the child psychiatrist.

The Learning Process in Children: Neuropsychiatric Considerations

The commonest single immediate cause for referral to our guidance clinics today is behavioral, academic, or social difficulty experienced by children at school. This fact, in itself, suggests the need for intensive study of the full meaningfulness of the schooling experience, the ways in which it affects the child and, equally important, the influence of the child's capacities and personality on the learning process. A further incentive to such study is the current national interest in our schools, a valid concern that has, unfortunately, tended to assume hysterical overtones in reaction to international fears and rivalries. The feeling that many children attending America's schools are not achieving their full learning potential is generating numerous re-evaluations of educational philosophy, teaching methods, and curriculum. Approached insightfully and with constructive motivation, such projects can lead to progress,

but there is the danger of the negative effects of oversimplification and overgeneralization. We find, for example, curriculum being blamed for all learning problems, with finger painting, home economics, and driver training incriminated as the arch enemies of science. Delinquency that interferes so markedly with learning is said to be due simply to coddling. Reading failure is described as routinely the result of inadequate early teaching. It would be comforting if the truth were so simple. In relation to the educational crisis that we are facing in America, child psychiatry has a major role to play in interpreting the multiplicity and complexity of causes of learning difficulties and in fostering a realistic child-centered approach in their handling.

The term "learning" has many meanings; in its most general sense it refers to the process by which experience leads to change. In this chapter we are concerned with a single type of learning, the acquisition of academic knowledge. The process by which this is achieved involves a wide range of factors. Impairment of learning may result from disturbance in any of these; as such it represents a symptom. There is, in fact, no validity in postulating a discrete diagnostic entity of learning disability. In recent years, as clearer concepts of the psychopathology of childhood have evolved, many other clinical problems (for example, mental retardation and juvenile delinquency), previously described as entities in themselves, have come to be recognized as part of a symptom complex reflecting a more generalized underlying disorder.[3,35] We can best approach our topic through a consideration of the multiple areas of the child's functioning involved in academic learning, disturbance in any of which may lead to the symptom of learning retardation or distortion. Most important are the following: (1) general intelligence, (2) specific capacities, (3) developmental readiness, (4) emotional freedom to learn, (5) motivation, and (6) opportunity.

Although we shall examine each of these factors separately, it is evident that they operate in an integrated manner in each child's learning experience, and, clinically, multiple etiologic components are often present. Because of this multiplicity of factors, no single disciplinary approach to learning problems is valid; neurological, psychological, psychiatric, and educational emphases must be brought together without preconceived bias in both clinical and research work.

General Intelligence

Any evaluation of a child's level of academic achievement must be considered in relation to his intellectual potential. In general, we can expect competence to be commensurate with mental age, recognizing that, in the learning pattern of the slow child, capacity to deal with abstractions and problem solving lags behind rote learning. But this whole area of diagnosis is by no means simple. Despite advances in techniques of measurement, accurate assessment of intellectual potential remains a difficult task. One of the unsolved problems is how to differentiate potential from actual functioning, as measured on a specific psychometric test or series of tests. This is, of course, a crucial consideration in planning for children, and one in which bias and wishful thinking tend to run rampant in the absence of objective indices.

In considering the relationship of intelligence and academic learning, we have become increasingly aware, in recent years, of the need to move, at least clinically, beyond a unitary concept of intelligence to one that takes into account the possibility of wide divergencies in verbal and nonverbal capacities in the individual child. Experience with the Wechsler Intelligence Scale for Children, with its separate verbal and performance I.Q. scales, has provided ample evidence for the validity of this differential approach. The two aptitudes are used in different situations and involve different types of learning—verbal and perceptual-motor. Group and individual tests that measure primarily capacity to deal with language symbols may be poor indexes of total intelligence and, as such, misleading. On the other hand, formal school achievement is much more closely related to the single factor of verbal intelligence, which tends to be disproportionately highly prized in our culture. These issues have particular relevance to the problem of reading retardation, discussed later in this chapter.

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From a research standpoint there is a pressing need for continuing work on these and related problems; detailed longitudinal studies investigating the meaningfulness of subtest variations on such tests as the Wechsler[47,48] should prove particularly fruitful. Meanwhile, in our clinical practice with children, all possible care must be used in the assessment of both intelligence and learning capacity, with major reliance on individual tests competently administered and interpreted by clinical psychologists, of whom, unfortunately, fewer and fewer seem primarily interested in evaluation and diagnosis these days.

Specific Capacities

In order for the child to learn to his full potential in the normal classroom situation, intactness of other specific functions, beyond intelligence, is required.

The higher senses—vision and hearing—must be adequate; the diagnosis of hearing defect is often difficult, especially in the uncooperative, inattentive child, and may be missed in the more common search for primary emotional factors.[20]

Neurological integration must be sufficiently intact to permit attention and concentration. The brain-injured child, experiencing difficulty in filtering background from foreground stimuli, tends to be overreactive and uneven in his classroom functioning.[6] Special education, permitting repetitive activities in small, quiet groupings for a period, can often be effective in preparing the encephalopathic child for return to the regular class.[42] This group of children is much larger than many workers recognize, and facilities for both their diagnosis and appropriate schooling are sadly lacking.

Language capacity, in the broadest sense, must be unimpaired. This includes verbal comprehension, expression, concept formation, the processes required for the learning of reading (visual-auditory memory and association), and ability to calculate. Disturbance in one or more of these language areas is present in the various forms of aphasia now recognized in children.[15,22] Learning difficulties involving aphasia are common and often unrecognized. Confusion still tends to surround this whole important area of the neuropathology of childhood; this is probably due to the fact that diagnostic criteria have been borrowed from work with adults with insufficient emphasis on the developmental aspects so crucial in childhood.[40] Aphasia will be considered in some detail in its relation to learning in our later discussion of reading.

Developmental Readiness

Educators have placed much stress on the concept of readiness as a prerequisite for learning. From the field of child development, the emphasis has been drawn on individual differences in maturational pattern, especially as they relate to children in the earliest school years.[14,31] Differentiated from intelligence and experiential influences, the factor of biologic readiness, which appears to be a reflection of specific integration patterns, plays a major role in the acquiring of speech and the learning of reading and arithmetic. While, for example, aphasia in the adult can generally be traced to known cerebral trauma in children, it is more often maturational in origin and represents a lag in the development of specific language functions. Usually, following the delay, spontaneous compensation occurs, although, on later examination, a residuum of difficulty may be diagnosed in the form of motor, sensory, conceptual, or mixed aphasia. A similar pattern is followed in older children in relation to reading. Differences in the development of such fundamental techniques as directional orientation and auditory discrimination may be wide in a group of first-grade children of comparable intelligence, and the influence of this factor on the learning process is crucial.

A vexing clinical problem for the child psychiatrist is suggested by these developmental considerations: In which cases can the early disability be expected to be overcome spontaneously through growth, and in which is specific help needed? Notwithstanding the validity of the developmental-lag concept, too often there is a tendency to wait too long for spontaneous compensation to occur, while the child is neglected, sometimes beyond remediation. We still see, in practice, a good many bright 16-year-old boys virtually illiterate, while work-

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ers are sitting by, waiting for nature to take its course. At present, our differential diagnostic skills are at best spotty, and there is a need for much continued interdisciplinary research into these vital maturational factors in personality development and learning.

Emotional Freedom to Learn

In order to acquire academic learning most effectively, the child must participate actively and must be free to invest appropriate psychic energy in his schooling experience. It is evident that emotional problems of any type may impair this freedom, and they therefore represent the underlying cause of learning difficulties.[33, 34] To discuss this large area in detail would require a volume in itself—in fact, a consideration of the complete psychopathology of childhood. Our present purpose will best be served by reviewing the general principles and relevant representative syndromes most commonly met in psychiatric practice with children and adolescents.

Along with the recognition of the relationship between emotional disturbance and learning disability, there has been a tendency to overgeneralize, with insufficient attempt to understand the specific ways in which the learning process is affected. In practice, it is difficult to predict when an emotional problem will undermine academic learning; many severely disturbed children, who, on theoretical grounds, might be expected to have learning impairment, do well in their school work. Such apparent paradoxes are sufficiently common to make definitive general cause-and-effect assumptions uncertain at best. Many factors that may not be germane to the specific emotional disturbance are involved, including the quality of gratification that schooling provides, the level of accomplishment possible, the degree of protection afforded in the classroom, the child's attitude toward competition, the family's expressed and covert attitudes toward school and learning, sibling relationships, and, most important, the relationship with the teacher.[29]

These and other analogous conditions of the child's total experience play a major role in determining whether an emotional problem, not primarily concerned with learning, will lead to secondary academic difficulties. It is these multiple interrelationships, unique in their qualitative and quantitative aspects in each case, that preclude facile generalizations. Further complicating the issue is the possibility that the emotional disturbance diagnosed in the child is itself caused by a basic learning defect such as a primary reading retardation (see p. 864) or a language disability. In clinical studies it is not always easy to distinguish reactive patterns from basic etiology, and there is a tendency to overlook the former. For example, the presence of relationship distortions in the life of a child, along with a learning difficulty, cannot lead to the a priori assumption that the distortions have *caused* the symptom. Whitehorn[30] has drawn attention to this important reality in his paper on the concept of "meaning" and "cause" in psychodynamics; he points out that, in any specific disturbance, a dynamic description of relationships may be accurate and yet have no reference to the basic cause. This caution takes on particular significance in our clinical work with learning problems in which biologic realities can be so easily overlooked in the often less-disciplined search for dynamic relationships. In this specific context Pearson[34] writes: ". . . at the present time there is so much emphasis on the importance of intrapsychic processes in all phases of medicine and education [that] psychiatrists tend to become over-enthusiastic about dynamic intrapsychic processes to the complete neglect of physiological and organic processes, for which they seem to have a psychic blind-spot."

These cautionary remarks, in the interests of clinical practice, do not imply that full, careful studies fail to uncover many cases in which a learning problem has its roots in the child's emotional state; Pearson[33] has, in fact, written a large volume on just such situations. Anxiety, depression, negativism, phobic preoccupations, and personality disorganization all may interfere directly and markedly with a child's functioning in the classroom. A number of common clinical examples will illustrate the various processes through which the impairment may occur.

REFUSAL TO ATTEND SCHOOL

This problem appears to be increasing in incidence and has a number of causes.[46] A

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neurotic conflict may lead to a phobia displaced to the classroom.

Peg, 10 years old, developed feelings of inordinate tension and nausea when at school, so that finally attendance was impossible. Study indicated a severe oedipal problem, with separation anxiety based on the fear that the mother would be attacked in her absence.

Another frequent cause of school refusal is more characterological and may reflect a power struggle within the family.[18]

Joan, age 8, could not be persuaded or forced to attend school and responded with temper outbursts and direct attacks on her mother when any pressure was exerted. Clinically, Joan was minimally anxious, but she was involved with inconsistent nondirecting parents in a chronic battle for control, of sufficiently long duration to represent virtually a way of life for the child.

Learning Block as Counteraggression

Children in whom a need for counteraggression is fostered within the family evolve various typical mechanisms through which, consciously or unconsciously, they express themselves. In the young child, feeding and toilet training are among the commonest media for dynamically induced oppositional behavior. Later, displacement outside the family tends to occur, with academic failure and delinquency the common symptoms; in the school situation, transference of negativism to the teacher, regardless of his handling of the child, may make learning almost impossible.

John, a bright 12-year-old, failed all subjects in the sixth grade. His teacher described him as unfriendly, uninterested, and unwilling to work. No remedial attempts within the school program or through tutoring had proved helpful. Later, psychotherapy revealed a fantasy of rejection by the parents on the basis of the younger sister's status, and an unconscious wish to strike back accomplished through total resistance to learning.

Anxiety That Interferes with Concentration

Many children, faced with conflicts outside the school, are so preoccupied in the classroom that attention, concentration, and memory suffer to the point that learning is impaired. It is interesting to note that, while grades are poor when such interference occurs, basic skills are not necessarily affected. In such cases, both techniques and facts are learned but are not applied in a meaningful way.

Paul, age 16, in the eleventh grade, has a verbal I.Q. of 133 and performance I.Q. of 136, and on the Advanced California Achievement Tests both his reading and mathematics levels are beyond the fifteenth grade. Despite this very superior level of intelligence and skills, he is doing failing work in all subjects except geometry. In psychotherapy Paul indicates that he cannot study; his mind wanders, and he spends much time brooding about the fact that he feels different from other boys because his parents are divorced and he is ashamed of his father. He knows how to do the work but cannot apply himself to assignments; assimilation of learning is intact, application severely affected.

In other cases, anxiety affects assimilation of basic skill materials.

Steven, age 14, is doing failing work at school despite a verbal I.Q. of 134 and a performance I.Q. of 132. Achievement testing indicates that he is functioning at a sixth-grade level in reading, fifth grade in arithmetic, and fourth grade in spelling. Careful study indicates no specific disability; the learning problem is psychogenic. Steven feels inadequate, fears competition, and tends to withdraw when he is threatened. His anxiety has interfered with his basic learning from the earliest school years.

This differentiation between assimilation and utilization in academic learning is important clinically in that definition of the process disturbance will influence treatment recommendation. While psychotherapy may be indicated in both situations, remedial tutoring, often helpful in assimilation problems, will usually be of little avail where the prime disturbance is in application.

Depression, Self-Denial, and Self-Punishment

Accomplishment at school involves a measure of pride and of self-gratification, bringing with it a sustaining feeling of success. The child whose inner conflict cannot permit such personal gratifications may experience the un-

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conscious motivation to fail. Depression may lead to inertia, with inability to sustain interest. When the need for self-punishment has been internalized, the ego may, at times, deny even minimal satisfaction through new accomplishment. Such dynamic constellations underlie a significant number of school failures in children and are often unrecognized, especially in the preadolescent years.

Despite a full-scale I.Q. of 127, Ruth, age 11, was making little progress in her schoolwork and was described by her teachers as "dull and lazy." She tended to be inconspicuous in the class and gave little behavorial evidence of emotional disturbance. She was referred for psychiatric study after her superior intelligence was diagnosed through individual testing at school. History indicated that Ruth had been adopted in infancy, after having been abandoned by her unmarried mother. In psychiatric interviews she revealed that her adoptive mother, when angry, reminded her of her background in uncontrolled, hostile, verbal attacks. The child reacted by retreating from the adoptive mother to a progressively stronger identification with the negative image of the natural mother. Her super-ego strength precluded delinquent acting out; instead, she internalized guilt and feelings of total unworthiness. Her school failure was an expression of this inner life and accorded with her self-image, unrevealed at school.

Symbolic Associations Affecting Circumscribed Learning Areas

In the cases described above, academic learning in general has been impaired by the emotional problem, rather than specific learning content being involved in the neurosis. This is the usual pattern; more rarely, a circumscribed blocking is seen. Here the particular subject matter invokes traumatic associations which the child's ego attempts to handle by avoidance.

Tommy, age 9, functioned well above his age level in all subjects except spelling, in which he was markedly retarded. He was referred for psychiatric help because it was felt that he was oversensitive and unduly introspective. During the course of psychotherapy, an interesting explanation for his spelling defect came to light. When he was 5 years old and beginning to manifest interest in spelling, two older boys in the neighborhood, as a ruse, taught him to spell a number of vulgar sexual terms without his knowing their meaning. At home he proudly repeated his new knowledge to his mother, who overreacted and punished him severely. To Tommy, spelling came to symbolize uncleanliness and danger, and his circumscribed learning block resulted.

Because cases such as this are dramatic and the explanation for the problem is comfortingly simple, and therefore particularly appealing to the psychiatric student, they have tended to be overemphasized in proportion to their incidence in the mass of learning problems seen in practice. Actually, they are relatively rare.

Psychopathology Other than Neurosis

While brain injury, affectionless personality, and schizophrenia affect the learning pattern, each in a characteristic way, the presence of the disturbance in the child does not, in itself, inevitably mean that major difficulties at school will ensue. The many other relevant relationship, attitudinal, and educational factors to which we have referred in our discussion of the neuroses play an equal, if not larger, role in determining total adaptation in these illnesses. This recognition is important clinically, because there is a tendency toward unwarranted exclusion from school of some of these children on the basis of diagnosis alone.

In an earlier section of this chapter, we have described the importance of neurological integration in the learning process and some of the problems and needs experienced by brain-injured children. The major concern of the child psychiatrist and the teacher tends to be with encephalopathic children in whom the damage involves associational patterns affecting visual-motor functioning, the suppression of response to extraneous stimuli, and shift or smooth transitions in motor behavior.[6] In the classroom these neurological deficits lead, respectively, to disturbance in patterned activities, hyperactivity or short attention span, and uneven or repetitive motility. Anxiety tends to lead to disorganization in the brain-injured child's functioning, and his emotional state is often the crucial factor in determining adaptability.

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Strauss and his coauthors[41,42] have outlined in detail the special educational needs of these children.

The affectionless child[5,9,36] presents, as his major symptoms, reduced capacity to establish depth relationships, inadequate social awareness and identifications, inability to control impulses adequately, and limited capacity for insight. In the thought process there is marked concreteness, with poor conceptualization that limits fantasy life and creativity; future goals cannot be envisioned. This clinical picture has a marked influence on learning. Basic skills and rote learning are much less affected than the incorporation of content in social context. Behavioral disturbance in the classroom is common to the point of presenting major management difficulties; in the absence of small groupings for special education, exclusion from school may, at times, be necessary. Treatment is extremely difficult because of the limitation or absence of relationship capacity; Bender[5] provides an excellent interpretation of the special educational and total treatment needs of this affectionless or psychopathic group of children.

As the clinical picture of childhood schizophrenia has been more clearly delineated,[4,21,28] the learning problems and educational needs of psychotic children have become a major concern of child psychiatry. The core problem in childhood schizophrenia is a dysidentity, an inability to establish a clear-cut self-percept and definitiveness in the appreciation of boundaries and identities. There is an amorphousness to the child's personality and thought processes that interferes with reality testing and leads to marked anxiety. Learning is frequently impaired by a tendency toward misinterpretation of stimuli, obsessive attention to insignificant detail, a limiting concern with orientational clues, and panic reactions when routine is disturbed. Some schizophrenic children have accumulated vast stores of relatively useless knowledge, frequently about numbers, dates, or locations; such orientational assurances gratify the child by lending comforting pseudo stability to his uncertain, floating world. The "idiot savant" is frequently a psychotic child displaying this restitutive mechanism. In long-term follow-up studies it has been encouraging to note, in some cases, a marked increase in learning capacity in adolescence. These studies suggest that even the severely autistic child may incorporate more meaningful knowledge than he can express; neglect of exposure to schooling experience is unwarranted. Among the techniques found most effective in the education of these children are small informal groupings, close contact with the teacher, simple repetitive programing, and reliance on music and rhythmic play; Abbate[1] has elaborated on these techniques.

Motivation

The term "motivation," as used in psychology, has many meanings; we are using it here to imply incentive or desire to accomplish a goal, the goal being learning. Many of the emotional problems that we discussed earlier involve various aspects of motivation as a component of the disturbance. In this brief section we are concerned specifically with the attitude of children toward school and learning, recognizing that this is a crucial factor in the learning process. Two types of motivation concern us; extrinsic, in which concrete reward is the goal; and intrinsic, which implies inner satisfaction as the incentive. The fact that a large number of children in our American schools today seem to lack motivation of either type is a valid source of national concern.

In our clinical work with children, a number of reasons for this problem are suggested. These are students who have little interest in learning and whose application is minimal. In every aspect of responsibility, they do just enough to get by, or less. They study little and do not involve themselves in learning. Among the total group a number of subgroups can be recognized. There are those who have been raised by parents who make no demands on their children, avoid all possible frustration of their impulses, and sometimes permit a frank reversal of parent and child roles. Others have been offered no values by which to live, and they gravitate, herdwise, to the most superficial "hood" identifications which leave them sadly empty; they are truly lost children, but in their

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behavior, manner, and dress, they can demoralize an entire school. A third group, passive and uncertain of status, tend to follow the leadership of these more aggressively nonconforming adolescents.

There is more to the problem, however, than these individual factors in children; the cultural determinant is vastly important and has received far too little attention. At a time when expediency is at a premium, when affluence is more prized than integrity, and when the headlines are more gruesome than the comic books, it is not surprising that many children are having difficulty in finding motivation for hard work and devotion. The major crisis in education today (and child psychiatry is equally deeply involved) is to find ways to offer children personal relationships and community values that will generate at least some intrinsic motivation for learning, for the sake of the too-oft-forgotten inner life.

Opportunity

The last factor to be considered in our survey of the multiple processes involved in academic learning is the opportunity for learning afforded the child. We can do little more than mention this topic in our concentrated survey, although it is a matter of much concern to child psychiatry. Involved are such issues as the educational philosophy that evolves in our schools, curriculum emphases, teacher training, and school design. Clinical study indicates clearly that a significant proportion of learning problems diagnosed in children have their origin in unfavorable circumstances prevailing at school. In our search for more complicated etiologies, we sometimes overlook the negative effects of overcrowded classrooms, lack of equipment, and unstimulating teaching. It is unfortunately true that the educational opportunity offered our children varies widely throughout the country, with primitive conditions not uncommon; the hazard of neglect is very real.

In regard to our schools, a number of issues are particularly relevant to the clinical concerns of the child psychiatrist. There is a great need for small-group special-education rooms for emotionally disturbed children who cannot function in the larger, competitive setting; the availability of such facilities frequently means the difference between a learning opportunity for the disturbed child and total educational neglect. Our inpatient psychiatric treatment centers for children are developing teaching techniques that may well be applicable in the public schools. We are interested, as well, in programs for gifted children and in retaining in the curriculum appropriate courses for the child who cannot handle academic work. Above all, we are interested in helping our colleagues in education in whatever ways we can to improve our children's learning opportunities.

¶ Reading Retardation

By far the commonest area of learning difficulty experienced by children is reading. Estimates of incidence vary widely but probably more than 10 per cent of children of average intelligence in our American schools are reading so inadequately for their grade placement that their total adjustment is impaired. Clinical and research interest in the problem date back many years. As early as 1843, Lordat described his own inability to read as a result of a cerebral accident. Through the years, many outstanding workers in the fields of neurology, psychiatry, pediatrics, psychology, and education have contributed a massive literature on reading disabilities. Bibliographic reviews can be found in papers by Bachmann,[2] Solms,[30] Hallgren,[16] and Rabinovitch *et al.*[27] The earliest descriptions traced etiology to a known, specific, focal cerebral lesion.[10] Later, numerous other etiologic correlations were described, including chronic illness, visual problems,[28] mixed cortical dominance,[32] developmental lag,[31] improper teaching, generalized neurologic dysfunction,[7] and emotional problems.[8] In the presence of these and many more etiologic possibilities, it is evident that inadequate reading, like other learning deficiencies, is a symptom rather than a discrete clinical entity in itself. Because of this, we[37] have suggested the term "reading retardation" to describe all

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cases, specific etiology to be determined in each individual instance.

The term is used in reference to all children or adults whose level of reading achievement is two years or more below the mental age obtained in performance tests. It appears valid to use performance rather than verbal tests as the index of mental age, because functioning on the verbal portions of such psychometric tests as the Wechsler or the Binet is significantly affected by the reading inadequacy itself, whereas the performance subtests are much less so influenced. The two-year discrepancy between mental and reading age is arbitrary, but it has the value of limiting the definitive diagnosis to cases showing significant functional reading inadequacy that inevitably affects school adjustment.

While visual, general health, and other causes occasionally operate alone to produce reading retardation, the large majority of cases fall into three major groups:

1. Capacity to learn to read is intact but is utilized insufficiently for the child to achieve a reading level appropriate to his intelligence. The causative factor is exogenous, the child having a normal reading potential that has been impaired by negativism, anxiety, depression, emotional blocking, psychosis, limited schooling opportunity, or other external influence. We have discussed these cases in earlier sections of this chapter. They are diagnosed as secondary reading retardation.

2. Capacity to learn to read is impaired by frank brain damage manifested by clear-cut neurologic deficits. The picture is similar to the early-described adult dyslexic syndromes. Other definite aphasic difficulties are generally present. History usually reveals the cause of the brain injury, common agents being prenatal toxicity, birth trauma or anoxia, encephalitis, and head injury. These cases are diagnosed as brain injury with reading retardation.

3. Capacity to learn to read is impaired without definite brain damage suggested in history or on neurologic examination. The defect is in the ability to deal with letters and words as symbols, with resultant diminished ability to integrate the meaningfulness of written material. The problem appears to reflect a basic disturbed pattern of neurologic organization. Because the cause is biologic or endogenous, these cases are diagnosed as primary retardation.

In clinical practice it is not always easy or possible, at the present time, to be certain of the factors operating in each case, although in most instances the situation is clear. Research now continuing in many clinics both here and in Europe[24, 51] should, in time, provide us with more accurate evaluation techniques. In all cases there is a mutual interrelationship between biologic and experiential influences, and in some children primary and secondary factors are both prominent. Accurate delineation of etiology is important, because it determines the treatment program and prognosis. In regard to reading problems, Levy's[25] and Lowrey's[27] expressed concern about a prevalent "anti-diagnostic attitude" in child psychiatry is particularly relevant. Lowrey comments: "In recent years I have been puzzled by what seems to be a tendency to treat first, and then inquire afterward what was the matter." Failure to attempt accurate diagnosis, with all cases labeled indiscriminately as reading disabilities, has led to the many divergencies in reports in the literature, and, more important, has probably afforded many children inappropriate treatment.

Although definite statistics are not available, it is likely that the large majority of children presenting total or severe reading retardation have a primary problem, with secondary or exogenous causation higher in the less severe cases. There is a strong predominance of boys in the incidence of primary retardation. The proportion of boys to girls is probably greater than 10 to 1. Many workers have suggested a hereditary factor with which this sex incidence is related, and there is much evidence in support of such a view,[16] although further research in this area is indicated.

In an earlier report[37] we have presented the findings of a study attempting to define the specific process disturbances in the primary group and to differentiate these from secondary cases. Five avenues of approach have proved particularly fruitful: (1) psychometric evaluation, (2) achievement testing, (3) psychiatric

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evaluation, (4) neurological appraisal, and (5) specific remedial reading therapy.

Psychometric Evaluation

The most significant finding in the primary cases, using the Wechsler intelligence tests, is a marked discrepancy between performance and verbal I.Q. The mean discrepancy is more than 20 points, with the verbal I.Q. lower than the performance by more than 40 points in some cases. There is a general verbal incapacity relative to intellectual potential which is much less marked in secondary reading retardation, regardless of the child's reading level. These data suggest how inadequate are verbal tests alone in assessing the intellectual potential of primary nonreaders. The fact that, in the past, such evaluations have been used has seriously clouded our understanding of the problem and has led to distortions in some reported studies. Statistical analysis of the 11 subtest scores on the Wechsler, although not conclusive in findings, suggests a greater difficulty with abstract or conceptual thinking, both verbal and nonverbal, in primary retardation, with greater relative impairment in social judgment in the secondary group.

Achievement Testing

The level of retardation is higher in the primary cases. In a representative group of 20 children with primary retardation ranging in age from 10 to 16 years, the mean discrepancy between performance mental age and reading age was found to be close to 5½ years, with almost total illiteracy not uncommon. Contrary to a view often held, the deficiency in arithmetic is almost as great as that in reading.

Qualitative analysis of the functioning of the primary cases on testing and during remedial therapy suggests the specific areas of disturbance producing the severe retardation. Many factors are operative in the normal process of reading learning. Intact vision, including adequate fusion, is necessary. Visual memory, visual discrimination, and visual association are all utilized. Through visual memory, individual letter forms and combinations are recalled; through discrimination, differences in shapes, sizes, and forms are appreciated; through association, the forms in their combinations come to suggest words and concepts. Auditory memory, discrimination, and association are equally important. Through auditory memory, sounds of consonants, vowels, and combinations are recalled in response to visual stimuli; differences in the sound of letters and the many nuances of combinations in words are discriminated; through association, sound patterns suggest concepts. Another requirement for reading learning is directionality with capacity for consistent left-right orientation. In the normal learning process most children utilize both visual and auditory approaches, although usually one tends to be used dominantly. Visual clues are taught through the sight, or look-see, method; auditory through the phonic, or sounding, method. In our most severely retarded primary cases, we find major difficulties in learning through either modality; others demonstrate a deficiency in either visual or auditory memory-discrimination-association patterns. Where there can be no reliance on auditory clues, the child attempts to learn through memory of total word forms, and it becomes almost impossible for him to do so effectively past the third grade. When asked to write the word "woman," he may write "lady"; memory has broken down, and there is substitution of a word related in meaning but totally unrelated in sound. Similarly, the child who attempts to rely totally on a phonic approach cannot progress. He may learn the sound of each letter, but he experiences great difficulty in combining multiple sounds meaningfully. For example, his attempt to read the word "hat" may never move beyond the sounds "huh-a-tuh." Difficulties in directional orientation are expressed in reversals of letter forms, so that "b" may be read as "d"; total word sequences are reversed, with "no" interpreted as "on." These and other related deficiencies in the basic techniques required for the learning of reading are found in varying combinations in primary reading retardation; they are not typical of the secondary cases.

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Psychiatric Evaluation

We have described the various neurotic and other exogenous problems that impair learning; the earlier discussion applies directly to our secondary reading-retardation cases.

The primary cases tend to exhibit a number of typical reactions. They show marked anxiety about their reading incapacity, are inclined to hold themselves responsible for the problem, and feel much guilt, inferiority, and frustration. They are often protective and defensive and may confabulate when asked to read. A most interesting finding, so common as to be considered almost pathognomonic, is difficulty in conceptual thinking in relation to orientation and such abstractions as time, size, number, and direction. Typical are such responses: A bright 12-year-old boy who lives 40 miles from the clinic is asked the distance to his home and how long it took to travel the distance by car. He replies: "Seven miles, I think it took 4½ hours." Sitting with two doctors, one 6 feet 3 inches and the other 5 feet 8 inches in height, a 14-year-old boy is asked which is taller; he correctly points to the taller man. Asked how tall each is, he states that the taller man is 5 feet tall and the shorter man is 9 feet tall; asked again which is taller, he points correctly, but he is unable to recognize the discrepancy in his number concepts. A 13-year-old boy, able to name the months of the year correctly by rote, replies that Christmas is in July and the hottest month of the year is February. In addition to these conceptual problems, various sensory or expressive aphasic difficulties are observed, although not so frequently. It is evident from these findings that the reading problem is only part of a larger language disturbance.

Neurological Appraisal

Drew[37] has reported on the neurological study of a group of children and adolescents with primary reading retardation. He describes a characteristic pattern, with much variability from patient to patient, summarizing his findings as follows: "Right-left confusion, various extinction or inattention phenomena, cortical sensory disturbances, mixed hand-eye preferences, non-specific motor awkwardness, dissociated dysgraphia, and speech and spelling abnormalities are all variously combined with the reading disturbance." He interprets these findings to indicate disturbed spatial orientation, with many features suggesting similarity to the Gerstmann syndrome.[38] Gerstmann[12] has elaborated on some of these phenomena in a recent paper on disorders of the body image. Drew concludes that primary reading retardation results from a developmental discrepancy rather than an acquired brain injury, and that the dysfunction primarily involves the parietal and parietal-occipital regions. Studies by Critchley,[11] Gerstmann, and Drew are particularly pertinent in providing directives for much-needed further research.

Specific Remedial Reading Therapy

There is a marked difference in response to remedial therapy on the part of the secondary and primary reading-retardation groups. Because basic capacities are intact, the secondary cases can progress rapidly, and results are generally gratifying. Psychotherapy is usually indicated because of the nature of the causative factor, but, when the reading level is low, it is often wise to add specific remedial work with a trained reading therapist.

The situation is very different with primary cases. Retraining is slow and unsteady, and the ultimate results are less favorable. Learning needs constant reinforcement, and numerous approaches—visual, auditory, kinesthetic, and others—have to be introduced.[45] Through careful diagnosis both the assets and the liabilities for reading are determined, and therapy is directed specifically to individual need. Training in directional orientation, visual memory, auditory discrimination, phonic recognition, sound blending, and numerous other techniques is called for. There tends to be little carry-over from day to day, and patients are often discouraged by their slow, uneven progress. Crucial to treatment is the relationship with the

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remedial therapist, who must have infinite patience and ingenuity. At the present time, many adolescents with primary retardation leading to illiteracy may, with remedial therapy extending over several years, achieve a fourth- or fifth-grade level of competence, although some advance further. While this is less gain than we would hope for, it does represent functional reading capacity, so essential in our society. While there are large numbers of these children in our schools, there are very few available resources for their intensive retraining; this represents a major field for development and calls for much interdisciplinary interpretation and planning.

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CHAPTER 44

PSYCHIATRIC PROBLEMS OF ADOLESCENCE

George E. Gardner

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TO MY MIND there are four major tasks confronting the child as he enters the adolescent years. I shall not list them in the order of their importance, because they are all important. Nor would I claim for them an all-inclusiveness in respect to the problems of the adolescent years. Yet, it is safe to assume that many tasks of a subsidiary nature can be subsumed under the four which I now outline.[6]

¶ Tasks of Development in Adolescence

1. I cite, first of all, the extremely difficult task of adolescents in the necessary modification of their unconscious concepts of parental figures—both father and mother—necessary for them if many of the subsequent and consecutive steps in development as adults are to be achieved. This is not solely a "drive for independence," as it is sometimes called, but involves an extensive alteration of the frames of guidance in behavior that have been strong structural elements in the child's personality. It is not difficult for us to note that to the young child his very security is predicated upon the "all-knowingness" and the "all-powerfulness" of his mother and father. Such powers have been his strengths, his reliable guides, and his protection in respect to his own impulses and the actions of others. But faith and reliance on such alleged omniscience and omnipotence in parental figures cannot be maintained in the unconscious concepts of the child, in the face of evidence repeated through the child's many experiences within and beyond the home that such is not the case; thus the anxiety of insecurity besets him. And presumably it is well that such is not the case, as it could easily act as an immovable counterstimulus to the child's own growth and development. Nonetheless, it is difficult for the adolescent to modify these concepts—or rather, it is even more difficult for him to find other reliable sources to take their place. Usually, as a first step, he tries desperately, as many a harassed parent of an adolescent can attest, to

place other people (almost any other person) in the same role as the parent, as the supreme counselor. But this continued personalization of desirable figures of omniscience and omnipotence is doomed to failure, since no one can reasonably and totally satisfy when put to the test. This device is also doomed, because, in the last analysis, whatever "knowingness" or "power" adolescents ever are to achieve in order to become adult must be impersonalized and must reside within themselves—as a part of their self-concept and not as the concept of another, and as self-directed, not other-directed, choices and controls. I need not emphasize the episodic—or worse—sometimes disastrous devaluation of parents that takes place because of this necessary step in growth, nor need I emphasize (as has been demonstrated again and again in history) the extreme vulnerability of all adolescents (or of adults who are still essentially adolescent) to the cry and to the seductive voice of the false leader or the leader with the false ideology or intent. That adolescents (of whatever chronological age) are appealed to—and respond to—such leaders is accounted for by the fact that the latter always promise, among other things, an omniscient who can do their thinking and an omnipotent who will be their power.

This task of "de-authorizing" and impersonalizing the controls over one's behavior is formidable. It may, of course, never be achieved, and if achieved it must be thereafter repeatedly reachieved; but if it is achieved, the first and crucial steps are taken in adolescence.

2. A second task (which, like the others I shall mention, is really a specific segment of the over-all task just discussed) is the need for the assumption of standards of morality, of right and wrong, that are acceptable and appropriate in the adult society. We are all aware of the needs, from society's point of view, in this respect. What I would emphasize is the adolescent's needs for inner controls, and I am not referring only to morality or right and wrong in regard to sexual behavior. I mean social morality—the rightness or wrongness of acts in all the roles that the individual must play in his associations with all others in society. The adolescent wants and needs universally agreed-upon and universally adhered-to, fixed, and unchallengeable standards of social conduct. Even more so does he need agreed-upon standards that are "meetable," that is, that he can meet in the sense that they do not repeatedly tear his personality to pieces through the anxieties and insecurities attendant upon impossibility of attainment. To imply that the adolescent is faced with serious tasks and with serious conflicts in regard to both tenets and models as he tries to discern and to incorporate such standards is a gross understatement of the situation.

3. The third task of great importance to the adolescent, and one generative of most serious conflicts, is the identification with the sex role for which he or she was biologically determined. The pressures of all the societies that impinge upon him—from the "parental society" even to the "political society"—demand with varying emphases that this task shall be completed and be final and nonvariant. This identification is not limited merely to the biological role the youth must prepare himself to assume, without serious conflict, in adult life; it includes also all of the roles—dominant and subsidiary—that society insists he must have if the boy is to be a definitive male and the girl a definitive female. With all the dangers, actual or alleged, factual or fanciful, that have been outlined for youth by adults or by colleagues, and in the light of all the deliberately contrived or silently condoned ignorance in respect to these sexual roles, it is a never-ending surprise to all of us, I am sure, that the adolescent ever performs this task in development or ever becomes a reasonably conflict-free adult. That adolescents do so is, I am convinced, due more to their innate resilience, their dissatisfaction with half-truths or nontruths, and their curiosity than it is to the sensible guidance that they receive from others.

4. A fourth task of adolescents is in that area that involves permanent decisions and choices that must be made by them as to educational and vocational futures. I am not speaking here only in the narrow sense of picking a course of study or of the selection of a future particular or specific job, though these decisions in themselves frequently involve serious inner conflicts

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when one reflects that the final conscious choices ultimately arrived at are probably determined—again with attendant serious conflicts—by deep unconscious needs that insist on expression in one's lifework. These in themselves would be conflictive enough, but they are compounded in their effect by the multitudinous pressures and varying value ratings, in respect to occupations, that arise from the differing groups—ethnic, family, school, community, and peer groups—with whom the adolescent is in daily contact. One thing is certain above all others in the minds of adolescent youngsters in regard to education or occupation or both, and that is that some of the choices that are made are practically irreversible, and that with them they commit themselves along certain circumscribed life courses and forever forsake others. If it is true, as alleged by Freud, that adult adjustment and maturity can be in large part determined by two standards—the ability to love and the ability to work—the successful solution of this educational and vocational task selection is a major accomplishment of the adolescent and is comparable to the task previously mentioned, the assumption of roles consistent with his or her sex.

In the face of these four inner conflicts—plus many others that we might cite as normally expected phenomena of the development of adolescents as a group, just from the mere desirability of growing up—what is the most characteristic response that one would expect in these children, and indeed the one which we almost inevitably note? It is a temporary stage of role indecision, or, as Erikson has phrased it, "role diffusion." It is a stage characterized by the selection of shifting, fleeting roles; of variable ideas, ideals, and values; an age one moment of determined high idealism and resolute standards, followed by phases of the seeming abandonment of both. They are, these adolescents—again through normal impulses to go both forward and back—at one time normally obnoxious or even destructive in their independence and heedlessness, and at another flagrantly and unashamedly immature, dependent, and babylike.

By way of illustration of the emergence and demonstration of these tasks and their allied developmental stages in adolescence, I shall present and discuss an intake interview with a sixteen-year-old girl and the subsequent intake interview with the mother. In my opinion, these two interviews highlight most of the problems and anxieties (and defenses against anxieties) that one will meet in an essentially "normal adolescent." Furthermore, the two interviews, when viewed as a whole, throw considerable light and emphasis upon the persistence of, or the reactivation of, many of those tasks in the earlier development of this child that are now seen to have been totally unsolved or to have been incompletely and inadequately solved in infancy and in the latency period.

Frances, aged 16 years 2 months, a high-school senior living with her mother and father in a small town south of Boston, herself telephoned the Judge Baker Guidance Center and asked for an interview to discuss her problems. Because of the unusualness of self-referral to the clinic, she was seen the following day.

When she came into the office, she announced in quite a rush that she had been thinking over her problems and felt perhaps they were not important and that it was silly for her to be bringing them up here.

She is a tall attractive brunette girl who is quite reflective in her manner and who expresses herself very fluently, though she is rather shy. With some reassurance from me that I was interested in her problems, she began to talk of them.

She had heard about the Judge Baker Guidance Center from a cousin who was a social worker in a child welfare agency in Providence. She told her mother she was going to the clinic, and although her mother thought it unnecessary, she did not object to her doing so. She did not mention it to her father. The only other member of her family is her brother, Frederick, 29, a lawyer, who is married and lives in Detroit.

The first thing she mentioned was her inability to get on well with her parents. She feels that father, particularly, picks on her and takes the attitude that she can never do anything right. She gave as an example an occasion when she was attempting to help her father fix a radio. He had asked her to hold a bolt while he worked on

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the mechanism inside the radio. He screamed that the radio wouldn't work and that it was her fault for not doing as he asked. She says this goes on all the time, and she feels that much of her activity in life is an attempt to prove to father that she can do things well. She started taking music lessons last summer against her parents' wishes, paying for them with her own money. She also makes very good grades in school and earns quite a bit working after school in a laundry. She feels all of these things, and many others she has done well in, have been done out of rebellion against her parents.

The second major thing she mentioned as troubling her concerned her inability to make and hold friends. Mother urges her to get into groups. Mother herself is quite a joiner and keeps up a furious round of activity in order to keep herself occupied, which makes her feel happier. Mother does all of these things by herself, not with Frances or with father. Frances hinted that there was marital difficulty between the parents. She remembers that there had been many serious quarrels between them when she was a small girl, and she was continually worried that her father might leave home. She seemed quite distressed that she had told me this and said that her parents would be awfully angry with her if they knew she had talked about these things, because they had told her not to.

As to her relationship with girls, she feels that she is always trying to please them and that, actually, she doesn't ever receive much satisfaction in having girl friends, because she is always the one to give in, and then she gets angry at herself for doing this. She said that she always tries to be liked and she feels that her tremendous efforts to be liked are rather silly, because maybe she would be liked more if she didn't try so hard.

Frances feels that boys don't like her. All the other girls have lots of boy friends, but she finds herself unable to interest them. She is sure no one will ever marry her. Frances feels that she is afraid of boys, and the fact that mother is very much the prude and will never answer her questions about sex contributes greatly to this.

In speaking of boys, Frances told me about her one boy friend, Louis, who is 26 years old. She met him two years ago when she was 14. She fell very much in love with him and her father and mother were very angry about it, but she now feels that if her relationship hadn't been forbidden by her parents, and if she didn't have this urge to defy them, she wouldn't have been this interested in him. He is of a different religion and her parents didn't approve of her going with him for that reason, and also because he is much older than she. Sometimes she sneaks out to meet him, and doesn't feel this is wrong because she has a philosophy that if you do something wrong, you will know it is wrong; and if she doesn't feel it is wrong to meet him this way, then it isn't wrong. In association to this, Frances also mentioned her boss at the laundry where she has a job after school. He is married and has two children, and yet Frances finds herself falling in love with him. She thinks the main reason for this is that he treats her as though she were an equal, which is something she never finds in her father. She worries about being attracted to older boys and men. Maybe it is due to the fact that boys her own age don't like her, but they are so silly and fresh. She also feels that part of the attraction she feels for these older men is due to the fact that they resemble her brother Frederick a little bit. It seems to her that in growing up, Frederick got all the breaks in life. He was allowed to go away to college and have more independence because he is a boy. This has always made her jealous.

However, she realizes that she is afraid of sex, and mentioned that she had an experience a year and a half ago that had frightened her. She didn't think she had been hurt by it, but evidently a boy had made advances to her and she had fainted because she was so scared. When she asked her mother whether she should let a boy kiss her, mother answered, "Later I will tell you about that; there's plenty of time."

Frances has applied for admission to a college in Boston, but would rather go out of town to college. However, father will not permit this because he feels that she would get into trouble with boys if she were unsupervised. This makes Frances very angry because she feels that all he thinks about is sex in this way, and her parents are continually harping on this and telling her of the dangers involved.

Frances brought up the subject of religion to emphasize the fact that father wouldn't admit that he is of his particular sect because of his business connections, fearing that his business would be harmed. However, her parents would be unhappy

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if she didn't marry a man of this same religious group, and it makes her feel bad to be caught in this situation of not being allowed to admit she is of one religion and yet being confined to friends who go to the same church. She said quite pathetically that what she would really like very much is a kind of religion that would be really hers.

Frances also feels that her parents are so childish and petty that she has to be a parent to both her parents in many ways, and gave me an example of how mother had been up in the air about something. Frances had advised mother what to do, mother gave the suggestion to father, and father thought the solution was a good one and they adopted it as their own.

We discussed the clinic setup and how it works. We discussed the possibility of her mother's coming, and Frances said that mother had expressed a willingness to come if necessary. Frances, however, wanted to pay her own fee—she doesn't want to ask them for anything—and in discussing this, it came out that father's business had not been too prosperous during the past two years and she did not wish to burden him with this added expense.

She was again distressed that her mother might find out that she had talked of some of these things here, and I said if they came up in mother's interview, it would be because mother brought them up herself, and that Frances' confidences would be kept as such. We arranged tentatively that Frances would pay a fee of 50 cents. This would be paid out of her own earnings, which she applies mainly toward college savings.

An interview with the mother was arranged. She is a very attractive, well-dressed lady who immediately took command of the interview and tried to hold it throughout the hour. She talked of many of her activities outside the home and seemed definitely to be trying to impress the worker with her educational attainments and her efficiency. She did not feel that Frances had any very serious problems except that both she and Frances' father had found it increasingly difficult to give Frances advice. In short, they were willing to give Frances all the help and counsel that they could, but Frances seemed to wish to turn elsewhere for help. The mother states that when Frances was younger, mother was annoyed by Frances' total disinterest in things that girls should be interested in; but lately she has been annoyed because of her too great interest in boys, particularly boys much older than she.

Mother said that Frances was a full-term baby and the birth was normal. Mother was surprised when she became pregnant with Frances, as it had been thirteen years since the birth of her only other child. She did not wish to take up again the responsibilities of caring for a baby. Father, on the other hand, was delighted at the prospect of having another child. He wanted another son—in fact, mother says, she too probably preferred boys—and they were both so sure the new baby would be a boy that they had bought "all blue things" for "him" instead of pink, and had selected the name "Francis" for him. When the new baby turned out to be a girl, they gave it the same name, "Frances." Though he was somewhat disappointed in the fact that the new baby was a girl, father always spent a good deal of time with her until about a year and a half ago (Frances was 14½), when they seemed to grow apart, and quarrels were easily generated when they were together. Previous to this, however, father and Frances were always together; they attended many sporting events and movies together, and she helped father with chores around the house.

Frances' early development was normal and her health was excellent. She was not breast-fed, as the mother did not have enough milk. Frances was weaned to the cup at 9 months and was very fussy and irritable at this time. Toilet training was begun at 6 months and Frances was completely trained at 15 months, save for occasional bed-wetting; this stopped entirely at 3 years.

Mother said that Frances was never a feeding problem in early life, but at the age of 13 she placed herself on a very strict diet because she was "getting too fat," and in a period of 6 months she lost 20 pounds. Her weight had dropped, through dieting, to 90 pounds, and mother became alarmed by this. She took her to a physician, who warned the patient that she was harming herself physically by not eating enough. Frances stopped dieting immediately and soon gained back the weight she had lost.

Frances never had any serious illnesses in childhood, and except for a tonsillectomy when she was 5, had no operations. She menstruated for the

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first time at 14½ years. Mother said that she had never been able to talk over sexual matters with her daughter, and whatever sex instruction Frances had, she received from her aunt, to whom she always went for guidance and advice. In this connection, the mother stated that probably she is old-fashioned in these matters because her father and mother were very strict with her and she was early led to believe that all things connected with sex were immoral or dirty.

Frances has always done very well in school and has had very good marks. In her early teens, she had insisted that she was going to be a physical education instructor, an ambition which mother feels grew out of her great interest in sports and her excellence at them. Mother again said that Frances never played with dolls or did any other "girlish" things but, on the contrary, was always out playing football and baseball with the neighborhood boys. She was a regular member of their teams. During the past year she has stated that she wants to be a physician, a nurse, or a social worker.

Mother emphasized again her own distress and the distress of her husband that Frances shows such interest in older boys, wishing that she would confine her attention to those of her own age group. Mother specifically mentioned Louis, stating that although he is a very nice boy, he is altogether too old and too "sophisticated" for Frances.

Mother described father as a rather shy, quiet man and gave the impression that she is somewhat dissatisfied with him because he has never shown enough push and energy to be successful in his business. In general, he is a very even-tempered man with quiet humor, but on occasion gets very upset and displays a "horrid temper" or else retires into a prolonged state of uncommunicativeness. Until recently, Frances was the one who could calm him down or bring him out of his moody spells, but lately she has seemed less interested in trying to do so.

Mother stated that she is quite willing to come to the Judge Baker Guidance Center for interviews with the social worker if we feel that Frances needs help. She did, however, list a fairly large number of afternoons when it would be impossible for her to come in town because of other meetings and obligations with which clinic appointments might interfere.

We may now use this case as a basis for our discussion in respect to the problems in adolescence. In discussing the case, I shall deal with the four main problems of adolescence that were commented upon above as they are exemplified by the material: (1) the problem of the drive for relative independence and autonomy; (2) the problem of the control of the sexual impulses and the establishment of an acceptable and accepted moral code; (3) the problem of a final and definitive identification of the boy or girl with that sex, and the sexual roles with which biology intended he or she should identify; (4) the problem of educational and vocational choices. In relation to each of these four problems of adolescence, I shall discuss the case material in regard to (a) the presenting problem itself; (b) the antecedents in early life that refer to unsolved or poorly solved tasks of development at various levels in childhood; (c) the present defenses used against anxiety created by the problem; (d) other defenses sometimes used by children other than this particular girl, Frances; and (e) case examples of extreme responses—responses leading to actual disabilities—that adolescents sometimes use in an attempt to solve these problems.

¶ Problems Relating to the Psychosexual Development of Children in Adolescence

As can be seen in the case of Frances, from the material which she and her mother gave to us at intake, she was, at the age of sixteen, finding it very difficult to allow herself to identify with the female sex with a view to later assuming the roles, sexual and otherwise, that would be required of her as a young lady.[8] Indications of this delay in maturation in these respects are seen in her anxiety about her relationships with boys and her reluctance to enter into close relationships with boys of her peer group. In addition to this, we can assume, from her own story and from the interview material with the mother, that she had been ill prepared in regard to the sexual information which should have been given to her in her preadolescent years.

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Most striking are the evidences of this girl's continuation of the bisexual orientation, which is characteristic not of adolescence but of the latency period, and equally striking are the evidences of an unsolved oedipal relationship, specifically the acute reactivation of the oedipal conflict within her (and even within her father!) which resulted in various defensive maneuvers used by both in order to control or allay anxiety.

If we review the case material as it refers to this child's early life adjustments and adjustments in the latency period, we can see where and by what method this fault in psychosexual development was inculcated, and how at the present time it is being expressed in blocked development and in unhappiness. In the first place, there is the prenatal concept or image that both parents had of the coming baby, which played no small part in shaping the psychosexual development of this girl. For example, mother did not wish to take up again the duties of raising a baby, inasmuch as it had been over a decade since the birth of her other child. During those years she had turned her attention outward from the home and away from the role of the mother because of the very fact that her only child, Frances' brother, had grown into adolescence. Her interests were directed beyond the home, and she visualized correctly the numerous difficulties involved in withdrawing interests from these activities and again using her energies in the role of mother. In addition to this, there is a suggestion that this mother had many of the outgoing and aggressive tendencies of the male, with possibly a minimum of the maternal warmth that would allow her to derive her major satisfactions from the role of the mother.

It should be noted, too, that both the mother and the father preferred boys to girls, and that it was their wish that this child, when born, would be a boy. So strong was this wish for a boy child that they prepared for the baby's coming by buying "all blue things," as is usual in anticipation of a baby boy. Finally, as an indication of their desire for a boy, they selected the name Francis for the expected child. When the child turned out to be a girl, they merely altered this bisexual name and called the girl Frances.

As in all such cases where the parents have a strong preference for one sex and not the other in their children, it is very easy to conjecture (and probably correctly) that all these prenatal wishes and hopes of the parents were, from time to time, brought to the attention of our patient, Frances. To be sure, this may not have been done directly, nor was it necessarily done with a view to hurting the child's feelings or minimizing her importance; nonetheless, the young girl, knowing this intuitively, knew also (as do all children) that the best way to receive the maximum amount of love and security possible from her parents was to be the type of child (including the sex) that the parents wanted. There is no question but that she set about unconsciously (perhaps somewhat deliberately) to identify in so far as she could with the sex of the child that was most wanted by the parents. In other words, she determined to be as much of a boy as possible. As the case material indicates, she did not engage in any of the activities that would be expected of her if she were a girl. She did not play with dolls nor help with the housework, nor did she attempt to learn the rudiments of cooking. On the contrary, she played like a boy in boys' sports. She tended to dress as boys do, and later, in the preadolescent years, did not make attempts to change this dress to that of girls of her peer group; nor did she experiment in relation to feminine hairdos and make-up.

In addition to this, it will be noted that this girl became a "pal" of her father. They went to sporting events together and did the chores around the house together, and they did these things with the exclusion of the mother. In short, here we have a case of extreme tomboyishness, even boyishness, and subsequently we note a prolongation of this male identification, or at least strong bisexual identification, up to and into the adolescent years.

But, beginning at the age of fourteen and a half, and perhaps earlier, we have hints that it was becoming more and more difficult for this girl to maintain her identity with the male sex and more and more difficult for her to deny her femininity. Not only did the results of physiological growth make it increasingly impossible for her to assume that she was to be a boy, but also we can conjecture that there

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were increasing pressures and demands by both her parents, and particularly by her peer group, that she take up the activities that are characteristic of girls in the teen-age group and give up those that are followed by boys of the same age or younger. It will be noted that the father, too, must have been assailed by the same pressures to give up his fantasy that this girl was really a son of his, and also to give up the fantasy that she would always remain close to him and afford to him whatever she was to give in respect to close relationships with people of the opposite sex.

The difficulties faced by this child, and the defenses employed in the face of these difficulties are quite apparent from the case material. In the first place, she found it very difficult to make relationships with boys in her own group because she was, as she states, "afraid of boys." It can be assumed that, because of her identification with boys in the preadolescent years and her minimal association with girls, she lacked the very practical techniques in respect to using proper attire, conversation, and behavior that are so necessary in the launching of even the most modest attempt in establishing relationships with adolescents of the opposite sex. This lack of techniques for identification with the girl's role is further attested to by her seeming inability to make friends among girls and to get along with them. It was only by extraordinary efforts to please them or to acquiesce in all of their plans that she was able to have any friends at all, and certainly she had no close friends nor any of the confidantes that adolescent girls usually have as valuable media for the exchange of questions, the discussion of problems, and the programing of their social life. Hence she attempted to be a boy as long as possible; but the facts of biology and physiological development, plus the pressures by her own peer group, made the maintenance of a bisexual status impossible.

In the face of all these conflicts, Frances attempted three defenses against anxiety, none of which were too successful. Because of the fact that many girls faced with the same conflicts carry these selfsame defenses to such an extreme that they constitute, in and of themselves, behavioral disabilities, I shall comment upon each of them at some length.

1. Both as a defense against her oedipal impulses and as an expression of the unsolved aspects of the oedipal complex, Frances found herself falling in love with older men. Her one boy friend, Louis, was ten years older than she, and she also found herself strongly attracted to the married man who was her employer during her afternoon work hours. Interestingly enough, she gives two reasons for her preference for older men: first, that they seemed to remind her of her older brother; and secondly, that the boys of her own age group were fresh and attempted to make sexual advances to her. The deeper reasons for falling in love with older men (of which Frances is unaware) are probably related to her still-strong unconscious wish for her father's love and the need to seek substitutes for this wish in the form of men somewhat closer to him in age. There is here, too, evidence of Frances' fear of sex and her inner realization that she was totally unprepared to cope with sexual expressions, however innocuous their aim, by any boys of her own age. There is seen in this mode of expression—that is, in her selection of older men as love-objects, a defensive response that is sometimes seen as a transitory stage in adolescence—the supposition that these relationships afford a greater degree of protection from sexual expression on the adolescent's part than is possible in the presence of members of one's own peer group. Unfortunately, many adolescent boys and girls learn that such protection is not forthcoming, and they become victims of seduction by men and women in the twenties or thirties.

2. It is interesting to note that, at approximately fourteen and a half, Frances placed herself on a very severe diet and continued this dieting until she had lost approximately twenty pounds. Dieting among adolescent girls is not an unusual occurrence, but it usually takes on the aspect of a fad, with temporary adherence to admonitions that may be voiced by parents or by their associates. Seldom, however, does one see the pronounced dieting and extreme loss of weight, as evidenced by this patient whom we are considering, without the reasonable conjecture that this need for extreme loss of weight is the result of uncon-

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scious motivations relative to the necessity not to assume the physical habitus and bodily contours expected of adolescent girls who are in the process of growing up. In these cases it is reasonable to suppose that this is another attempt, futile though it may be, to deny their femininity, and as in the case of Frances, to retain a sylphlike or even boyish figure as an indicator that female sexual development has not taken place. It is to be remembered, too, that excessive eating and the attainment of marked obesity in adolescents of either sex (but particularly in girls) can be an indicator that they are attempting to make themselves as unattractive to the opposite sex as possible. Finally, it is not unusual to see children who are struggling with the unsolved problems of early sexual relationships who alternate severe dieting and extreme loss of weight with periods of marked overeating and obesity.

Although Frances ceased her dieting and seemed to have done herself no irreparable harm by this curtailment of food intake, it is well to keep in mind that very serious excesses in this type of response to conflicts can lead to serious emotional and behavioral disabilities in adolescence, and, in fact, in the unusual case they can even lead to death through the physiological imbalances that may be set up by rigid and prolonged refusal of food. I am referring here, of course, to the condition anorexia nervosa, which is seen from time to time at this age level, and which is principally a condition to which girl adolescents are subject. (From time to time, one encounters an adolescent boy who exhibits the same extremely disabling and life-threatening response.) All intensive psychotherapeutic and psychoanalytic work with such adolescents would seem to indicate that the central and most powerful motivating force resulting in dieting to the degree that extreme emaciation supervenes is the desire on the part of these adolescents to stalemate physiological growth in the sexual sphere, and thereby to continue a denial of their identification with the members of their own sex. Coupled with these attempts at maturation arrest and refusal to assume the sex role for which they were intended, there usually is uncovered material that indicates persisting infantile notions of the possibility of oral impregnation, together with strong oral sadistic infantile fantasies.

3. A third mechanism, or rather technique, set in motion by this adolescent girl in her attempt to ward off or deny the persistence of her oedipal impulses toward her father was a deliberate attempt to set up a certain "distance" between them. From fourteen years on, she began to give up her role as a companion and pal to her father. She did not attend sporting events with him, and she refused to be his helper in the chore activities in the household. Furthermore, she was no longer his confidante and understanding counselor. She did not attempt to calm him down in his moments of anger at the mother, nor did she try to bring him out of his intermittent states of uncommunicativeness and moodiness. The father of this adolescent also seemed to follow this pattern of establishment of both spatial and psychological distance between them. It was as if he (owing to his own unconscious positive feelings of which he was, of course, unaware) was aiding and abetting, in so far as he could, his daughter's attempts to cope with both the unsolved and the reactivated elements of a strong oedipal complex—a task in development that should have been solved when the child was four or five. We can see, of course, in the light of the psychosexual history of the child as outlined above, why this solution to a normal task in development could not be found at that earlier age level.

Two frequently observed types of responses on the part of both adolescent children and their parents of the opposite sex are to be generalized from the material presented in this single case. The first is that, without a single word being spoken openly, the unconscious of the adolescent child "speaks to the unconscious" of a parent of the opposite sex, and vice versa. The psychoanalysis of adolescent boys and girls highlights this phenomenon repeatedly. Secondly, the behavioral response engendered in both, in the face of such oedipal conflicts, is this gradual but none the less definite establishment of "distance" between the child and the parent. This type of response is not referable principally to the mechanism of

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"devaluation of the parent" that is so large a part of the striving of the adolescent for independence and autonomy, but rather it has a specific reference to attempts at the solution of persisting and operating remnants of previously strong and powerful oedipal impulses.

¶ The Problem of Overcoming Dependency Upon the Parent and the Striving for Relative Independence and Self-Direction

A problem of great concern during the adolescent years is that involved in, and motivated by, the drive for emancipation and independence on the part of the child.[4, 8] Obviously, this is a drive for *relative* independence, inasmuch as the child, for a number of years, has to maintain a certain dependency upon the parent for care, protection, and sustenance until he becomes self-sustaining. As suggested above, a successful solution of this problem is dependent upon, and in large part influenced by, the solutions that have been made in earlier life to the problems involving security or insecurity, the freedom for exploration of the environment, and the affording to the child of opportunities for self-direction and decision making, in gradually increasing amounts during the latency period. In other words, if the earlier adjustments in regard to these items in the child's life have been faulty or inadequate, the problem of increasing freedom from parental control, the overcoming of excessive dependence on the parent, and the gaining of a state of self-sufficiency will be much more difficult. However, the internal pressures of the child, plus the pressures from colleagues his own age, from his parents, and from society as a whole, insist that he find a solution for these problems involving the attainment of independence in adolescence.

Nevertheless, the drive for adult status in adolescence immediately sets up certain conflicts within the child. On the one hand, the adolescent feels driven to be independent of his parents, to make his own decisions regarding his comings and goings, and to have a right to choose his own friends and to determine his own educational and vocational future. Everything about him and everybody about him insists, or seems to insist, that he shall assume these responsibilities. On the other hand, there are always many fears that contemplated independence brings to the mind of the adolescent boy or girl. Together with his drive for independence, the adolescent has a parallel or concomitant fear of losing or giving up the parents and all the material and emotional gifts that they can give to him. He fears also the possibility of making the wrong decision, of choosing the wrong type of friends, of selecting the wrong course of study, or, perhaps, of selecting the wrong intended vocation for his life's work. Adolescent children do their very best to conceal carefully all these fears in order to convince their parents and others of their competence, their all-knowingness, and their bravery. However, the elements of this conflict manifest themselves in that typical state of adolescence characterized by continual indecision and change in respect to needs, desires, intentions, and programs.[1]

The various aspects of this initial drive for emancipation from mother and father are seen quite clearly in the foregoing material relating to sixteen-year-old Frances, whom we are using as a paradigm and model for outlining the major problems seen at the adolescent age level. It will be noted that she makes her own clinic appointment; she refuses to have her parents pay for her interviews; she is unconcerned whether or not they wish her to come to the clinic for help, or whether they wish to involve themselves in the help that may be extended to her or to them. She refuses to take their advice and counsel and seeks others' counsel and advice from what *other* source is available to her. On the other hand, she complains that the parents do not give her credit for the good features of the counsel and advice that she gives them on matters within the household, and feels that in the eyes of her parents, or at least in the eyes of her father, "I can never do anything right." Furthermore, she takes music lessons over their protests and pays for them herself. She chooses a boy friend with whom they do not wish her to associate. She wishes to go to one college; her parents

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protest and insist that she go to another. She alleges that her brother, not she, has always been the favorite of the parents; and finally, she prefers a religion other than that followed by her parents. Coupled with all these indications of strivings for independence and self-decision, she works afternoons and Saturdays in order that she may not be dependent on the parents in a monetary sense.

It should be noted, however, that the parents of this girl, as is true with the parents of all adolescents, seem to be caught in the selfsame conflict.[5] These parents wish for Frances' independence and self-sufficiency, but they also fear and dread the loss of her love and the removal of her dependency upon them. It is very difficult for parents to accept or even contemplate the fact that they are no longer so absolutely necessary in the lives of their children at fourteen, fifteen, and sixteen years of age, and thereafter, as they were when their children were infants or in the middle grades. The complexities and complications in responses for ill or for good in the face of these two selfsame conflicts in the adolescent child and in the adolescent's parents are sometimes extremely difficult to clarify in the minds of either the parents or the child, and many times they are even more difficult to treat effectively.

Although it does not appear as a prominent factor in the case of the adolescent girl under discussion, there is one mechanism sometimes involved in the drive for emancipation on the part of the adolescent child that occasionally can lead to very serious or even disastrous results as far as the child's present behavior or future life is concerned. I refer here to the mechanism of "devaluation" of parents that adolescents seemingly must first make in their advance and progress toward adulthood. This mechanism is used by all adolescents, and in more than 90 per cent of the cases it is safe to assume that it is not used to the degree that a behavioral disability results. The origin of the need for this extreme devaluation of the parents as a stage or step in growth seems to lie in the fact that this is the one best way in which the child can modify his infantile pictures and evaluations of his parents as being both omniscient and omnipotent. This internalized image of the parent as being omniscient and omnipotent must be modified, and modified drastically, if the child's self-identity is to be assured and if he is to progress successfully to adult status.

Although these devaluations of parents are innumerable, and broad in extent, they usually include the areas of action, the various ideas, and the ideals and ambitions with which the parents have been vitally concerned in their attempts to bring up their children in a mentally and socially healthy manner. There is, at least temporarily, a repudiation of all that the parents feel is worth while. Although this overthrow of authority usually may be confined to authority as exemplified by the parents, in some instances there is a temporary tendency to overthrow all authority and to devaluate all authority figures in society, a maneuver that may lead to definitely antisocial behavior. At any rate, even in the normal child who remains relatively well adjusted in adolescence, his devaluation of the rules of conduct and the moral, ethical, and political principles enunciated by the parents, in large measure leaves the child temporarily with no certain values and leads to the intermittent, sporadic, and sometimes chaotic assumptions of values inherent in almost numberless other individuals or groups of individuals. This rapid, changing assumption of varying and even conflicting values leads, in turn, to that picture and status of "role diffusion" that has been commented upon so many times in the literature as characteristic of boys and girls at this stage of development.

As an example of the inherent destructiveness possible in the use of this mechanism of devaluation, I should like to cite some brief excerpts from another case, that of a fifteen-year-old boy. The material from this case is also important, to my mind, because it emphasizes the persisting effect upon adolescent task solution of poorly solved tasks of development which were present in the child at earlier age levels, notably in respect to (1) rejection by the mother, (2) unsolved oedipal wishes, and (3) sibling rivalry. It is equally important in that it demonstrates quite clearly the effects of previously established neurotic conflicts upon

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the adolescent's choice of his educational future and his vocational choice. These will be commented upon below.

Allen, 15, was formerly an honor student but now refuses to do any work in school. In the past two years he has become increasingly antagonistic and sarcastic to both his parents. He seems to have developed almost a hatred of his father, and seizes every opportunity to belittle him—his work, his ideas, his interests, and his associates. Although at times Allen still evidences regard and affection for his mother, there are periods of a day or so when he shows open and marked hostility toward her.

Both parents have always worked hard and are very ambitious for the patient and his nine-year-old sister. They state that this is the second episode of such extremely belligerent behavior on Allen's part, the first having occurred over a period of months following the birth of the sister.

Allen was petted and fondled and given much attention by both parents—and in fact was "spoiled"—until his sister was born when he was six. Since that time, because of the demands of the new baby upon the parents, plus demands on their attention of activities beyond the home, Allen's needs and wishes have received much less consideration from them. He reacted violently to this rejection and began to show unabashed jealousy of his sister, did his best to come between her and the parents, and began to show open hostility and hatred toward both father and mother; and even though the parents were quite willing to grant him things about the house that he wanted, Allen began to steal food, candy, and money, preferring this method to actual gifts from them.

Allen's early development was normal. In fact, he was precocious in that he talked before he was a year old. He was breast-fed for five months; he reacted in a very antagonistic fashion when put on the bottle, which he hated. His mother forced him to drink from it, waiting until he was tired out and nearly asleep to accomplish this. In a six-month period, when he was 4½ years old, he went through the whole gamut of childhood illnesses.

Allen is of average height and weight, fair nutrition, with soft small muscles. He tells of occasional dizziness and car sickness. His vision is very defective, and he has worn glasses since he was eight.

Allen is in the eleventh grade, and for the first time is not even passing in some of his subjects. At present he shows a particular interest in the German language, Hitler, and other things German. The mother and father are particularly distressed that Allen is failing in school and that he shows little or no interest in going to college or in becoming a professional man—ambitions which they have had for both of their children.

On psychological tests Allen was found to have superior mental ability, with an I.Q. of 123.

Now what are this boy's scholastic and vocational ambitions? Our interviews with him are startlingly illuminating in the light that they throw on the subtleties involved in a child's determination of his career, and on how cautious we must be in evaluating our children's ambitions for school and for the years thereafter. Through a consideration of these, we can see to what degree and to what serious ends the mechanism of devaluation of the parents can be directed in adolescence.

In interviews with us, Allen tells us that he wants to become a professional fencer. He is not interested in ever going to college or entering any profession. Now in case you may feel that this ambition of Allen's (to become a professional fencer) is akin to the passing fancy of a very young child, it is to be noted that Allen is dead serious about this ambition, and in addition our patient is 15 years old and has long since passed the "fireman, cowboy, and Indian" stage of the 8- or 9-year-old. Furthermore, although this boy has refused to pay any attention at all to his school studies as his parents fervently wish he would, he has read everything he can find on all aspects of fencing and about swords and armor from ancient times to the present, and his knowledge of these subjects is astounding. To this he has recently added an interest in archaeology and geology and old Roman coins.

He tells us, "My friends call me a Germanophile because I like the Germans and the way they do things." He is interested in Germans and Germany because of their arms and the armor they wore (another interest), and the fencing that the Germans do, and he is interested in their guns and daggers. Germans and Germany go with

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arms and armor because they are great fighters—that is, the Prussians are. He is interested in the militaristic Prussians, who, he says, are the best militarists in the world. At the time of his first interviews, he was voluntarily taking German studies with his Latin teacher, though he would not do his Latin lessons.

Another interest is riding. Riding goes with fencing, and they go together because you can use a long saber when you ride, and you can control the prancing horse with one hand, and cut heads off of people with the saber with the other. This led to his discussing his desire for a pair of riding boots. He would like a pair that come up to his knees because they look so well and sound so well as you tramp on the pavement with hard leather heels. If you are on horseback with a long saber and with the boots, you are practically invincible.

He has an enormous amount of information about pistols and states that the best gun today is a German gun, although he also likes some specific kind of ancient gun, a type unknown to the doctor. He needs to get more money in order to get more swords and more armor and more guns. He sees no end to his desire for more swords. "I'd like all the swords and all the armor in the world if I could have them." I said that that wish to have all the armor in the world must stand for something else, and he said, "Yes, for something all right, such as nicking somebody I don't like and defending myself. I should have been born six hundred years ago, Doctor, because if I had, and there were people I didn't like, I could kill them all outright, and it would be fair because they would have the same chance to kill me with their swords."

He thinks he may go to Heidelberg rather than Harvard, but then he doesn't know because if his saber breaks in a fight at Heidelberg, he might be killed.

In the next interview Allen has a new interest. He is learning the alphabets of various languages, and writes out the Russian alphabet for me and his name and mine in Russian. The Russians are proving to be more warlike than the Germans, and hence he is beginning to admire them more than he does the Germans.

In later interviews he discussed his newest interest, going hunting with his father. This is soon noted by the doctor to be a serious and precarious area of activity on this adolescent boy's part. Hunting with his father is by no means taken up by Allen on a pal-to-pal basis. He does it in order to demonstrate his superiority over his father in the use of firearms and in killing. He ridicules his father for his mistakes. He takes delight in telling me that father is stupid in his lack of knowledge about guns. He tells me father is going to get killed in the woods some time if he is not careful. "Somebody is going to get killed out there hunting." Again, long riding boots come up as an issue.

A week later he took up again the discussion about another proposed hunting trip with his father. "If that fool aims that gun at me again I'm going to shoot him." He told about father's buying a red and black checkered shirt to wear in the woods. "At twenty feet you can't see the red at all! *Somebody* will surely shoot him!" (Father is very careless when hunting, and according to Allen doesn't know how to handle guns.) There follows a dissertation about the gauges and calibers of guns, and about rules and regulations of hunting in Massachusetts. (We were somewhat concerned about this material in relation to hunting and suggested to the parents that perhaps the father and son should not hunt together for a while.)

Allen tells us later that he wants to take saber lessons because it is more dangerous, and he is eager to buy German sabers at $23 per pair and riding boots at $14 per pair. "You can get your head cut off, but of course you can cut off the other fellow's head, too, if you're fast enough."

I need not emphasize what this boy is trying to do through—and to express through—his educational, recreational, and even his vocational interests and intentions. I would emphasize, however, how seemingly unaware both the boy and the parents are of those drives and needs and of the repetitive, continual demands that are present to satisfy his extreme aggressive and devaluative impulses toward them. I think you can see, too, how terribly close to expression with dire results these devaluative drives seem to be. I shall not go into the intricacies of the treatment of this adolescent boy, except to state that the aims of treatment were to ensure that he gradually came to realize the meaning of this behavior; that is, that his life

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as an adolescent was dedicated literally to fighting a sham death battle against his parents, particularly against his father.

It is to be noted also that, in contrast to our patient Frances cited above, the mechanism of devaluation of the parents in Allen has seriously involved the "work area" of the child, that is, the area of education. Every attempt possible is made by Allen to eradicate within himself the assumption of his parents' educational ambitions and hopes for him that he did assume in his earlier school years.

And finally, it is quite apparent that Allen's attempts to solve the problem of the necessary and expected independence demanded of adolescents have reactivated in full force the faults in the solution of earlier tasks in development which were presented to him in the oedipal period and at the time of the birth of his sister when he was six.

It is to be noted, too, that there was a definite "spread" of the personality developmental fault in the latency period to the extent that there was a faulty solution of practically all of the tasks of this period that relate to the control and sublimation of the aggressive drives.

¶ Tasks in Adolescence Relating to Educational Achievement and Vocational Choices

As can be seen in the clinical cases briefly outlined above, two of the major tasks of the adolescent involve the making of decisions (in many instances lasting and irrevocable decisions) relative to (1) present and future educational programs and (2) the choice of a lifework to be followed as an adult.

In both of these cases, the attempts at a solution of these tasks were influenced and altered appreciably by the neurotic problems and defenses not directly concerned with either education or vocation. For example, in the case of Frances, her attempts to continue in the "pseudo boy" role prompted her to hope to become a physical-education instructor, though she gradually but definitely modified these ambitions toward femininity, first by her hopes to become a physician (an essentially male profession), and later by her desire to become a nurse or social worker. But it is to be noted that her endeavors to devaluate the parents and their ideals did not lead to an abandonment of educational aims and aspirations, nor did they lead to a status of underachievement.

In the case of Allen, however, we see the disastrous effects of long-continued neurotic expressions both upon the work output in school and in his abandonment of all vocational aims consistent with his intellectual ability. His desire for revenge upon (even destruction of) his parents resulted in the choice for an ultimate vocation of a type of "work" (fencing) that should have become—and remained—the subsidiary expression of a hobby or avocation. He became, in essence, one of the very best examples of both the "underachiever" and the "deviate overachiever" that are seen frequently as single-behavioral disabilities in the adolescent-clinic population of any child-psychiatry unit.

These aspects of adolescent cases are valuable for us to consider because they do highlight the feelings and urges, and the fantasies based on these feelings and urges, that are present in many adolescents and, in turn, are directing their interests or lack of interest in their studies. I think you can see, too, how difficult it can be for the parent in his or her attempt to change such attitudes. It is difficult, in the first place, because the nuances of feeling are so subtle in their expression, and in the second place because the parent is usually involved, in some way or other, in the very problem he is trying to aid the child to solve.[2]

Up to this point I have emphasized those attitudes toward studies and jobs that are fixed by the earliest emotional responses of the child to frustration, insecurity, loss of love, and deprivations—all of which may be difficult to detect and even more difficult to alter to any degree. There are other things, however, which can occur in these interpersonal relationships of the child and parent which usually become formalized *later*, and about which we can do even more to eliminate or—much better—if forewarned, to *prevent* their becoming a harmful force in the child's life at all.

What parents need to do, of course, in respect to their adolescents' ambitions, is to see to it that their appraisal of their children is as

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realistic as they can make it—realistic as to the child's innate abilities along intellectual, social, athletic, and even vocational lines. It is difficult for parents to entertain these realistic appraisals of their children and their desired expressions, likes, and dislikes. But there are certain difficulties which can get in their way about which I should like to comment:

1. In the first place, I shall comment upon a cultural phenomenon in our American life that seemingly has always bedeviled American parents and, even more, their adolescent children. This cultural notion is the desire (in fact, the feeling of necessity) on the part of American parents that their children should jump from the economic class in which the parents find themselves to the next higher economic class, if they are to consider themselves at all successful. Most parents feel this to be a necessity, and their need is transmitted to the children directly and indirectly in hundreds of ways. The laborer feels that his child should be trained for the white-collar class; the clerk's son, for business; the businessman's son for one of the professions. It is a subtle though powerful force in our culture. Many times this is harmful in that it keeps both the parents and their children from making the realistic evaluation of abilities and goals that is so necessary if either parent or child is to have any peace of mind. All children cannot be greater successes than their fathers or mothers, and some children (being much more realistic in the matter than their parents) recognize this as a fact and would be willing to accept it. But unfortunately many parents will not let them—such is the pressure of this centuries-old drive in our American society.

2. A second source of occasional parental lack of realism concerning their child's educational and vocational future is their tendency to identify their child inextricably with some other person, and act toward the child—and expect the child to act toward them in regard to his studies and his future—as if the identification really were true.

a) First and foremost is the parents' identification of the child with themselves. There are many unconscious motivations behind this sort of behavior on the part of the parents, and all of them must fight it. They must fight it because, by such identification, they try to thrust upon the child the ambitions and hopes that they had—or still have—for themselves, and they are as impatient with the child because he does not embrace them as they were with themselves because they did not fulfill the selfsame hopes and ambitions. The child may or may not wish to be what the parents (one or both) dearly wished to be, but, in the interests of his mental health, it is best for the adolescent to decide this point.

b) Another basis for unrealistic parental attitudes sometimes arises from their identification of their children, not with themselves but with someone—usually a family member—whom, for some reason, the parent or parents deem more worthy than themselves. Thus the boy soon learns from his parents that they consider that he is just like Uncle Joe and hence will, of course, be a lawyer—a very successful lawyer—like Uncle Joe. Or the daughter Elizabeth is exactly like—in speaking and in mannerisms—second cousin Alice, who is such a hit on the New York stage; or she is as intellectual as Aunt Nellie, who was a professor of philology at Vassar. The intricate and extensive struggles that adolescent children go through to live up to—or once and for all violently to deny—such identifications are frequently seen.

c) In the third place, there is the identification of the child with a class monopoly on one particular college, or one particular graduate school, or one particular profession, that makes realistic evaluations and choices on the part of both parents and children very difficult. For example, for generations no Snodgrass has ever gone to any college save Yale, so little Elmer shall go to Yale. Or for generations there has always been a representative of this particular branch of the Smythe family on the faculty of the Harvard Medical School and the staff of the Massachusetts General. So Jimmy Smythe soon—very soon—learns of his preordained identification. Again, such identifications make realistic choices for Elmer and Jimmy and their parents unnecessarily difficult.

3. There is sometimes, too, the parents' compelling need to have their child stand out as a unique individual—that he shall not be the *usual* youngster, but that he shall be *unusual* in his intellectual, vocational, and avocational

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accomplishments. (Many times, the child's actual endowments prevent this.) The average child, even though he is happy and well adjusted, is sometimes not a source of contentment to the parent.

4. An associated phase of development of quite a different sort, but equally as troublesome to parents of adolescent boys and girls, is an assumed hyperintellectualization on the part of the child. By this I mean that the child may demonstrate an absorbed interest in theoretical abstractions and in intricate economic and social problems that either alarms the parents concerning the child's stability or leads them to assume that this proves the child is fitted for some highly intellectual vocation. It usually portends neither but, rather, indicates some attempt at solutions to problems regarding sex and morality by removing them from *that* realm and talking about them endlessly in the safer area of the abstract. Educational plans fixed with the child on the basis of such temporary developmental phases, too, can be unfortunate.

I have pointed out some of the barriers to parents of adolescents assuming such attitudes, in order that the parents can be helped to avoid them. But there are, in addition, other things which both the parents and the school can do to aid the adolescent child himself in getting realistic appraisals of himself and of his future. Both can be tolerant and can encourage in our adolescents a sensible estimate of themselves in physical and mental attributes, as they compare themselves to their associates of the same age group. They can urge them to be justly though quietly proud of their assets, and forestall, modify, and eliminate feelings of inadequacy that may temporarily arise because of unmodifiable liabilities or lacks. It is obvious that the schools can and should do more of a specific nature in this area than is now done. Definite attempts should be made in all schools, through courses in educational and vocational guidance, to acquaint adolescent children with the widest possible knowledge of the greatest number of study and job choices. Even though the adolescent may carry out his earlier life's wishes and fantasies in adult life, still society offers him—if he can but get a survey of them—hundreds of worth-while and satisfying ways of doing so. This material should be supplied him. This, in turn, is "realistic" in regard to needed information—needed by all adolescents.

¶ The Control of Heterosexual Impulses and the Establishment of an Acceptable Moral Code in Adolescence

The adolescent, in his attempt to establish and maintain a socially acceptable and emotionally satisfying code of behavior and attitude in relation to the expression of the sex instinct, finds himself confronted with a twofold problem, the varying aspects of which constitute the nuclear conflict in the throes of which adolescents usually find themselves at some time in the turbulent years of maturescence.

1. One aspect of this problem is the absolute necessity that the adolescent make an "identification" with the members of his own sex. This identification must be established in such a manner and with such rigidity that he overcomes, in so far as is possible, the inherent bisexuality with which all of us are endowed. Perhaps the subtlety of this identification makes it almost nonapparent, but it is a process and drive that best explains large segments of the adolescent's behavior. Particularly is this process involved in that behavior of the adolescent that seems to us bizarre and chaotic. However, in normal times and under normal social conditions, this establishment, through identification, of the orientation necessary for fulfilling the future biological role of the individual is accomplished without incident by the incorporation of the ideas, attitudes, and social and moral outlook of the parent or of parent substitutes, such as the teacher, the club leader, the family clergyman, or the physician.

This process is a gradual process of maturity, subject to acceleration, retardation, or even regression, and, as a matter of fact, the maturity or immaturity of the individual adolescent can in large part be judged by the degree to which this particular process has advanced. On the other hand, the failure of the child to "grow up," "become a man," "mature," in the

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sociopsychological sense, will, in turn, lead us to an investigation of the kind and number of "identification objects" that the child has had in his immediate environment—father, older brothers, neighborhood leader, and others. The adequacy of these objects and their relationship with the child have to be considered.

The point of importance for us, however, in our consideration of the sex behavior of the adolescent, is that the adolescent not only must make this identification with his own sex but also must demonstrate to elders and colleagues, by his actions, that he is no longer the shy, diffident, bashful schoolboy that he once was. The directness or indirectness of this expression of the instinct, or to what extent or limits the adolescent goes in this all-important "proof," or in what way he accomplishes it to his own and his comrades' satisfaction will depend on many factors, but the expression will inevitably take place. It might be well to note here, in the interest of tolerance of the adolescent, that as far as the expression of maturity goes, he is "condemned if he does and condemned if he doesn't" show evidence of maturity of sexual interest and outlook, and this even by his own parents. As stated above, the fact that parents wish their adolescents to grow up and be independent, and that at the same time they wish them to continue to be children and dependent upon them, has never made the task of the adolescent an easy one.

2. This, in turn, leads us to the second aspect of the twofold problem confronting the adolescent in his attempt to find an adequate and acceptable code of sex behavior. Concomitant with the cultural demands that adolescents become identified with members of the proper sex, and that they give evidence of readiness to assume the role of father or mother later in life, is the ever-present demand that the adolescent forego the expression of the sex instinct. That repression and control are necessary if the best interests of the child and the community are to be served is, of course, beyond argument. What interests us here is the manner in which this control of instinctual urges must be carried out, and the direction or source from which the control comes.

The hoped-for mechanism of control is, of course, an *inner* control—that the adolescent himself, by the time he reaches maturity, will have incorporated standards, repression mechanisms, or inhibitions of such kind and nature that, no matter what external changes take place, he will be able to hold in check his instinctual drives. The presence of this inner control, this ability to forego the pleasure of the moment for a later socially acceptable type of expression, in short, the strength of the ego of the individual, is, like our previous criteria of identification, also an indicator of maturity.

Needless to say, the ego strength of the adolescent is periodically weak, and the child gives evidence of his endeavor to strengthen these inner controls through external controls or external "consciences"—through his religious interests, club interests, and self-imposed codes and rites. Of equal importance is the fact that external factors can accelerate or retard this maturity. In the main, however, the most powerful controls that make it necessary for the adolescent to forego expression of the sex instinct are external ones—the supervision and prohibitions of parents and law-enforcement agencies, and the scorn and condemnation that such expression would evoke from families, neighbors, and colleagues. These forces, when present, properly insist on a mature attitude and a mature respect for convention, and they aid and strengthen, in turn, the inner mechanism of control that the child has already partially established.

Both aspects of this twofold problem of maturity can be accelerated or retarded by external factors, and it is my feeling that either a spurious retardation or a pseudo acceleration of development is apparent in all atypical, antisocial, or even pathological behavior in adolescents.

A further factor of influence in respect to the adolescent's identification needs to be mentioned. It is usually assumed that children identify themselves with the parent of the same sex, and that thereby, under favorable conditions, worth-while standards of behavior are inculcated. In regard to the deeper and perhaps more fundamental aspects of personality development, this is undoubtedly the case,

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but the more immediate objects of identification and patterns of behavior that the adolescent chooses are the members of the age group just senior to him, and he strives to participate in the activities and interests which they exhibit. Hence, if you would understand the atypical, asocial, or even antisocial behavior of *early* adolescents at any particular period or under any defined set of external conditions, it is well to study the behavior of the *late* adolescent group, for early adolescent behavior will always be an approximation of it.

I should like to present, at this point, some clinical material in order to illustrate the various struggles that the adolescent may have in respect to the control of sexual drives and to highlight the defenses employed to establish and maintain these controls—defenses that vary in nature and in intensity.

I have chosen for consideration an adolescent who has been subjected to both an overrigid ("overgood" if you wish) environment and a particularly loathsome environment, and hence the material will illustrate (in the extreme, of course) many of the problems, at least the sexual problems, that are seen in all adolescents in both types of environments.

Arthur, 16, is an only child who is living in a slum area in Boston with his mother, Mrs. W. The father and mother were divorced when Arthur was 3, and he went to live with his maternal aunt, a schoolteacher. Arthur lived with this aunt until he was 14 years old, when the aunt died, leaving her estate to Arthur. This is dispensed through her attorney. After her death, Arthur returned to live with his mother, who married for the second time six months later. Stepfather had had two admissions to a state hospital, and was recommitted there a few weeks ago. Arthur followed his aunt's religion, but since her death has gradually grown away from the church. Arthur and his mother live on the $15 a week dispensed by the attorney, plus the $3 a week contributed regularly by the boy's own father.

A family agency had known this family eighteen years before, and on referral a few years later. Home conditions recently were found to be utterly deplorable. Mother is epileptic and has deteriorated. Stepfather was at that time home from the state hospital but was unable to work. Arthur showed many alarming symptoms. He feared that he was going crazy, considering himself weak, puny, and run down, and for this reason was taking a muscle-building course. He often felt that he was being laughed at and talked about by all the people in his neighborhood. He was quite bitter about stepfather and resented his being paroled from the hospital to the home.

Practically nothing is known about the father except that he is supposedly of good family. Mother is the younger of two children. She is still having frequent petit mal and grand mal seizures, spends a great deal of time out in the neighborhood, is behind in her bills, and is a very poor housekeeper. She seems convinced that some of the men in the neighborhood have designs on her. Arthur's life from the age of 3 until he was 14, when he returned to live with his mother, was in great contrast to the present. The maternal aunt was an art teacher, a rigid person of high ideals. She owned her own home, gave the boy excellent physical care, was very religious and reared him in her faith, and imbued him with ideals for a college education and with an appreciation of good books and music.

Very little is known about his early development and childhood personality. He was a close companion of his aunt while she lived, and probably had no friends during that period. Since returning to live with his mother, he has not only been friendless but has often felt that other children in the neighborhood hate him and ridicule him behind his back. He is nervous, tense, lonesome, sensitive, and unhappy; spends a good deal of his money buying secondhand books on electricity; and paid quite a little for the correspondence course on muscle building. He attended camp this summer, and while his adjustment there was not too bad, he was unhappy, did not wish to remain, and came home after a few weeks. He says that he wants to attend a university and take up electrical engineering.

On physical examination Arthur was found to be slightly short for his age and ten pounds underweight. He has marked facial acne. Throughout the examination he showed marked concern about his physical condition and asked numerous questions about the various body systems examined.

On the psychological examinations Arthur was found to have an I.Q. of 111, with a Performance

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I.Q. of 116 and a Verbal I.Q. of 102. He evidences no special disabilities.

I should like to summarize in some detail the material covered by this adolescent in his first eight interviews at the clinic. These can be divided into two parts, according to the material presented. The first, which includes four appointments, had to do with the following topics:

1. There was an almost continual condemnation, on Arthur's part, of Mr. W, the stepfather, still ill with an agitated depression. The boy was particularly distressed by Mr. W's going out on the street where everybody could see him, thereby bringing disgrace upon Arthur and his mother. Arthur openly wished for the man's death or wished that he would be taken back to the mental hospital, because of the effect that he was having on Arthur's mother. When Arthur was questioned about this, there did not appear to be any cruelty. On the other hand, there seemed to be a rather warm relationship between Mr. and Mrs. W. But the boy was particularly concerned with the effect on the mother through the alienating of her friends. In other words, the stepfather's "craziness" was going to be interpreted by the neighbors as craziness on the part of all three in the household.

Arthur was particularly angry because the money which came to him from his aunt's estate was being used to support Mr. W, and there is no question in the examiner's mind that Arthur would have carried this hatred and antagonism to the point of starving Mr. W if he quite dared to do it. As stated above, much of the hour at each appointment was taken up with this boy's open hatred of Mr. W. No amount of explanation on the examiner's part that the man was ill and needed attention and help, and that we would do our best to see that he got it, modified any of Arthur's feelings. The boy, himself, did not disguise at all that he was extremely jealous of Mr. W and wanted his mother all to himself. He covers these underlying feelings by a pretense of overt hatred of the mother.

2. The second important feature of his discussion with the doctor had to do with Arthur's physical condition. The boy complained bitterly of his lack of strength, of the fact that he was inferior physically owing to lack of proper food because his mother wouldn't feed him or because he had to go out to eat in restaurants. Arthur has had a persistent acne of the face and attributes this to his mother's neglect, her not giving him the proper food. At this stage of our discussions, he told us about the course that he was taking with Mr. Atlas to improve his physical condition, and was very much worried about his ability to carry out the provisions of this correspondence course in physical exercise. He did not wish to go to the YMCA or to any other group placement, not because he was not interested in such programs, but because they would take time from his own correspondence course in physical betterment. He asks many questions regarding his physical condition, carefully skirting the area of sex, but reaching out for some help in relation to fatigue, lack of concentration, and other well-known adolescent worries. No attempt was made at this time to interpret these meanings to him.

3. As stated above, much of Arthur's concern had to do with money matters. The boy is determined to control his money, to give none of it to Mr. W, and to give to his mother only such amounts as he himself deems necessary at the moment. This control of money matters extends to the paying of rent or the buying of some particular type of food at a particular time; and Arthur attempts to dole out the money piecemeal, always complaining that Mr. W eats too much. His attitude in this regard can be summed up by the statement, "Why is he allowed to eat when he doesn't work?"

4. Little is said by Arthur regarding his early life except that he veers from painting it in rosy colors, as a time when he had all the food and clothes he needed, and the house where he stayed was warm and there were no rats or cockroaches, to a condemnation of the aunt (who was a schoolteacher) as a very restrictive guardian who never allowed him to play with the boys in the neighborhood, though she might allow him to bring certain ones into the house, and who gave him many long talks about the evils of sex and of association with bad girls. However, Arthur states that at that time he was happy. He attended church with his aunt, went to Sunday School, and, even with the restrictions which she imposed, her death was a terrible blow to Arthur. He never speaks of his aunt without crying, and goes over and over the circumstances of her sudden death on the beach when they were spending Sunday

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there. There follows always in his productions a contrast between that life and his poverty, destitution, and lack of love in his present home.

5. Arthur does not go out socially. In this early period of his talks with us, he emphasized the horrible conditions of the neighborhood in which he lived, the bad people who lived there, the fact that he didn't trust any boys or girls for fear of what they might do to him. He would have nothing to do with any suggestions that might be made as to his association with the Neighborhood Settlement, the YMCA, or his returning to his church in order to get allied with young people. He never ventured out of his house after school; and it should be added here that Arthur is determined that he will get a high-school diploma, and spends all his afternoons and evenings studying. His marks last year were average or a little lower than average, but he did manage to get promoted and is a junior in a technical high school at the present time. His ambition is to work in some field of radio.

During this first month of Arthur's coming to the clinic, our attention was directed to two things: (1) the necessity of hospitalization for Mr. W and physical care of the mother, and (2) possible camp placement for Arthur. Arthur accepted a placement in a caddy camp only after considerable worry and talk, and arguments with himself and with the examiner. It was very obvious that this boy did not wish to leave his mother and then take chances with associations with boys his age in camp, but he always replaced these possible positive feelings by stating that he was not going to leave Mr. W and his mother there to "eat up my money." However, he did go to camp, though he remained there only two weeks, and upon resumption of treatment this fall, which brings us to the second half of Arthur's discussions, he stated that he "could not stand the loneliness" at camp. He missed his mother and wanted to get back to her. He summed up by stating, "I would go for a walk in the evening, and I would take a long look at that empty lake near the camp, and I became so lonesome that I just had to go home."

In the second series of four interviews, Arthur's productions changed somewhat, and he gradually turned away from the external problems to problems and conflicts of his inner self. For example, he told that at 12 years of age, he first learned about sexual intercourse together with the evils of masturbation. He still was not sure that he knew about procreation and wanted us to help him with information. He was given a book to read, and upon completing it stated that it wasn't very satisfactory because it didn't answer his questions. The examiner told him that we had planned to have a follow-up session in these matters, and asked him what his problems were. He was unable to tell us for some time. However, he returned to it later in relation to his physical condition when he was complaining about his inability to gain weight, and the fact that he felt he was going to die. When asked what his fears were about dying, he said, "I didn't know that I was being poisoned mentally." On further questioning, which was done with great difficulty because of the boy's reticence, it was found that he had equated masturbation and gonorrhea, and he was desperate for a cure in order that he might not go insane. He had seen the word gonorrhea in an advertisement, looked it up in the dictionary, and found that it was characterized by (and these are Arthur's own words) "a mucopurulent discharge." He tried to find out what a mucopurulent discharge was, and the nearest he could find to it was a description of semen; and hence he drew the conclusion that masturbation and gonorrhea were the same. Arthur made a further erroneous elaboration that untreated gonorrhea became syphilis, and that he was going to die in an insane asylum because his brains were rotting. He said, "What can I do, Doctor, to get over this disease, this terrible disease? You are a psychiatrist. Tell me what I can do so that I can once more get control of my mind." The patient shouted this request in a panicklike manner, and it was some time before we could reassure him. He kept repeating that he did not want to go insane, that he didn't want to end up in an insane asylum like Mr. W. He wondered whether Mr. W had syphilis. He wondered if his mother's spells were caused by syphilis, because they were epilepsy, and she had been in a "mental hospital" for them.

(We then started a long and detailed re-education of Arthur regarding sexual matters and venereal disease, and in the course of these discussions many of Arthur's attitudes as to association with boys and girls became clear.) It was

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soon apparent that he did not fear his neighbors because they thought Mr. W was insane, but because he was afraid they would begin to think *he* was insane because of his own "disease," and hence all of them would know that he and his mother and Mr. W probably had syphilis. He did not wish to associate with other children because of his fear of contaminating them, because he did not wish them to know he was diseased. (These thoughts he had had since the age of 12, and he very definitely dated it to his reading the dictionary at that time.)

Since this period of re-education, Arthur has been more and more concerned with trying to make contact with some boys and girls his own age in some groups in the neighborhood. His attempts, however, have been merely intellectualistic in that he continually goes over and over the ground with me as to why it is impossible for him to join the local church activities or to go back to his own church. He continually refers to the technical difficulties, his lack of sociability, his not knowing what to say; and he asks just what formula can be used when he goes to the minister or to the boys' club.

In the eighth appointment he came late for the first time. (He was usually ahead of time.) He immediately apologized because he hadn't gone to any group activities or to the church, and we told him that we expected him to get up his courage rather slowly, and that didn't mean that he had to feel that he had done wrong in our sight. Arthur felt greatly relieved at our not scolding him and then stated that Mr. W had finally been taken back to the hospital. We suggested that it must be nice to be with mother alone again, and he immediately entered into a long tirade against Mr. W, and the latter's effect on his own reputation in the neighborhood. We pointed out again that Arthur was really not so much concerned about the neighbors' finding out about Mr. W as about their finding out about Arthur, although what he was worried about didn't exist in him, that is, gonorrhea and insanity. Following this we told him that we thought it was only natural that Arthur should be a little jealous of Mr. W. We supposed that Mr. W did give companionship and sociability to mother during the years when Arthur wasn't with her and she was alone, that is, before she married Mr. W, and the boy readily admitted this was so and stated, "Well, Mr. W isn't so bad. That is, he isn't too bad when he's well, but you know he *should* work and support himself and my mother, and not leave it all to me."

He then spent the rest of this hour thanking me for helping him about sex information and about his fears of gonorrhea. He states that he still wonders if what I'm telling him is the truth, though he says, "I have no fear about your kidding me." We reassure him again that what we have told him is the truth, and tell him that we expect that from time to time his original fears will return; that when they do, we will talk them over again. He ends the hour again by telling us how difficult it is to be sociable, particularly with girls. He states, "My aunt used to tell me that all girls are bad, and it is hard for me to believe you."

It is possible, then, through a discussion of this material, to catch a glimpse of some of the most serious problems that many adolescents must solve—either alone or through help extended to them by parents, associates, or physicians. Paramount in importance in this boy's case, of course, are the problems relating to sexual expression and attempts to identify himself strongly with members of his own sex, with a view to assuming the role to be required of him at a later date.

In addition to the detailed problems of sex adjustment seen in an intensive study of this boy, I think the case is particularly pertinent in that it shows the evidence of, and the problems attendant upon, the retardation in maturity that was a result of his earlier markedly sheltered life in the home of his aunt. It is as if his environment had succeeded too well; even had his aunt lived and had he stayed with her, he still would have had a difficult time in adolescence.

But note also that side by side with these problems resulting from retardation and overprotection, we have in the very same case the demands for an accelerated maturity—the insistence by the disastrous breakdown of his "home" when he was fourteen that he assume an adult role and take care of himself, make his own decisions, outline his own future—his educational and his vocational plans. Even the problems of buying his own food and provid-

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ing for the heating of his room were his to solve, and all this in a community setting that can be described at least as harsh if not actually vicious.

There are numerous points of interest in this boy's responses, a few of which I shall discuss.

This boy's information regarding sexual matters was woefully inadequate as he approached puberty; but more important, his first information (largely self-acquired), in addition to being erroneous and productive of many severe conflicts in itself, was acquired in a setting already destined to cause many serious mental conflicts. He desperately needed corrective medical information.

His aunt, who had protected him—rigorously and rigidly protected and supervised him in all normal boyhood contacts—died at the time that he entered puberty. His period of mourning and his return to his own mother (with the adjustments needed in regard to both) coincided, and both occurred simultaneously with his awakening interest in sex. From the information gained from him we can be sure that, like many adolescents, he never had a chance to learn even the rudimentary knowledge acquired by children brought up in more "normal" childhood settings; nor did he have a chance to have the customary and usual misinformation modified in the street-corner and curbstone consultations of which most boys avail themselves. Paramount in importance among the fears of adolescents regarding sexual expression are those that involve a fear of insanity, a fear of physical illness, skin diseases, loss of strength, and loss of the ability to concentrate. Our patient had all of these fears. In addition, he had a common bit of misinformation that chronic gonorrhea becomes syphilis, and the unfortunately truthful information that untreated syphilis may make for insanity. Hence, by association of masturbation with gonorrhea and both with syphilis, we have the ultimate in the adolescent fears of the consequences of masturbation.

What then are some of the defenses that this boy used that are commonly seen in adolescents whose problems (though they may be of less intensity) are patterned after those of our patient?[3]

1. Of extreme importance was his isolating himself as a retreat from any and all situations that might stimulate him sexually. What were some of the specific responses used to isolate himself from stimuli that created tension?

a) He went directly home from school without talking to *either* boys *or* girls, and, save for the necessity of going to the corner to buy his supper, he never left his room until he reported for school the next morning. In this way he was not forced to talk with any boys who might bring up the matter of sex, and he was not subjecting himself to temptation with girls. He attended a high school that has only boys as pupils and men for teachers, and though this set of circumstances may seem to have been mere coincidence and not at all the result of his choice, it is interesting that his first question, at the examiner's suggestion that possibly a preparatory school away from home might help, was (both fearfully and hopefully expressed) as to whether or not any girls went to such a school. He admits, of course, his strong interest in girls, but is afraid to trust himself; it was he himself who interpreted his isolation most correctly when he said, "I protect myself from them [girls], but I don't want to."

b) Within the home also, he protected himself from hearing or seeing the sexual activities that he imagined went on between his mother and stepfather by locking himself in his room away from them.

c) He always entered the house before dark, as he feared that he "may be attacked by the bad girls in my neighborhood," or that "if I am seen out at night, I may get blamed for all those things that go on in my neighborhood"; and he then added significantly, "I bet you think I'm a sex fiend because I worry so much and think so much about sex."

d) Even when he was alone in his room, this isolation was carried out further in that he refused to listen to comedy programs on the radio or any programs that had women members in the cast. He would not listen to mysteries or programs of crime. He listened only to the "Symphonic Hour" and the "Classical Album," and never to dance music or love songs.

Thus this adolescent, by the above four devices, kept sexual stimulation at a minimum in so far as his external world was concerned.

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2. Another defense complemented that of restriction, because it enabled this adolescent better to handle his strong sexual strivings. I refer to the mechanism of reaction-formation. He continually repeated, "*All* girls are bad" or, when most angry, "*All* girls are bags." He added to this, "All sex is disease. All sex is weakness."

It is not difficult to suspect that an additional defense of adolescents was here in the process of formation. I refer to the defense through asceticism, which has been commented upon extensively in the literature. If such is the case, we would soon have had a more or less complete repudiation of instincts by this boy, and it seems to me that he was definitely on the road to such a protected and protective position in his attempts to handle his conflicts.

Finally, as far as this individual case is concerned, what this boy did *not* do should be emphasized—what reactions he did not have that are used frequently by adolescents in conflict, what defenses he did not employ. Why he did not do so, we cannot explain—any more than we can predict (or explain) the choice of a neurosis.

1. In the first place, he did not run away. Many adolescent boys, faced with conflicts involving the rivalry and jealousy of a stepfather acquired in or near puberty, will become chronic runaways. It should be noted that this may happen when the external situation (economic and social) is entirely adequate. It is a neurotically determined act, and one extremely difficult of solution. In adolescence such runaways usually entertain the fantasy of a later return to the home and mother—a return in triumph to rescue the mother or to care for her in splendor and luxury.

2. Our patient was not a truant. In fact, he has studied diligently and was ambitious for a college education. It is interesting, however, in the light of his educational interests, that he has never resorted to another favorite adolescent defensive device in that he has not used intellectualization as a solution and has not thereby evolved, as we might expect, some intricate and involved theoretical system of morality or of the social order as a mask and defense.

3. Finally (and this is perhaps quite beside the point in that it usually has no demonstrated direct reference to the sexual instinct but does have a bearing upon his well-established moral code), it should be noted that this boy has not resorted to any delinquent behavior and is unknown to the courts. He does not steal, and I would have you note that he does not steal even though he lives in the worst slum section of the city of Boston, and he himself is not only deprived of the little "luxuries" that a fifteen- or sixteen-year-old boy in his depressed neighborhood has, but he sometimes (together with his mother) is without food and without the money to buy it. Furthermore, other necessities—adequate clothing and housing, heat and light, dishes and bedclothes, etc.—are lacking. Again, it is traditional in his section of the city that boys his age do steal and are united in groups for that very purpose. But Arthur does not steal.

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PART SEVEN

Language, Speech, Communications

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CHAPTER 45

GENERAL THEORY OF COMMUNICATION IN PSYCHIATRY

Jurgen Ruesch

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WE LIVE IN THE AGE of communication. Radio, television, newspapers, and circulars flood us with messages, as do invitations to attend cocktail parties, give speeches, or sit on committees. We all are haunted by slogans and clichés; and through the medium of advertising our professional concerns have been transmitted to the public. People on the street talk about the doctor-patient or parent-child relationship, and a term such as psychoanalysis has become part of the popular vocabulary.[20] But in spite of all this awareness of human relations and the availability of rapid transportation which enables people to see one another with the greatest of ease, modern man seems to feel lonelier and more helpless as time goes on.[33]

¶ The Contemporary Scene

The development of communication and transportation machinery, the control of the machine through information, and the impact of mass communication upon the individual have had a profound influence upon psychiatry. In former centuries, scientists took social relations for granted; today, they have made these functions the subject of pervasive study. This reorientation not only gave birth to the behavioral sciences but transformed the psychiatrist from an alienist into a personality specialist, social manipulator, community expert, and family doctor.[32]

The scientists' and doctors' growing awareness of social problems and the emphasis on communication in public life have been associated with a new approach to psychopathology. Every psychiatrist is familiar with the fact that when he opens one of his textbooks and runs across the description of a pathological phenomenon—be it hallucination and delusion or resistance and regression—the pathology is described in terms of the patient's communicative behavior. And in practice the therapist

meets the communicative process and its disturbances at every step of his work, perhaps as a difficulty in understanding the patient or as a management problem. All psychological therapies—and this includes psychoanalysis, psychotherapy, group therapy, hypnotherapy, and psychodrama—utilize the medium of communication therapeutically. Even the drug, shock, and lobotomy specialists are, by necessity, concerned with communication, and the only difference between their approaches and those of the psychotherapists is the locus of operation. Physical treatment methods impinge upon the patient's organs of communication whereas psychological and social procedures affect the functions of communication.[27]

The phenomenology of abnormal behavior, the therapist's role, and the choice of his treatment methods all are interwoven with the prevailing ecology and social structure. The contemporary trend toward the two-children system, the early separation from home, and the concomitant disintegration of the closely knit community structure have left the individual without an external source of human support to reassure, help, and sometimes threaten him. In the past, the individual was controlled from without by people who were personally known to him and with whom he had spent much of his life. This continuity and consistency in human contact resulted in the establishment of a sense of belonging and of responsibility, and it favored the development of controls from within. The vanishing of outside controls and the concomitant weakening of internal controls have left a vacuum which now is being filled by somewhat strange impersonal ties. Intimacy is being replaced by parapsychological relations;[12] the actor on the television screen sits in the living room, shares the family life, and inconspicuously sets standards as if he were a personal friend. And in urban as well as suburban living, families and faces quickly come and go, relationships have become impersonal, and real friendship or kinship groups are being replaced by casual, opportunistic, neighborhood, occupational, or recreational associations. The old-fashioned patriarch has been replaced by an impersonal authority called public opinion.

On an organizational level, this tendency toward impersonal relations is reflected in the accumulation of rules and regulations that are formulated by the state, the large corporation, or the labor union. We live in the age of highly organized corporate empires[16] which are distributed all over the globe and are interconnected by means of communication. Modern living is governed by a bureaucracy that controls everything from health to employment and from thinking to the choice of a marriage partner.[40] And the psychiatrist has become part of this social machinery—the trouble shooter of society, as it were. In the old system, people were either "in"—that is, they participated in the family and community life as regular members—or they were "out" and became adventurers, criminals, or insane. Today, this division is blurred, and the "ins" and the "outs" are almost overshadowed by the "in-outs"—that ever-growing array of marginal people, neither sane nor insane, neither criminals nor upright citizens, but persons who did not manage to get on or hang onto their respective band wagons. With this change in the social structure goes the disappearance of the classical syndromes of psychopathology and their replacement by an increasing number of borderline cases—immature and unidentified individuals afflicted by atypical or heterogeneous conditions. Theoretically and therapeutically, the interest of the psychiatrist has veered away from the study of the mind, or the soul, to the consideration of human relations, communication, and social interdependence.[21]

¶ A Psychiatric Theory of Communication

In spite of apparent technical or theoretical differences, a convergence of scientific thinking can be observed in the fields of communication engineering,[5] ego-psychology,[6] learning theory,[11] and action theory.[18] This similarity—at a higher level of abstraction, of course—comes about because scientists at a given historical period share many of the basic assumptions that are made about life, death, and health and about the human being's physical and social func-

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tions.[32] But there is another and perhaps more cogent reason for this convergence of views. When a scientist has come to the end of his observations or experimentations, regardless of his personal philosophy, theoretical scheme, or technique, he must report his findings to himself or to others in communicable terms. This process of communication, in turn, alters his original ideas—even his findings—to such an extent that the processes of observation, recording, reporting, and interpreting become inseparably linked. Since, in the process of interpretation, the cultural heritage and contemporary views weigh rather heavily—particularly because language is culturally determined—the prevailing views of man and nature creep into the scientist's conclusions by the back door, as it were. But for psychiatry, things are even worse.

While in all other sciences the object of study is distinctly separate from the investigator, in psychiatry, object and subject of study merge into one. Since the subject of investigation is not a chemical compound or an anatomical structure but communicative behavior, the psychiatrist is called upon to pull himself up by his own bootstraps. He first observes communicative behavior of self and of others; then he records these signals in his head, on tape, or on paper by using certain signs and symbols; and finally he reports his findings to others by using another set of signs and symbols. Any psychiatric or therapeutic situation is so heavily determined by a multiplicity of symbolic transformations that inferences made about what really exists—for example, the inner psychic structure of an individual—usually turn out to be fiction. Therefore it seems wiser, safer, and less distorting to refrain from farfetched and abstract extrapolations and to limit the understanding of both pathology and therapeutic practices to simple empirical abstractions, This conclusion has two consequences: first, that more attention is paid to formal and quantitative characteristics of communication than to the signifying property of signs; second, that, when content is considered, it is confined to situations and persons that are familiar to the therapist. The therapist then can add his own experiences to the information on hand without relying too much on the signifying property of the patient's words.

In subsequent paragraphs a few principles of a psychiatric theory of human communication have been sketched.

1. People relate to each other through communication—a process which can be both observed and experienced. The intraorganismic functions[29] of men which include such phenomena as feeling, thinking, and memory at present can only be postulated. Their exploration is dependent upon a two-person or multiperson situation in which the individual communicates his experiences or performs a task.

2. The unit of study is not confined to a single individual but comprises all the people with whom a person habitually stands in communicative exchange. In such social systems, part functions are always functions of the system as a whole, and the chains of causation are circular, if not more complex.[32]

3. The artificial division of individual, group, and society, which formerly handicapped workers in the social sciences, need not be maintained. All messages originate in a human being, traverse human beings, and find their destination in a human being. Thoughts and feelings of an individual are as much the result of signals traveling along certain pathways as are interpersonal statements or broadcasts by a radio station.[25]

4. In order to be able to communicate, any organism or social organization must be equipped with the function of perception, that is, the ability to register incoming signals. Such an organism also must be able to evaluate, that is, to store previous impressions, to scan new impressions against the background of old ones, and to make decisions. Finally, any such organism must be able to transmit messages—to express the results of internal deliberations and to signal these to others. These three basic functions which characterize all living matter become, as it were, an organizing principle of nature.[27]

5. In order to be understood, signals must be phrased in terms which are understandable to others. The technical aspects of this process are referred to as codification. When the receiver understands the code, the signal to him becomes a sign. Language is a sign system by

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which people have agreed to abide. It is characterized by the fact that the significance of the language signs must be known to a number of interpreters and has to remain relatively stable, regardless of the situation.[17]

6. The accumulation of signs and their orderly arrangement is referred to as knowledge if it exists inside of a person, and as information if it is accessible to others. Knowledge and information enable people to predict events to come, to react in a meaningful way at the moment, and to recall past events. This usage of the term "information" differs from that of the communication engineer, who conceives of information as a purely quantitative notion.[34]

7. Regardless of what code or language is used and what kind of information is transmitted, specific instructions have to accompany any message if it is to be interpreted properly. These instructions are often referred to as "metalanguage," and the exchange as "metacommunication." In verbal speech the metalanguage is couched in the tonal qualities of the voice, expressed through gestures, and contained in patterning of speech. In written language it is conveyed through interpunctuation and spacing of the sentence and through the context within which it is written.[32]

8. When a person or group has expressed a statement, this action, when perceived by others, will have an impact. Eventually, the reaction of the other person is relayed back to the sender and serves to clarify, extend, or alter the original idea. Feedback, therefore, refers to the process of correction through incorporation of information about effects achieved. This function is basic to all learning, correction, and self-correction.[41, 42]

9. In therapeutic communication the psychiatrist is interested not only in content and analogies—features which psychoanalysts have worked out in a superb way—but also in the form of communication. The matrix, the envelope, the mold of the feedback processes is the critical problem of therapy. It does not matter whether the discussion is carried out on the couch, in the chair, or standing up, or whether the subject is the collective unconscious, the oedipal conflict, or commitment; in all these situations and regardless of the content, feedback has to occur if therapy is to take place. Feedback is learned by the child first in the nonverbal mode, and only later does he become aware of the signifying property of words which then are fitted into this ready-made nonverbal bed.[24] The success of all of the communication therapies thus is determined by the extent and the type of the feedback processes that take place. If correction and self-correction do occur, the patient is back on the road to recovery.

¶ Popular Misconceptions About Communication

Theories and abstract principles frequently are in danger of being misunderstood. People who habitually deal with transcendental notions, for example, may conceive of communication theory as a mechanization of the human being. But those who use communication theory claim to advance neither a theory of ethics nor a theory of values. They merely purport to formulate and explain the processes that human beings employ to influence one another. Even the point that communication theory does not do justice to inner psychic functioning can hardly be maintained; all that can be said is that communication theory does not speculate about intrapsychic structures. After all, the inner life of another person is accessible only through verbal and nonverbal exchange, and, in a social situation, what is done or said is determined as much by one participant as by the other. Inferences about personalities, then, depend upon who is looking at them. In listening to a patient's report of past events, therefore, the psychiatrist does not assume that he gets an eyewitness report. On the contrary, he assumes that, although the patient may have participated in the events he mentions, his present expressions are designed to cope with a current situation involving himself, the therapist, and perhaps other people. This does not imply that the signifying property of the signs used is completely ignored; it merely means that, at the time an experience is reported, the reporting is treated

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as a new event which has more bearing upon the "now" than upon the "then."

In discussing communication, communicative intent is frequently confused with communicative effect. Any action, be it word, gesture, or practical implementation, has an impact if it is perceived. Both sender and receiver are influenced by it, regardless of the sender's initial intention. To follow Shannon and Weaver's definition,[34] communication includes "all those procedures by which one mind may affect another. This, of course, involves not only written and oral speech, but also music, the pictorial arts, the theatre, the ballet, and in fact all human behavior." At no time, in face-to-face encounters, can the receiver separate the intentional from the nonintentional component of a message. The engineer's notion of noise[5]—the variable that accounts for interference in the transmission of signals—can hardly be applied to human communication, in which neither the channel nor its capacity can be specified. The context, a previous situation, or incidental events may shape the effect of a message as much as the intentional expressions of the sender.

Frequently, too, verbal communication is identified with intentional expression and nonverbal communication with unintentional expression. Unfortunately, this division cannot be maintained either, and the reverse is often true. The child or the very sick patient may express his statements in nonverbal terms, merely using words as modifiers. Verbal and nonverbal modes of expression are as intertwined as the content of a message is with the metacommunicative devices which serve to time, emphasize, or instruct. In practice, therefore, the therapist has to be content to watch the effect produced by a verbal statement or an action sequence rather than to speculate about intention. As a matter of fact, the only way to infer intention is to study the impact a message has had, because the conscious intention of the speaker may not have been his unconscious intention, and often the speaker himself discovers his own intention only after having observed the impact he has created upon others. Intention, therefore, can be determined by hindsight only.

Sometimes the engineers, statisticians, and natural scientists level another kind of criticism at the theories sketched above. They maintain that behavior has to be quantifiable. Without entering into a discussion of the merits of the scientific approach,[32] it is well to remember that, so far, quantification and measurement have not contributed to the understanding of individual behavior. The a priori assumptions that pertain to any kind of measurement—nonparticipation of the observer, difference in time and space scales between observer and observed, anonymity of particles studied, and stability of the yardstick—do not apply to the study of inner experience.[19] Paradoxically, scientific measurement or the appreciation of mass effects is successful only when the observer is not too well informed about the subject of his study. If the physicist were to know atoms and molecules personally, each labeled by name, age, and place of origin, and were he to take their individual life histories and follow their fate over millennia, he would realize that measurement of mass effects would tell him little about the individual particle. Likewise do the circumstances and actions that provide for therapeutically effective experiences occur in patterns which are destroyed when quantitative analysis is used to dissect them. In the field of human communication, quantification is, at best, useful for the assessment of the extraorganismic components of the process—channels, signals, codes—but not for the most essential component—the impact of a message upon the participants and its evaluation. Reaction to stimuli and interpretation of messages depend upon earlier experiences, and since these are not the same in every person, not even in identical twins, the prediction of outcome will remain limited except for very special situations.

Most measurements are time-consuming, but communication and psychotherapy are processes which rely upon immediacy. The therapist cannot wait for the results of a test, and he cannot delay for hours or days his responses to the statements of his patients. When a person makes a statement, the reply or lack of reply on the part of the doctor acknowledges, amplifies, contrasts, or contradicts. In tying state-

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ment to statement within the mind of the patient and from person to person, reorganization of disturbed communication becomes possible. The human fields of endeavor that cope with learning, skill, and experience rely upon patterning and timing. Time-consuming analytic and reductive methods which break behavior into component parts have proved ineffective and nonsensical. The scientific fallacy is obvious: Because certain assumptions and methodologies have helped to master the material environment and physical health, and because they have been successful in improving plumbing and transportation, it does not mean that they are applicable to the universe of human experience. We therefore have to accept the fact that present-day scientific methodology has not as yet elucidated many of the problems inherent in human experience, communication, and psychotherapy. And perhaps it never will.

The Communication Expert's Contribution to Psychiatry

Perhaps one of the most significant advances in psychiatry has been the clarification of the role of the observer. Observation at a distance by a neutral observer yields different results from inquiry undertaken in close participation with the patient. To have been exposed to the manipulations of the patient, to have been lured into the maze of a neurosis, and to have been the subject and object of transference and countertransference leave an imprint which is quite different from that experienced by a man who observes behavior through a one-way screen. The description of pathology, therefore, is dependent upon the roles of the participants and the nature of the system in which the observations were made. The idea that the information obtained depends on the position of the observer in psychiatry was first expressed by Sullivan[35] in his concept of participant-observer, and later was amplified by Ruesch[31] within the framework of a theory of communication. For the development of a general system theory of behavior, it is relevant to remember that the attributes of the naturally existing system (patient) are complementary to the attributes of the observer system (psychiatrist), and that both cannot be stated with accuracy at the same instant. The more we know about one, the less we know about the other.

In practice, this results in essentially three different ways of reporting behavior.[23] When a psychologist talks about personality structure, he acts as a somewhat distant observer who minimizes his own characteristics, the situation, other participants, and the place and time of observation, and maximizes the time-enduring properties of the subject. The patient thus is described as if he lived *in vacuo*. This procedure is useful in understanding and predicting behavior if the specific participants and the context of future situations are unknown. But in psychoanalytic and psychotherapeutic situations in which the therapist engages in two-person communication, the picture is quite different. Here the other person is being tested in an ongoing exchange, and many of the generalities listed under the heading of personality study have to be qualified, modified, or entirely discarded. The picture obtained is time- and context-specific, and generalities about other people, situations, and contexts are boiled down to specific incidents. What is said and done within the period of the two-person interaction is weighted more heavily and used as data more than is information about what happened before or will happen afterward. Here the patient is experienced as an individual who responds to the therapist's operations, and vice versa; and it is this knowledge of the other person's response that enriches the therapist's picture and comprehension of the patient.[23]

The observation of the patient in a group emphasizes different aspects again. Role distribution, teamwork, timing, and sensitivity to context matter more than the over-all features described as personality structure or the dynamic, ongoing interchange experienced in two-person situations. The individual here is seen as a member who either furthers or interferes with the task of the group, and his expressions are weighted with regard to the benefit the group derives. The report will vary, depending upon whether the investigator acts as an

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in-group or as an out-group observer; thus it is obvious that a crime appears quite different from the prosecutor's viewpoint as opposed to that of a family member.[23]

Another contribution of the communications approach to psychiatiry has been to point to the fallacies inherent in verbal communication. We owe primarily to Whorf[39] the insight that the manner in which we assign words to the various parts of the universe influences our ways of thinking. If we have created a word to denote a quality or part aspect of an event, we eventually come to treat this verbal unit as if it really existed independently in nature. The world of verbal unreality thus becomes a danger to all disciplines in which a one-to-one check of word against natural event is difficult if not impossible.[24] This danger is particularly prominent in science when words denoting hypothetical constructs eventually enter the general vocabulary. People then often attribute body and substance to such words and may argue about the super-ego and the id, for example, as if they were bodily divisions of the human organism. Awareness of the vicissitudes of communication in scientific procedure may help us to avoid this pitfall. Particularly if theoretical formulations are restricted to the empirical level of abstraction, any generalizations made can be readily referred to the operations from which they derive.

Familiarity with the characteristics of nonverbal denotation is another bulwark against verbal unreality.[33] The symbolic function of gestures, actions, and objects cannot be dissected, and their impact is immediate. Much of the distortion introduced by words is due to the time it takes to describe a short-lasting event, whereby the organism has to combine words that were heard half an hour ago with words that are perceived now. This combination and recombination of verbal symbols in an individual's head is stimulated and governed by nonverbal factors. When nonverbal perception and expression do not function, verbal communication becomes difficult if not impossible. While the psychoanalysts have worked out in detail the relationship of content and verbally related memories to therapeutic effect, it was left to those therapists who dealt with the psychoses — notably Sullivan,[35] Fromm-Reichmann,[9] and Rosen[22]—and the child specialists—Szurek,[36] Redl and Wineman,[19] and Levy[18]—to point out that attitudes and responses of a nonverbal nature are an integral part of therapy. In the psychoses, and this includes many borderline cases, feedback is disturbed in the nonverbal mode. The patient, not having mastered response and interaction in terms of movement, emotional expression, and gesture, is incapable of engaging in meaningful verbal exchange.[1] Therapy in the psychoses, therefore, has always employed doing (occupational and recreational therapy) and utilized skin stimulation (continuous baths, wet-sheet pack, proximity of nursing personnel, insulin therapy); in other words, unwittingly, psychiatrists long ago chose to approach their psychotic patients in the nonverbal mode, with emphasis on the stimulation of the proximity receivers. Among the psychotherapists, those who are nonverbally skilled are particularly successful with the very sick, and only when the patient has mastered, with their help, simple feedback functions in the nonverbal mode is verbal exchange likely to improve.[24]

Another effect the communications approach has had upon psychiatry is to shift the emphasis from theory to procedure. Patient and doctor actually use words, gestures, and actions to influence each other. These communicative operations so far have received little, if any, attention. Under the concepts of transference, transference neurosis, and countertransference we find some references to the actual exchange;[30] others are included in case reports;[8] and again others in the description of dream interpretation[7] or hypnosis.[43] But on the whole, the actual communicative exchange and, particularly, its nonverbal components are described in global terms such as interaction, support, working through, etc. The lack of a vocabulary to describe nonverbal action is in no small way responsible for this shortcoming, but at least the foundations for the evolvement of a special language have been laid.[3] This involves the study of both disturbed communicative behavior[23] and the therapeutic methods used to cope with it.[24]

Another innovation introduced into psychia-

try is the notion that although only one patient may have symptoms, the group in which he lives is the seat of the disturbance. Every individual is part of a communication network, and his malfunction can often be understood by studying this larger system. Furthermore, it has been discovered that the individual needs to be a member of a group and needs the support as well as the criticism of other group members. Under the influence of child psychiatry and social psychiatry, it has become common practice to take various members of a group into treatment, and the results seem to be better than if one individual alone is subjected to therapy.[37]

Studies of experimental communication[15] and of communication in animals,[38] although removed from psychiatry, have certainly raised a number of new questions. The study of special networks, the capacity of channels, the amount of information, the redundancy of language, the physical characteristics of speech, the role of phonetics, content analysis—all of these topics have come under critical scrutiny and, directly or indirectly, are bound to help the psychiatrist in his work.[5] But these scientific contributions cannot be taken over wholesale. They first have to be sifted, reinterpreted, and adapted, and, inasmuch as therapy is an art, it depends on the therapist's skill to convert knowledge into therapeutic action.

¶ The Nature of Psychological and Social Pathology

Elsewhere[23] the author has elaborated and illustrated the hypothesis that abnormal behavior is associated with physical or social interference with communication. Just as the metabolic functions serve the purpose of tying man to his material surroundings, so does communication connect him to his social surroundings. Interference may take the form of injury or disease affecting the instruments of communication—that is, sense organs, nervous system, or effector organs; it may appear as a genetically determined disturbance such as mental deficiency; or it may take the form of functional interference resulting in personal or social pathology. Clinically, such interference is manifested in emotional states such as alarm, anxiety, anger, guilt, shame, fear, or depression; in disturbances of thinking such as dissociation or flight of ideas; in attitudes such as the tendency to be suspicious, aloof, or dictatorial; or in social approaches such as withdrawal, argumentativeness, or mutism.

Any form of interference not only elicits momentary responses on the part of the individual but also leaves traces inside the organism which continue to exert an effect upon his behavior. In dealing with pathology, therefore, we have to consider not only the results of direct impact but the symbolic representation of such impact inside the human being as well. The more intense and repetitious the interference becomes, the more significant are the traces left in the human being. By the time an individual reaches the age of twenty or thirty years, traces of past experiences determine much of his behavior. It is a well-established fact that in all adult psychiatric patients, the symbolic processes are disturbed, and, although current difficulties with other people may be at the root of the trouble, internal obstacles derived from previous experiences usually prevent the patient from successfully coping with the current difficulties. The various forms of communication therapy not only aim at improving the patient's ways of communication but count upon the fact that a successful exchange will leave traces within the individual and be superimposed upon the memories of the past that are disruptive to communication. Thus it is obvious that social and intrapsychic processes are inevitably linked together.

Functional interference with human communication is frequently related to deviations in intensity. Since the capacity of the organism is limited, overload or underload which affects the sense organs, the central nervous system, or the muscular system may exert a disruptive effect. In ordinary language we call the result of such interference stress, strain, overstimulation, or exhaustion. Deviations in timing—messages that arrive too early or too late and which therefore have lost their relevance or are threatening because the individual is not prepared—are responsible for another host of dis-

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turbances. A third group of disturbances results from messages that, in themselves, are perfectly respectable but which do not fit the physical situation or the social context, or do not reach the right participants—a misplaced call, a lost letter, a secret message that reaches strange ears. The phenomenology of these disturbances can be summarized in a little verse:[23]

> Too much, too little,
> Too early, too late,
> At the wrong place
> Is the disturbed message's fate.

Almost all functional disturbances of communication can be traced historically to the fact that one person impinges upon another and produces frustration by ill-timed, badly quantified, or inappropriate messages. In children, these circumstances can be verified by direct observation. For example, devious acknowledgment by selectively disregarding or emphasizing certain aspects of the message may produce intolerable frustration for the child.[28] Or an individual may receive a message the content of which is threatening; or he may continuously be bombarded with hostile action, as in warfare. Regardless of the nature of the quantitative or qualitative deviations, it is well to remember this salient point: Since man needs a certain amount of gratifying communication in his life in order to learn, to grow, and to function in a group, all events that significantly curtail communication eventually will produce serious disturbances. When communication becomes too frustrating, man finds ways to protect himself by withdrawing, screening, or otherwise controlling the exchange. But through this control the feedback characteristics frequently are lost, so that the purpose of communication—correction of information and performance—is defeated. If an individual discovers that communication does not work at all after having tried it over and over again for many years, he is likely to withdraw from the nonfunctioning system altogether, without being able to establish himself in another well-functioning network. This latter condition is referred to as functional psychosis, in which the feedback circuits progressively are confined to the organism of the patient.[23]

In individuals, pathology of communication is often kept alive by others who unwittingly reinforce it. How can a young man give up his dependent role vis-à-vis his mother if the significant experience and contact with her are based upon her making decisions for him? If this young man were to make his own decisions, he would temporarily or permanently alienate his mother, whose existence was built around control of her son. The anticipated unpleasant breakdown of communication and his lack of skill in making decisions prevent the son from asserting himself. The same applies to the girl who cannot relinquish her self-destructive seduction as long as she acts on the assumption that men will perceive her only if she offers herself as a target for their mental cruelty. Communication pathology which develops over the years may, at times, remain dormant until a specific stimulus triggers it into existence. Weaning a person from his pathology is difficult, because either its intensity is so great that all other experiences in contrast appear flat and unfulfilling, or the withdrawal symptoms are so unbearable that the patient prefers to stick to his pathology. But if the therapist can keep the trigger stimulus muted until the patient has developed new and more fascinating patterns of experience, a desensitization does occur. Control over the trigger stimulus may be achieved when the significant relatives and friends of the patient are taken into treatment.

A discussion of the nature of communication pathology would be incomplete without mentioning that no fundamental difference exists between normal and abnormal communication. All the elements found in ordinary communication are present in pathology, and vice versa, so that the criterion of abnormality is not related to the presence or absence of a certain ingredient. Instead, abnormality must be conceived of as a pattern that ceases to be functional. When the feedback devices do not bring about a much-needed correction, and when behavior has become stagnant or repetitious, then we are entitled to talk about pathology of communication. Freud considered repetition-compulsion as the core of the psychoneuroses; we now refer to this phenomenon as

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feedback. Pathology can be conceptualized as being maintained by processes which, instead of correcting (negative feedback) often increase its extent and direction (positive feedback). The art of therapy thus is to break into this circuit and change positive feedback into negative or corrective feedback.

If abnormal communication is viewed as a quantitative deviation of normal communication, how then can one explain such emergent phenomena as hallucinations or catatonia? The answer is simple. Today we know that when external input is suddenly reduced, it is replaced by an imaginary internal input. The less the pressure from the outside, the greater the activity of the fantasy, even to the extent of creating hallucinatory experiences.[14] Catatonic states usually are triggered into existence by a heightened reactivity to some minor stimuli producing anger or threatening coercion, or by a lessened reactivity to very powerful stimuli threatening exclusion or isolation. The emergent nature of these phenomena is only an apparent one, and careful observation will reveal that, under stress, tendencies that existed before are reinforced. The novice observer's attention then is drawn toward the features he did not perceive before, and he believes that something new has been added.

¶ Therapeutically Effective Processes

If we attempt to explore the secrets of psychotherapy, we invariably fall back upon its first and most important requirement—that, in addition to the patient, there must be another person present who is accessible and visible, who can be talked to, and who is ready to understand and to respond. Once interpersonal feedback is established, the exchange elicits in the patient the sensation of pleasure. To be acknowledged is pleasant; to be understood is gratifying; to be understood and to agree is exciting. This gratification becomes the driving force which induces the patient to seek further improvement.

Understanding is not to be confused with agreement. Agreement involves decision-making and commitment; understanding does not. Agreement means that the information supplied by one person corresponds to the information held by the other person, whereas understanding does not imply a correspondence of information. Since the first step of therapy is to achieve understanding, the therapist, to the best of his ability, attempts to establish in his head a model of what is going on in and around the patient; and once he has succeeded in doing so, he imparts his understanding to the patient. By establishing as correct a relationship as possible between the model in the therapist's head and the events in the patient's life, and by validating this model consensually, the patient himself becomes aware of contradictions and inconsistencies between his private views and his actual behavior. As the exchange continues and the therapist perceives behavioral features which are not represented in the patient's model, he can, by feeding back to the patient the observations he has made, further correct the inaccuracies in the model.

The second method open to the therapist is the mobilization of information which is available inside the patient of which he (the patient) is not aware. This information does not necessarily represent repressed material, but, because of lack of communicative exchange, the patient may not have been able to organize certain pieces, and they may have been left unused.

The third method which the therapist uses is to add, out of his own wealth of knowledge, some pieces of information which the patient may juxtapose to the old information he already holds. In so doing, the therapist conveys to the patient facts which have been ascertained by other people, and the patient is given an opportunity to compare his own experience with that of others.

Interpersonal feedback, therefore, produces three results—mobilization of unconscious information, utilization of nonintegrated information that the patient already possesses, and acquisition of new information. Correction of the patient's old body of information thus occurs when the patient is exposed to a picture that is somewhat different from the one he has held before. But the magnitude of the difference determines the outcome. If the dif-

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ference is too great, the patient will reject the new version; if it is too small, the patient will not see any difference at all. Corrective feedback, therefore, is bound to differences in views which, in order to be effective, have to be of optimal magnitude.[26]

A second determinant of effective correction is related to the "what," or the topic under discussion. In most instances the therapist cannot work through all areas of experience of the patient, and therefore he has to make a strategic selection. This will depend somewhat on the school of thought he follows and the theory by which he abides. But by necessity he will have to concentrate on, among other things, those aspects which interfere with the communicative functions of the patient. This would involve: (1) sharpening the patient's social perception—the behavior of self, of the other participants, and of the context in which his daily communications take place; (2) correction of the procedures of evaluation and decision-making, involving the scanning of memories, the combination of newly received information with old information, the abstracting of conclusions, and finally the initiation of action in accordance with these conclusions; (3) clarification of his emotional reaction to things, people, and situations—current as well as of the past; (4) development of the language and symbolization systems which the individual possesses, thus helping him to use modes of expression which are appropriate for the general context, the number of people involved, their roles, and their personalities; (5) appraisal of the appropriateness of knowledge and skill relative to the type of occupational and recreational activities in which he is engaged; (6) correction of his metacommunicative processes—that is, of those devices which serve, both in expression and in perception, as instructions for the interpretation of messages; and (7) training the patient in observing the effects of his actions upon others and helping him to include these observations in his future actions.

Once the groundwork has been laid for correction of part functions, the more difficult task of integrative rehabilitation moves into the foreground. Integration means to coordinate word with action and feeling with thought, and, in turn, to synchronize internal experience with outward-directed activities. The aim is, of course, to help the patient mobilize all his resources for a given task and use thinking, feeling, and action in unison. This is achieved by painstaking work in which the emphasis is not on pathology but on experiences that are felt as full. By comparing his satisfactory experiences with the disjointed ones—engaging in love-making without feeling, or making plans for tomorrow without carrying them out—the patient is made aware not only of what is disturbed but also of what he misses.

The tracing of a disturbance to its historical roots is valuable in that it adds to understanding, but this understanding in itself is not therapeutic. To spend hours in exposing the patient to a study of his pathology is justifiable only if it also leads to an understanding of those functions that operate satisfactorily. Understanding the past does not shift the balance to make pathology unrewarding and healthy functioning rewarding. This task is implemented by therapeutic operations which reflect the therapist's orientation to the present—the now. By minimizing the past and the future, the patient experiences the feeling that the therapist is with him in what he does, thinks, and feels today. The present, in all its ramifications, then becomes something the patient can learn to focus upon and eventually to accept. Communication with another person about matters which are currently active becomes rewarding because the patient discovers that whatever change may occur can only occur in the present. Manipulation of the past or the future is an illusion which prevents people from coping with their existence.

If one agrees with the existentialists that experience is the basic datum of psychiatry,[2, 4] one has to add that therapeutic communication is an experience in itself. The sharing of information and the pooling of knowledge give a person a sense of mastery. Anxiety is diminished, obstacles are overcome, and the limited power of one individual is amplified through the support of others. The result is a feeling of security. The experience that, in ordinary liv-

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ing, behavior is censored in action rather than in fantasy provides for relief; the facts that the therapist will not destroy and damage the patient and that the patient's fantasies cannot annihilate the therapist contribute toward a lessening of feelings of guilt and frequently toward more independent thinking and action on the part of the patient. After much work, the patient usually discovers that communication provides for an experience of shared concern which eventually may facilitate action. In the therapeutic situation the slogan of symbolic freedom and limitation of action seems to produce therapeutic results.

Of course, this does not mean that, in therapy, the basic personality structure of people changes. Rather, attitudes, social approaches, and skills that are already established can be redirected to be used in a more productive way. The narcissist can be helped to communicate through creative production; the paranoid may find a worth-while cause to fight against; and, by associating with each other, marginal people can be made to accept their deviance without feeling strange and separate. If, at the beginning of therapy, the patient was motivated to seek help because of anxiety, fear, anger, guilt, shame, or depression, he gradually learns to seek more fundamental gratifications. One of these is the pleasure of communicating, and the exchange between patient and therapist may become one of the major incentives not only to continue therapy but to extend gratifying exchange to other people as well.

But therapy does not progress satisfactorily unless, concomitantly, certain daily life situations contribute toward gratifying experience. A man who has never dated a girl in his life will have to take this step once, and no amount of talking to the therapist can substitute for it. However, the pleasure found in the interchange with the therapist may have given the patient enough security to undertake this anxiety-provoking first step. And after the first date he may then elaborate his experience with the therapist in order to prepare himself for the next step. This close integration between life situation and therapeutic communication has to occur if the patient is to improve. Only when the patient lives as nearly as possible a full life does therapy progress satisfactorily. But if therapy is used as a defense against living or as an end in itself, the patient has to be given vacations from therapy until such time as he begins to participate in extratherapeutic situations. The strategic moment to take therapy out of the center of the patient's interest has arrived when the patient is about to enter a new phase of his life—change of domicile, the arrival of a child, a new job. Once the patient is able to experience these events and manage them alone, then therapy will become as it should be—a side issue only. And then progress is rapidly made.

In any discussion of therapy, the psychoanalytically oriented person will raise the question of the role of transference. The answer to this question is that what was said about therapeutic communication constitutes, in effect, nothing else but a detailed study of transference phenomena.[30] But, while in classical psychoanalysis the patient is left to his own fantasies and associations until such time as he himself comes face to face with his distortions and then perhaps experiences a sudden insight, in therapeutic communication, distortions are not permitted to grow to such magnitudes and are corrected little by little as the opportunity arises. If, at the beginning of an acquaintance, every person must make assumptions, assign roles, and act on the basis of past experience, nonetheless the image of the other person has to be rectified and adapted to the newly acquired information as time goes on. This slow rectification is the process that the patient has not learned to undertake. In the ambulatory therapeutic situation, unfortunately, the limitation of activities favors the establishment of distortions which can only be reduced if more aspects of existence are shared by doctor and patient. In an inpatient setting where the doctor can play, walk, or even eat with the patients, the distortion of role is somewhat less prominent. The more varied the situations are in which doctor and patient have contact with each other and the more there are other people involved and present, the more the realistic

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aspects of the relationship will dominate the picture, keeping transference and transference neurosis within bounds.

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CHAPTER 46

SPECIFIC PROBLEMS OF COMMUNICATION IN PSYCHIATRIC CONDITIONS

Rose Spiegel

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WE HAVE A DOUBLE CITIZENSHIP in the universe of communication: Communication concerns us as part of the human experience, as the *sine qua non* of all experience, and even of life itself. And in our specialized concern with psychiatric patients, communication is a prime tool of therapy. All psychotherapy—that is, all those therapeutic endeavors which use the interaction of personality as the essential tool and which meet the difficulties of the patient directly and in terms of his psyche and his personality—revolves around communication.

¶ Communication and Personality

Communication deserves to be an essential goal of therapy rather than the incidental achievement it often is. The psychiatric patient often is incommunicado—cut off from relatedness to others both by his disorder and by the impaired understanding of him by his family and community. Not only is the psychiatric patient's communication with others seriously impaired; so also is his relatedness to himself—his intrapsychic communication. As part of therapeutic achievement, he is to be helped to communicate better with himself and with others; consequently, those in psychiatry and the allied professions require a particular sensitivity, skill, respect for communication between people and within themselves. Certainly the social and professional communities can better understand the psychiatric patient as they become more receptive to the possibility of communication with him, as they extend themselves in an inner listening.

There are numerous approaches to communication. It has its physics and mathematics;

its biology, physiology, and psychology; its techniques and skills; its philosophy, its anthropology; its relation to art and entertainment. Though we tend to assume that communication is singularly a human achievement, it can be defined in terms ranging from the interpersonal to the inanimate and mechanical. Before we center on our own psychologic and psychiatric concerns with communication, let us take note of several definitions.

Weaver, who attempted to apply Shannon's mathematical and engineering theory of communication to "the broad problem of social communication," presented the following definition. Communication, in its very broad sense,

> . . . includes all of the procedures by which one mind may affect another. This, of course, involves not only written and oral speech, but also music, the pictorial arts, the theatre, the ballet, and in fact all human behavior. In some connections it may be desirable to use a still broader definition of communication, namely, one which would include the procedures by means of which one mechanism (say automatic equipment to track an airplane and to compute its probable future positions) affects another mechanism (say a guided missile chasing this airplane).[25]

In an over-all biologic sense, communication involves all the processes setting up the two-way relatedness of the organism to its animate and inanimate milieu; narrowly, it is the transmission to the organism of a datum from a field of its relatedness—external or internal to it—which affects or conditions or touches off its responsiveness and/or responses.

In psychologic, human terms, communication is the establishment of psychologic relatedness between the person and an experience or field of experience, and includes the various processes involved in setting up this relatedness.

Speech and verbal thought are the crowning, specifically human achievement of communication. Our end organs and special senses are in the service of communication with the physical cosmos. At the opposite pole, communication involves the fundamental interaction with the refined and cultural subtleties in civilization.

Communication is a dynamic process—experience in itself and also the gateway to other experience. Communication not only is a psychobiologic means, it is also an end—a process whose fulfillment brings its own gratification.

Innate in all living beings is the drive to communicate. We have our being in a universe of communication. We are at the center of our physical cosmos, of a social and cultural world of people and ideas, of a direct, immediate interpersonal world of varying closeness and distance. And within us is the intrapsychic world.

When we think of communication in interpersonal terms, it appears as a brief encounter between persons involved in a specific transaction which is delimited in time. On further reflection, we recognize a continuous, long-term process. Indeed, we recognize the synthesis of various kinds of communication processes on various levels in the person himself, and between him and the other communicator.

In the first version, communication is an event occurring in "time the present"; the person is viewed on his presenting surface in the interaction. If we consider his inner communication processes at all, it is cross-sectionally. In the long-range view, we relate to communication as the flow of experience that has patterned the person to communicate as he does—his psychologic experiences, particularly those bearing directly on communication, the maturation pattern of communication, the cultural contributions affecting communication. Communication in this sense has some of the quality of growth and maturation. In the episode of communication, the whole person enters the transaction; furthermore, he has been shaped as a personality by his specific life experience in communication. Lastly, there are fairly characteristic patterns of communication for the various kinds of personality disorder that fall within the province of psychiatry.

The Communication Circuit

In an operational sense, every person is in a communication circuit, consisting essentially of the *sender of the message, the message,* the *receiver* (and *integrator and interpreter*) of

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the message, and his *response* to the message. The communication circuit has a pattern reminiscent of the familiar one of the reflex arc.

Every person is a communicator; he plays various roles, with different and varying intensity, whether at various times or at the same time. Indeed, in some senses, the person himself is the message.

The message, of course, is not necessarily verbal. It may be a feeling state or a construct of meaning. It may be a datum of the outside world on which the receiver builds his meaning. The sender of the message, indeed the receiver of the message, is not necessarily a person, but, by and large, we shall consider the communication circuit in its personal sense.

The message to be communicated may be directly interpersonal or it may be intrapsychic, with the message from one part of the personality transmitted to another. The communication may be between the person and his society, and may even influence the culture.

The communication circuit may be fulfilled or may be attacked even to the point of annihilation. Either the fulfillment or the attack may be directed by a person toward communication with himself, with others, or toward some facet of the outer world. In short, communication may be conjunctive or disjunctive.

The Message

The relationship between communicator—whether sender or receiver—and the message is many-faceted. The message, in one sense, is an extension of the sender, and how it is received is a measure of the recipient. It may, indeed, be a connection between them, part of a continuum from one to the other. Yet the message has its own identity. What gives the message its essential character depends on four dimensions: (1) the psychologic modality that enters into the communication, (2) the means by which the communication is effected, (3) the reality to which the message pertains, and (4) the meaning contained in the message.

The message conveys both a psychologic modality and a meaning. The psychologic modality may be a feeling state, sense datum, or construct of meaning. The meaning is contained in or elaborated from the psychologic modality. If the psychologic modality is an idea—that is, a construct of meaning—the meaning is contained in it. If the psychological modality is a mood, say depression, the receiver may empathize the mood and only as a subsequent step derive the meaning from it, recognize it for what it is, or attach an interpretation and significance to it.

Sometimes the impact of the modality is so direct and intense that the experience is delayed in any cognitive sense. In early infancy the feeling states which a young infant empathizes from others occur before his development permits cognitive extraction of meaning, although he is profoundly affected by the experience.

The means by which the message is conveyed are surprisingly important. They are intrinsically connected with the psychologic modality of the message and help shape the message. On a psychologic level, the message may be communicated seemingly directly, as by empathy, or clearly indirectly, by the mediation of signs and symbols. Feeling states are often conveyed empathically, constructs of meaning by sign and symbol which permit elaboration and precision hardly attainable without them.

Meaning comes close to being the datum of the message, its explicit content sense. The term "meaning" is also used to indicate the fuller, richer significance outside the tight package of explicit content sense. For simplicity of terminology, however, the term "significance" is suggested, to indicate what the message "really means."

"Significance" would relate the message to the human reality from which it arises. "Significance" would show the connection between what is intended and what the message states, in spite of any disparity between them. For instance, the meaning of the words or the gesture of a message may be explicit derogation; the significance may be that the person is reacting in this way to anxiety evoked from outside the communication situation and displaced onto the other communicator—as often occurs in transference in psychoanalysis; or, the significance may be a counteraggression to hostility, and so on.

It is quite apparent that both explicit meanings and their fuller significance ought also to

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be ascertained in communication relationships in the world at large, for significance is the encompassing denominator for the message and its communicators.

The Role of Signs and Symbols in Communication

Of the several modes of interpersonal communication, our focused and conscious awareness generally is on the play of symbols. The symbol-using and symbol-making processes are related to mentation. The evidence at hand is that this functioning begins early in infancy, but later than the modes of body-language and empathy which function almost from the time of birth. The role of symbols, however, reaches far beyond the interaction in interpersonal communication and is based on fundamental physiologic and psychologic functioning, namely, on symbolic process. This process involves meaning, which, in its highest sense, encompasses conceptualization and our attempts at understanding.

Related to the use of symbols is the use of signs. How symbols and signs function for us is significantly different, but they have one important operation in common—they convey meaning and they both are involved in the basic psychologic operation of the quest for meaning and understanding. Indeed, they may very well have a linkage in their evolutionary roots. Symbols and signs depend for their qualitative difference not so much on what they are made of as on the uses put to them by our minds, for the same entity or phenomenon may now be a sign, now a symbol.

The sign essentially is directed to giving information, the symbol to conceptualizing. The loose definition of symbol, as something that stands for something else, turns out to contain some of the most challenging problems of thought, reality, and experience. More specifically, a symbol is a representative of an entity, phenomenon, occurrence, or conception, and serves as the vehicle for conceptualization of the referent.

SIGNS

Signs clearly are of elemental importance for creature survival in a universe of dangers and beneficences. Signs enable a reading of danger before the event, or a pursuit of food or mate after indication of its existence. Time is gained, by means of some signs, for a kind of foresight, for choice and decision. Functioning through symbols is a much later biological development which permits such psychologic luxuries as thought for the sake of thought.

In operational terms, a sign indicates the existence or presence of something, or the occurrence of an event, of which the sign itself is a part or accompaniment, a foreshadowing or residue. A sign, in being directed to giving information (though it may be misleading or inept), has a certain practicality. Some signs command.

In our lives, we have two kinds of sign experience—those which we read to our uses, over which we are the authority, and those to which we are subject, which exact a response from us directed by others. The latter include our man-made signals, epitomized by our bells—from alarm clock to fire engine. Such signs go beyond giving information of necessities and dangers—they command. In our context we are most interested in the first kind of sign, from which we read and learn.

In our interpersonal world we depend on signs of emotion, behavior, and attitude, from others, to inform us of the state of being behind these signs. We even read signs of ourselves, part of an "objective" relationship to oneself—contributing to self-appraisal.

Though we are quite fallible in our reading of signs, we proceed on the basis that they are genuinely indicative of a correlated condition—the blush of embarrassment, the timbre of the voice in rage, the disarray and dilapidation of an extreme of schizophrenia, the rigid self-contained movements of the extremely obsessive person. These signs do not necessarily depend on the intended design of communication by the person whom we read by these signs. We read them in a kind of behavioristic human-animal psychology. Professionally, we observe physical, emotional, and behavioral states—signs that we read and interpret and which enter into formal diagnosis.

The communicator in interpersonal situations may use what ordinarily are signs of a condition to convey specific intended mean-

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ings to the other person and to evoke an emotional and behavioral response. The easiest and extreme example is that of the beggar displaying his sores as a plea for alms, as well as the subtleties employed by hysteric personalities; that is, signs may be used manipulatively or with intent to deceive, mislead, or influence.

Signs introduce an important modification of interpersonal communication. The very quality of objectivity in their use tends to deflect the relatedness which has the quality of being *between*, to the quality of being *about;* that is, the relatedness is less an open person-to-person fluidity, a rapport, and more a reading of information. The message conveyed by the sign may lead to other kinds of relatedness, and the information may be reacted to with an immediacy of emotion, but relating to the sign introduces some detachment. Signs, when reliable, validate or prove the existence of the entity or condition which is its referent. All the functions of the sign are derived from the theme of the existence of its referent.

Symbols and Symbolization

Through various functionings involving symbols, we are enabled to relate conceptually to our several worlds. Within the psyche, by means of symbolic process, we transform experience into symbols, into hierarchies of symbols. Some of this symbolization goes on outside of awareness, the evidence of its functioning having been obtained through subtle observations in psychoanalysis and child study. In other words, symbolic process relates us conceptually to experience, even though some of the links are unconscious.

Symbols and symbolic activities function not only in the utilitarian exchange between persons but also contribute to the soaring reaches of the human mind, the building of constructs of thought and imagery which add to the culture. Symbols and symbolic activities, when pathic, bring down grave disorders in our personal life or even large-scale human tragedy.

Symbols enable us to think about an entity or phenomenon when it is absent or even intangible, and to conceive of the physically nonexistent. Symbols enable us to imagine. By means of symbols we express intricate states of being, we can exercise foresight, we remember and recall; that is, symbols serve us in the experience and functioning which are centered within us and also in our relatedness to others. The inner and outer worlds of symbolization communicate with each other. Our thoughts, dreams, and fantasies are often communicated to others; our symbolic activities in patterns of movement and behavior also speak.

Symbols may exist in the outer world and have outer form or concreteness, or they may exist entirely within us as an expression of symbol activity and process. The basic symbol modes of our inner life are *sense percepts, logical constructs* of thoughts, and *sense imagery.*

Sense percepts relate us to outer reality on the creature level. We process experience with physical modalities into perceptions which actually are representations of reality. Sense percepts—what we "know" we see, hear, touch, taste, and so on—are actually a symbolization of the perhaps unknowable outer reality.* In consequence of some kinds of organic damage to our bodies, these symbolizations of physical reality are not achieved. In some psychologic disturbances, the perceptions of outer reality are disturbed; that is, the symbolization does not bear a normal relation to outer reality.

Both in the intrapersonal activity of thinking and in the exchange of thoughts and ideas with other people, symbols typically are logical constructs. In dreaming and reverie, another variety of intrapersonal symbol activity, symbols typically are sense images. However, people may dream in logical constructs and think in sense images.

The symbols we use in the exchange of ideas are intended for cognition by others and so are agreed upon, accepted as convention. These are the consensually shared meanings which contrast to the private, often unshared meanings, the so-called autistic meanings. We are most familiar with, or rather, most focused on word language as a carrier of meaning, but word language is just one variety of symbol.

* We are dangerously near the philosopher's playing field of what is outer reality and what is our sense experience of it. As Langer puts it succinctly, it is a "surprising truth that our sense-data are primarily symbols" (Ref. 18, p. 16). We may say our sense percepts are symbolizations of signs of reality.

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In the exchange of ideas, the receiver of the communication has his own inner processing to do with the symbols sent him, or else the communication fails. To the sender or initiator, the symbol serves not only as vehicle for thought, in the sense of passive transfer, but as embodiment, container, and representative of the thought or experience for which he dynamically selected the symbol. These inner experiences are part of the process of conceptualizing by means of symbols. The use of symbols for the exchange of ideas is, then, an interpersonal and intrapersonal process and also culturally determined communication.

We recognize the symbols of sense imagery as belonging to the vast undersea life of the unconscious. Besides the private symbols from our autistic life, there are those more or less private symbols which are processed into art forms. All these symbols of dream, fantasy, and art form re-present experience.

Sense images are rooted in three kinds of basic experience, which give rise to three kinds of symbols—the universal, the individual, and the cultural.

The universal symbols, as Fromm has designated them in *The Forgotten Language*,[13] are related to the intrinsic and fundamentally human condition, both in the present time and as far back as we can stretch our knowledge, and therefore are more likely to be shared intuitively and empathically. Universal symbols include also the basic sexual symbols of Freudian symbology.

The second root of experience relates to special circumstances of time, place, person, and event which affect one's life. These more circumstantial experiences and their derived symbols are less likely to be communicated empathically or intuitively than are the universal symbols. Symbolization derived from special circumstances may properly be designated as individual symbols (what Fromm terms "accidental").

The third root of experience concerns the interplay of the person with his culture. Culture in the large and in the family subculture provides us with some of the materials for thought in the form of word language. The culture makes its impress on us through the symbols and symbol activity of art, entertainment, and prestige—symbols which we share with our society.

The impress of the culture on symbol formation begins in our early upbringing. Sullivan [26,27] has traced this influence, which operates partly through the mothering person, in the growing child's development of the self. Socialization of the child involves the superimposition of symbolization on such physiologic events as eating and excretion. This symbolization is in terms that are partly shared and partly highly individual, and they vary in their availability to his consciousness.

Symbolic Activities

We engage in a variety of operations which either are the equivalent of symbols or which produce symbols. These are symbolic activities. Artistic expression, scientific pursuits, and religious rites are symbolic activities of large significance through which we communicate with the culture and, indeed, in some ways with all mankind. Other symbolic activities are on the smaller scale of the individual's functioning, for instance, speaking and gesture, and the inner events in thinking and the reverie process.

Still another range of these activities is related to personality and to its disorders. We express ourselves symbolically through our actions, behavior, and interests, by which we are read and misread. Our choice of occupation is not only a practical matter but a symbolic expression of ourselves. Some actions of an obviously instinctive nature have a symbolic dimension; for instance, sexual intercourse is not only a basic creature event but a highly symbolic and communicative experience. We attach symbolic significance to one or another event or interpersonal situation, and our symbolic significance may be at variance to the intrinsic meaning of the referent.

Interpersonal Communication

Rapport

When communication is consummated between persons, the experience is of an almost incommunicable, buoyant sense of openness, at-homeness, and acceptance—a sense of the flow of thought and feeling in a shared

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rhythm. It may transcend the specific verbal language or include it as a component. Loneliness is transcended. Meanings are understood. Verbal and nonverbal communication fuse. There is a sense of "being on the same wave length," "in tune with each other," "in touch." Rapport has this quality; most intensely, "being in love" contains this sense of open relatedness, or the illusion thereof.

Most interpersonal communication is more pedestrian—a grinding exchange of words whose meaning and significance is more laboriously achieved.

Some of the difficulty and unfulfillment of interpersonal communication is attributable to the misapprehension of the empathic mode.

Empathic Communication

Empathic communication occurs through the reading of subliminal signs of another person's behavior, emotion, etc. It is an open question as to whether there are still other avenues of communication that enter into empathic communication. Through it we apprehend affect, emotion, body feeling, and attitude. What the sensory channels are in this kind of communication is not known, but it does require the bodily presence of the persons in the circuit. Perhaps better than the circuit, as the figure of speech, is the image of a magnetic field of force.

Empathic communication is not verbal, does not depend on statements of the feeling state, but may accompany language, for instance, through the ring of the voice. The apprehension of feeling states, which provide one kind of meaning, is through the immediacy of the feeling itself. The receiver of the message experiences the feeling state itself, whether consciously or unconsciously, as a similar reverberation of feeling in his own psyche. This message we may relate to in quite a number of ways—from identification, to anxiety, to repression—but the first experience of the receiver in empathic communication is the *felt* meaning which may be outside of cognition.

Body-Language

Body-language includes the sense of the basic physical presence of another person, the sense of the impact of another person, his quality of movement. It includes gestures, the body attitudes, that the person does not intend but which reveal him, and also those which he does intend and by means of which he communicates. The former are signs by which he is read. The latter, in some respects, are equivalent to his word language and so function as symbols to convey his meaning.

The body-language of another person is apprehended by direct observation and also by our predilection for taking on the movements and body tensions of another in our mimetic responsiveness (which may be one of the reasons for the pleasure in watching a dance recital).

The complexity of sexual relatedness includes all modes of communication, verbal language being the least, and interpersonal relationships in the usual sense being only a part. The "message" is the person himself. The partners carry high symbolic significance for each other (not to be confused with esteem or love). The intensity of sexual intercourse depends on empathic communication and the immediacy of direct body relatedness, to which symbolic value is added.

Spoken Situations

The spoken situations generally contain a great deal that is mutually understood, both of meanings that could be made explicit and of deeper, empathic, inarticulable moods and meanings. For we carry with us the aura of our life experience, both as outer events and inner thoughts. Shared meanings of the culture and subculture are recognized intuitively by how they have molded us. These implicit meanings reach the other person by the subtle signs from which we can be read—from the clothes one wears to what makes one smile.

Entering into spoken situations are the shared, consensually defined meanings which are set up by the culture, as in the established symbolic meanings and significance of language, of gesture, of certain forms of behavior and activity. Another range of such symbol meaning which enters into interpersonal communication is derived from family and group definitions. In addition, private and autistic meanings cast their aura on a spoken situation, often to obscure it.

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Spoken communication depends a great deal on the readiness to communicate, on the expectation and the availability for verbal relatedness. These enter into the sense of consummated interpersonal communication in the experience of rapport.

SILENCE

In interpersonal communication, there are occasions when silence occurs—with varying significance and varying comfort and discomfort for the participants. Silence has its eloquence. Silence may express noncommunication in a deep sense, inarticulateness in spite of the wish to communicate, or fatigue. It may be due to a person's absorption in experiencing himself to the exclusion of the outside world. There may be the companionship of a shared mood, needing neither words nor gesture. Or silence may be indicative of hostility, may actively convey belittling operations to the other and be intended to evoke disquietude in him. It may arise out of a profound negativism about communication, which we encounter in a wider range than, for example, the disorders of schizophrenia and depression.

People differ in their need for silence. For some, there is a premium on filling the air with sound. For many, silence is anxiety-provoking and evocative of childhood ostracism by an angrily silent parent. But silence may also clear the way for empathic exchange, for deeper communication. Thus silence may well be considered a mode of communication.

Intrapsychic Communication

ORGANIZING ACTIVITY

Intrapsychic activity organizes the messages received from the inner world of emotions and body states, and from the outer world. The organizing psyche is derived from all the experiences up to that point in time at which the new experience occurs, as well as from predispositions that we cannot accurately assess as isolated factors. As an example of the latter, we recognize that we have our personal inclination toward one or another sense modality of symbolization. For that majority of people who are eye-minded, not only language but visual images are the means of recording and storing messages.

Communication from within includes messages from the side of us which rarely comes to explicit word formulation—not only from emotions but from affective states and bodily conditions that contribute mysteriously to our general sense of ourselves. How these are symbolized, how they affect other symbolization, is still uncharted territory. However, it appears to be a reasonable assumption that at some point symbolic processes within the receiving person act upon these messages.

SYMBOLIC PROCESS AND SOME DISTORTIONS IN RESYMBOLIZATION

Intrapsychic communication involves the recognition, interpretation, creation, and expression of symbols, symbolic activities, and meaning—all of which enters into our mentational activity and into the experience of the self which give the sense of "I am a person."

Resymbolization of the message received ultimately transforms it into the interpretation that enters awareness, or, in emotionally significant experience, the interpretation that is forbidden to awareness. The interpretation may be a genuine comprehension of the symbol meanings, may be quite remote, or may be a distortion. The epitome of the comprehension of meaning, significance, symbolism, and reality is manifest in intuition, which is the consummation of understanding in depth.

An interpretation is utilized, whether or not it corresponds to the actual understanding of the symbol and its meaningful content. For instance, in rationalizations, significance has been reformulated, resymbolized conceptually, and cast into a language form acceptable to our consciousness. In conversion hysterias the process of resymbolization turns away from what is consciously verbal and into somatic expression, with subsequent resymbolization into awareness.

We may ask ourselves the difficult question about a person: Does his interpretation of the symbol and its meaning match the reality behind the symbol? This is a way of appraising his apprehension of reality.

RELATEDNESS TO THE SELF

The relatedness to one's self and one's organism clearly includes the Socratic prescrip-

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tion, "Know thyself," and the full self-knowledge of ideal psychoanalysis. It includes insight; that is, an intensity, depth, and fullness of self-knowledge with a sense of the roots of one's behavior and experience; a recognition of one's motivations and emotions and of the forms in which they are expressed.

Experience of oneself on the level of self-knowledge and self-awareness depends on permitting awareness, feeling, and recall. Experience of oneself as fulfillment includes not only hearing but listening to and heeding the messages from affects and bodily states, from reverie processes. It involves their consummation and their transmutation to thought. It involves not only permitting messages but seeking them. It involves focal attention. It has its linkage with interpersonal experience in terms of emotional gratification and values.

Intrapsychic communication may be cut down and turned off its true course in the prosaic and everyday denials of the self which do not form the clinical syndromes of psychiatry, but which deplete the experience of living.

Psychologic Aspects of Verbal Communication

Verbal language is, by and large, our favorite form of conveying messages, particularly interpersonally. It is part of the collection of skills whose continued competence is a function of one's consciousness and thought, of emotional fluxes, of somatic and psychologic health. Verbal language becomes disturbed in the not-unusual experiences of fatigue, stress, and anxiety. It becomes characteristically altered in such clearly psychiatric disorders as the schizophrenias and depressions.

Though language is a specific mastery for every person, its emergence depends on three root processes which are derived from our biologic and cultural heritage, namely:

1. Man "instinctually" is a symbol-making creature.
2. The verbal language of the culture directs the individual's thinking along the thoughtways of the culture.
3. Communication, including verbal language, is subject to a process of maturation in each person's life, beginning in infancy and affected by his earliest interpersonal experience.

The existence of speech and language for all human beings seems to be bound to the human propensity for symbol making. That we are "instinctually" symbol-making beings is the keystone of Cassirer and Langer's hypothesis concerning the origin and function of language for mankind. In effect, they point out that language is both the proliferated outer form and the consummation of the psychologic process of symbol making. From the innate necessity for symbol activity, they derive the corollary that the gratification of this drive is an end in itself and its own reward.[7,18]

Language, the Culture, and the Individual

Word language offers the prime demonstration of how the culture acts on the person from his earliest infancy. The culture begins its use of language as a tool through the sanctioned, explicit verbal meanings and forms whose mastery begins in childhood and is a continuing challenge.[30] Language provides the culture with a channel for the transmission of its attitudes and meanings. More tenuously, a specific language reflects its culture through the experiences it names (and those it doesn't), in the identified (and unidentified) abstract qualities, in what's proper to talk about.

Most subtly and elusively, the specific language, per se, in its intrinsic structure, exerts a molding force, presses thought into direction by the meanings implicit in its own structure. Whorf, from his researches on the great language clans of the world, adduced evidence for the thesis that a culture patterns the thoughtways for the individual through the conceptions implicit in its language. Concepts of time, space, and movement are conceptualized differently and characteristically for the respective great language clans. For instance, the Hopi language (American Indian language clan) recognizes, in contrast to syntactical English (Indo-European language clan), an experiential dimension of time which we lack. "The Hopi realize and even express in their grammar that the things told in myths and

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stories do not have the same kind of reality or validity as things of the present day, the things of practical concern."[31] Such implicit conceptualizations embedded in a language are, according to Whorf, even more powerful than explicit word meanings.

Within the same linguistic family, the member languages not only have their respective verbal idioms but their characteristic emotional tone. The earthiness of one language is the vulgarity of another. The emotionality whose verbal expression is good form in Italian is suspect as oversentimental in English. The courtly verbal forms that still are currency in Spanish would be an artifice in English. It is quite an achievement to master the thought-ways of a second language and culture and learn to live in them psychologically.

The obstacles to communication—in social encounters, in psychotherapy—which arise from linguistic differences can surely be diminished by awareness of their existence and by the wish to communicate, by the attempt to have a meeting of minds and personalities. In contrast to the communication problems of the denizens of Babel, people sharing a language have a sense of relatedness to each other. Though many of their shared meanings are derived from other factors in the culture besides the language, the community of language is a prime factor in establishing this feeling of relatedness, of being at home with others speaking the language.

INDIVIDUAL EXPERIENCE AND THE FUNCTION OF LANGUAGE

When we focus on the person himself as the unit, we see that verbal language meets certain subjective inner necessities for intrapsychic and interpersonal communication. Compared to the other symbol forms, words possess great precision (though the analytic philosophers are more impressed with the vagueness and condensed meanings in ordinary language.)

In the domain of intrapsychic activity, words symbolize reverie, thoughts, and emotion in a form that has great mnemonic advantages. Words make convenient packages for memory, both as long-term mnemonic devices and in the swift transition from one thought to the next. Language helps focus consciousness on subjective experiences that tend to be elusive, particularly when inarticulate. Thus word language enables us to stabilize experience, whether to think about it, talk about it, or recall it. In none of these respects, however, is verbal language the only means of capturing experience.

Word language helps to stabilize meanings. It is opposed to autistic meanings. Of course we know, from the rapidity of change in American English, that meanings won't stay pinned down to words; and, as we know from our subjective experience, autistic meanings attach themselves to words.

Word language permits building hierarchies of meaning, from image for a concrete object to abstraction of a quality or meaning. Thus it organizes thought and experience, one level of organization forming the floor for the next. Word language makes interpersonal communication of thought easy. It fills in what the empathic mode of communication, which essentially serves the affects, can hardly accomplish.

These very functions of language lend themselves to misuse and misunderstanding. Verbal communication is often considered to be antithetic to empathy, and, indeed, verbal language is often used to din out empathic perceptivity. A challenging problem is: Is this antithetic relationship an intrinsic necessity? Verbal people are particularly prone to assume: no articulate verbalization, no thought; no thought, no intelligence. We tend to disregard what we know very well—the structuring influence of emotion on thought, the truth in the proverbial "wish is father to the thought."

Another misuse is overabstraction, by means of which one becomes divorced from the reality underlying the words. Indeed, one of the marvels of language is its relationship to deep processes and experiences without which it could not function.

Words serve not only to express and communicate emotion but also to drain off emotion. Emotions, when inarticulate, may express themselves in behavior and deed directed at the environment or may be repressed. Breuer and Freud's first contribution to psychoanalysis was the concept of abreaction—the discharge of the repressed emotion into verbal emotive

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expression. The channeling of emotion into verbal expression instead of into action on the environment has been one of our major socializing forces—not without unfortunate by-products in terms of overrepression and constraint of emotional experience.

Some of our subjective experiences, when our use of language fails us, show up its functioning when it is "normal" and integrated. A language experience familiar to most of us is the sense of distress when we are at a loss for words to name a feeling state. Having a word for a thing or for an observed phenomenon is a great convenience; having a word for a subjective experience is a great comfort. The naming and identification of a new and disquieting emotion reassures one of emotional kinship with one's fellows (unless the recognition of the feeling state is self-deprecatory). Indeed, sometimes any label is preferable to no label, a fact which has important implications for psychotherapy.

Words built into sentences can convey a whole thought, in contrast to isolated words. But single words can carry a sentenceful of meaning, depending on the contextual situation, on the associated nonverbal communication. Single words with the force of sentences are part of the experience of each of us, submerged generally in deep memory. It first occurs as a step in the maturation of the young child in dealing with language and meaning. We occasionally encounter it in ourselves when we are greatly fatigued, or when coming up from deep sleep. With some creative people in the press of accelerated thought and imagery, the words come tumbling out in phrases indicating ideas but not expressing them in the smooth verbal order that is their later form.

Discourse in words is something volitional and learned; something that has become second nature. Nonetheless, like all learned processes, it may become disorganized under great stress or privation, and it has characteristic patterns which enter into psychiatric disorders.

Symbol Forms of Verbal Language

There are two great subjective modes of symbol activity which correspond to the two great categories of symbol form into which verbal language falls. These modes are thinking in logical constructs and fantasizing in imagery. The corresponding modes of verbal language have been designated by Cassirer as "discursive logic" and "creative fantasy." The term "creative fantasy" does not exclude the fact that both kinds of symbol activity have their creative aspects.

It is essential to understand the characteristics and the distinctions—and the rivalries—between these two basic styles of language and mentation in order to get a better sense of their role in different patterns of personality and mind-set. Indeed, they are particularly pertinent in the communication disorders involved in obsessional thinking, in schizophrenia.

Discursive logic operates by means of what may be called "denotational symbolism." The meanings of the symbols are precise and sharply defined and within the range of cognition. Discursive logic is often considered to be a close indicator of reason.

The symbolism of myth is metaphor, which deals with connotations, with analogies seen in the phenomena occurring about us, and with imagery arising from fantasy and the unconscious. The meanings of myth are not easy to pin down but shimmer with elusiveness and paradox, and sometimes with the challenge to reason that characterizes dreams. Myth has significance rather than precise meaning in the semantic sense. The symbolism and significance of the mythic mode are communicated in imagery, narration, or the dramatic form. More often than either camp would acknowledge, discursive logic is a hidden partner under the final polished form of the mythic mode.

Often the mythic mode is called "prelogical," with the implication that it is qualitatively and chronologically the rudimentary precursor to logic, with the further implication that lingering in the myth-making mode indicates a kind of retardation of the psyche, an emotional arrest in the "golden age" of childhood.

The writer subscribes to the view that the mythic mode has a logic of its own, often a logic about human nature, a logic of the psyche, whose relation to discursive logic is paralogical rather than prelogical, and with which it is not necessarily incompatible.

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The division of language symbolism into discursive logic on the one hand and into metaphor and myth on the other is paralleled by the inclination of different personalities toward one or the other of these vast congeries as the most natural way of experiencing thought and intellection. Some persons verbalize their experience in highly metaphoric form or in dramatic style, which often is suspect to the person who favors the logical, abstract pattern. It is astonishing how difficult communication between these two mind-sets may be, particularly if embodied in psychiatrist and patient.

Communication and the Child

We have noted that the emergence of language for the individual depends, in part, on the human pattern of maturation of communication. The child's experience with communication subsumes a number of impressive facts which are pertinent to our interest in psychiatric disorders:

1. The culture, both through its language and through nonverbal means, has an intricate action on the child's communication.
2. The role of the mother is fundamental to the emergence of communication in all its modes.
3. Many difficulties in interpersonal communication and many disorders of communication as skill derive from disturbed communication in childhood.
4. Some kinds of interpersonal disturbances of communication in childhood as well as in adulthood evoke anxiety and even panic.

Communication Between the Culture and the Child

The culture communicates with the child; it reaches into his cradle and molds the patterns of his behavior, his thinking, and his feeling. It injects meaning; it shapes his symbolic operations. It prescribes the kind of cradle he lies in, how his mother holds him; in short, it steps into the communication between mother and child in the earliest nonverbal and preverbal modes.

Through the language itself, the culture affects how the child conceptualizes even such elemental experiences as relate him to the physical cosmos (the Whorf hypothesis). Shortly after the child enters the symbolic mode of language, the culture begins to communicate with him concerning interpersonal behavior. The culture molds not only the thinking but what emotions are acceptable, and defines the "proper" way of showing emotions and moods, of communicating emotion.

Broad View of Communication from Infancy to School Age

The newborn's potentiality for communication is realized under the sun of parental affection, tenderness, communication, teaching, and encouragement. The most striking achievement is speech, a miracle of development. Though the emergence of speech and language is responsive to good parenting, nonetheless it is subject, in its progression, to the general human pattern of innate order and timing.

Speech is but one element in the child's communication. From the beginning, communication is enhanced by other functionings and experiences which converge on it, such as vision and the other special senses, the competence of arm and hand movements, etc. However, the child himself is greater than any one sense or ability, as the experience in teaching physically handicapped children demonstrates.

Communication is indissolubly bound to the learning process. Indeed, the learning process is one indication of competence of communication. In the first two years of life, a phenomenal development of one mode of communication after another proceeds, beginning with the newborn's total receptivity and culminating in the rudiments of verbal language. In the next phase, between two and four years, words become organized into syntactical form. After language has become a rather competent tool for the child, he not only uses it interpersonally but carries on extensive audible private monologues for his own gratification. The meanings are often uniquely his own. By the

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time he enters school, social language exchange, with standardized accepted meanings, overshadows his inner language.

The Emergence of Spoken Language; the Role of the Mother

Communication progresses from the presymbolic phase in the newborn state to the symbolic mode of language and gesture in early childhood.

The Neonatal Period. In the neonatal period, the first month of life, the infant is essentially passive-receptive in communication, as in his other relatedness. He may be said to be *subject* to communication. He receives communication from his mother, predominantly through the closeness of direct body contact and also through empathy. Some inarticulable impress of her becomes incorporated during this presymbolic period in what is to be deep body-memory.

Nursing is his one focused activity. We might say that the nipple is the only "sign" that is meaningful to him in this phase of *protocommunication*.

In his first two weeks his vocalizations are not recognizably correlated with situation or stimulus. Between the second and fifth weeks, specific sounds correspond to specific discomforts and are read as signs. These first vocalizations are communications of affect and are outside of consciousness as we know it.

Early Infancy. In the next period, early infancy (two to four months), the baby becomes more active in communication, more participant both as receiver and sender. He receives his information through direct body contact, empathy, and the emergent special senses. To the newborn's receptivity he adds two modes of operation—responsiveness to the signals coming in from the outside world and the beginnings of volition in sending forth messages.

With the development of the distance receptors—in the order of smell, vision, and hearing—his apprehension of the physical and personal world about him increases in range and precision. He begins to reach out, with hand and attentive vision, to the objects and the world that he apprehends. A most important innovation begins later in this period—eye-to-eye communication between baby and mother.[11] He has begun to vocalize, with indication that he enjoys it, and to respond to the human voice—an expression of the drive to communicate. Toward the end of this period he imitates sounds.

The messages he sends early in this period still are of affect. Whole-body movement is his expressive language, the forerunner of gesture. He protests and cries with his whole body as though to thrust away what offends him, and he gurgles and expresses delight with his whole body. At the end of this period he begins to indicate his wishes by what he reaches for with his hands, by what he turns away from in avoidance.

Mother has begun to enter his dawning psyche not only as the deep introjection of the presymbolic phase but as an image which takes form cognitively, that is, in early symbolization.

For understanding her baby, mother still depends on reading the signs of voice and cry and body tone and movements. His cry is the prime sign, with its range of intonation and meaning. Parenting includes respect for the cry.

Latif[10] points out that it is the mother's responsiveness to the baby's whole-body expressive movement that helps narrow it to gesture, since his movement is read and anticipated. His response "thus becomes merely symptomatic, i.e., symbolic."[10] In the maturation of communication, gestures are among the earliest symbols understood, imitated, and exchanged by the infant.

Mid-Infancy. In the next period, mid-infancy (five to eight months), his range of vocalization and of syllabification widens. Mother re-enforces selected sounds from his vocalization which are in the range of her language, and appeals to his imitativeness in their affectionate interplay. She reads the first meanings into his syllables—da-da, ma-ma; she structures little situations to which the word is appropriate, and the learning of speech begins.

The infant gives indications of direct messages, addressed to mother—of fear or anxiety.

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He gives evidence of other meanings—recognition, command, refusal; information as information is a later achievement, whether with gesture or in words.

Late Infancy. The period of late infancy (nine to twelve months) culminates with the achievement of words. The baby's gesture of "bye-bye" is established. Between the tenth and twelfth months he responds to commands of various sorts, including pointing to parts of the body. Two words or more are reported quite uniformly at the twelfth month. Infancy, etymologically without speech, is drawing to a close.

Second Year. In the second year the vocabulary increases, and the child enters the naming stage and can identify objects pointed to in pictures. The first phrases, sentences, pronouns, and prepositions occur in the twenty-third and twenty-fourth month, the peak of achievement.[20]

Socialization of Language; Autistic Meanings

The child is next involved in the complexities of language and, soon after, in communication situations centering on verbal discourse. This encompasses the preschool period, up to about six years of age.

The child acquires considerable skill in vocabulary, syntactical form, and above all, in meaning. Both shared and private meanings settle around words (Sullivan). In later childhood, in Sullivan's view, the child's enlarging world of school and people presses on him to relinquish or submerge his private meanings. Thus the mastery of shared language meanings enters into the child's socialization and acculturation.

In *The Language and Thought of the Child*, Piaget,[22] reporting on two six-year-old children in a nursery, observed the distinction between private monologue in the presence of a person and true conversation. The first variety he designated as "egocentric," the second as "socialized."—

Egocentric language is hardly restricted to children. Certainly our verbal ruminations, whether or not voiced, are egocentric in Piaget's sense. And we all have experience with people who require the presence of another person as a backdrop for their verbal performance.—In socialized verbal communication, the child engages the other person in conversation with intended exchange. The egocentric language behavior precedes the socialized in the development of the child and is gradually supplanted by it.

Vigotsky,[29] in his discussion of childhood speech in "Thought and Speech," gave a different interpretation to Piaget's observation of "egocentric speech." His view was that egocentric speech is really private inner speech, a reverie process which is not the forerunner of socialized speech but is on another track of development and function. The speech is still audible because the child has not yet learned to be silent, to internalize speech.

We may conclude that language serves the child in several functions—as exchange in interpersonal communication, self-expression to others, and self-experience in reverie and thought. That is, the functions of childhood language are communication with the self as well as with others.

Where Mothering Can Go Astray in Communication

We have seen how the emergence of language is integrally bound to mothering. The interplay between mother and baby is essential not only to his learning but to the structuring of his personality, which depends very much on interpersonal communication. Without this interplay, the damage is overwhelming—even to life itself.

There are, of course, other destructive modifications which involve the child's communication besides its absence:

In the long period of their relatedness by direct body contact, does he receive the jarring physical impact of an unconsciously hostile, anxiously tense, or overefficient mother; or is there gentleness and tenderness in the handling of his body?

Is he empathically flooded by parental moods of depression, commotion, anxiety, and rage?

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The preverbal child reaches out for affection, for body contact, cries out in flicks of anxiety or distress. Is his mother available for nonverbal communication?

Is he given—and asked for—more massive "love" than a baby or child can take or give?

Is there a disparity, a "double take," between verbalized affection and the feeling tone which the baby and young child empathize? Perhaps the mother can neither give nor take physical responsiveness, and the disparity between her withdrawal and her affectionate verbalisms confuses the child.

In the period of language learning, is he subject to excessive pressure, by either parent, because of a high premium on performance and language precocity?

Is the emphasis on reason and logic such that the child is pressed to make up reasons—in effect, to produce rationalizations to meet his parents' queries?

Perhaps the child is not granted adequate psychologic privacy for his reverie processes and his developing relatedness to himself. Are his explorations into the physical world about him hindered?

Traumatic Experiences in Childhood Communication and Later Personality Disorder

The following are instances of disturbed communication in childhood, viewed from the adult side of the bridge.

Respecting the Cry.

Ellen S., age twenty, in psychotherapy for an acute schizophrenic episode with hallucinations and mutism, recalled mother's stated position concerning an infant's crying: "I will not have a spoiled child. No child of mine cries."

And the baby had been allowed to cry herself mute. The classical open safety pin found jabbing into the crying baby did not invalidate mother's rule; and the pediatrician who maintained that little Ellen was crying because of hunger was a sentimental weakling.

In early childhood Ellen had asthmatic attacks. Now the lack of respect for the cry of babyhood was replaced by a lack of respect for verbal self-assertiveness. In adolescence, Ellen learned what would work—a brooding silence would invite mother's prodding to find out what was troubling her. By this means, mother's controllingness was outmaneuvered into a modicum of effective communication.

"If I say something," said Ellen, "it won't be respected; only if I seem to withhold. Any wish was met with a logic about why I shouldn't have the wish; and I gradually let the logic seep in and replace the wish."

The Unavailable Parent.

Marvin G., a young engineer twenty-six years old, was incapacitated from functioning in his profession by fluctuations of rage and depression, and he was churned with open anxiety over his impulses to violence. His rage dated back to the birth of his brother when he was two years old. What for him was proof of being unloved came from his mother's seeming indifference to him, and his father's preoccupation with newspaper politics. Marvin responded with empathized depression to mother, and sometimes with rage. When he wasn't wistfully reaching to father, Marvin experienced distructive rage toward him, who communicated only with arguing and formulating.

"Mother was depressed when I was a kid, and she would sit and stare out the window and turn away and shrug her shoulders when I spoke to her or touched her. I felt mother cut contact; I was like a ship cut from moorings with no one at the tiller. I was in a depression and waiting for someone to take the tiller . . ."

Affection Through Words Instead of Body Closeness.

Anne H., thirty-two years old, came to psychotherapy following a suicidal attempt during a postpartum depression. She was extremely obsessional, in her thinking and in her household activities, and teetering on a knife-edge between anxiety and depression. She was given to long, tense, sulky silences in psychotherapy. Apropos of her "resistance" she said, "What's the use of talking? It's futile. All I got from my mother was praise, words, for giving up to my sister. Never a touch, never a hug."

In contrast to her experience of limited communication with mother was her sense of excessive

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transparence with father, a lack of psychologic privacy between them.

"We understood each other too well. He was transparent to me; there was a frightening sense of communication. He would say, 'I know, I know,' and I would feel that I had to flee."

Disharmony Between Words and Affect. Marian O., a young woman in an anguished depression following the death of her father, came to analysis with a congeries of distressing symptoms—a sense of confusion and of alienation from herself, a cynical probing for hypocrisy, a provocative teasing of authority figures, including the analyst. Her communication in analysis was baffling. She was given to verbal pyrotechnics; though her words as language were meaningful, there was a quality of unrelatedness to what she was actually experiencing at the time that, nonetheless, gave a sense of meaninglessness.

Both her parents had been talented people: mother aloof, controlling, and overintellectualized; father moody, brilliant, and divided in his numerous interests, of which his daughter was but one. In the high value put on language performance, Marian was precocious. She had always felt lonely, first from her parents and later from her less "special" schoolmates.

"I doubt if I ever communicated with anyone, if it means having the feelings and words coordinate. No one communicated at home."

The Child as "Captive Audience." Avery R., twenty-seven years old, had a learning block which had seriously interfered with his accomplishment in college in spite of high intelligence and even originality of ideas. He was inarticulate in the interaction with verbal people but expressed himself fully and maturely to those to whom he felt protective. He had difficulty in concentrating, in listening to any prolonged discourse by anyone.

"Mother doesn't want any comment. Any comment I make is an interruption."

["Even agreement?"]

"She wants agreement, but more than that she wants to prove it to herself aloud, so when she talks I don't quite listen. I daydream, I make plans, and just listen to her sometimes here and there and nod."

Should this example be captioned, "The mother with 'egocentric speech' "?

Faulty Interpersonal Communication

The Spectrum of Faulty Interpersonal Communication

The spectrum of faulty interpersonal communication covers a wide range. Its nodal stations are shown in the diagram below.

These may all be accomplished by discourse itself, or without words. Nonverbally, the means may be any of those which we have already mentioned—nonverbal symbolism, direct body contact, body-language, empathy, of affect. A communicator in the faulty interaction may or may not be aware if the process is in himself or in the other person.

Grossly Destructive Communication. This communication may be imbued with hostile intent, consciously or unconsciously, or may be inadvertently destructive without hostile intent. For instance, exposure to a person who is consumed by rage or hatred is a negative experience, even if an absent person is the target; that is, emotions which have a destructive force make an impact on the receiver even if he is only a bystander.

The message of the verbal discourse may be hostile in its literal content, as a vituperative or derogatory attack on the other's self-esteem or on his good values. The literal content may be nonhostile, but the significance may be hostile—for instance, some techniques of ridicule. Or verbal discourse may be an attack on reasoning, as some incredibly destructive kinds

Grossly destructive communication	Authoritarian communication	Disjunctive communication	Pseudo-communication	Noncommunication

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of arguing are. The hostility may address itself to distorting the relationship of symbols to reality, to introducing gross error.

The attack may be on interpersonal communication itself, by shouting down the other person to din out communication, or by silence. Silence may be a refusal to communicate or a refusal to permit communication. It may be an attempt to imbue the target person with a sense of ostracism, unworthiness, loneliness, disrelatedness, or confusion. Destructiveness with hostile intent may be conveyed by body-language (brusqueness of physical contact, a shunning avoidance), by rejection or disparagement in voice quality, or by facial expression and gesture in subtle eloquence.

Hostile communication may introduce stresses into the other person in his relationship with himself or with others as part of the direct hit of hostility. By attacking the other person's meanings, values, and significances, one reaches into him to attack his sense of self and disrupt his intrapsychic communication. Hostile communication may break up his natural rhythm, tempo, and patterns of communication.

Authoritarian Communication. The most blatant examples of authoritarian communication are the "brain washings" with police-state techniques.[15] In the authoritarian-communication situation, one person or party commandeers and controls communication so that production is exacted from the sender, without respect to his wish to participate, with heavy pressure on him to structure the verbal message in the form insisted on by those in control—not necessarily in terms of fact or truth—with repressive hostility for nonverbal responses.

Questioning, with the intensity and persistence of inquisition, is one of the destructive tools. Another is the pressure on the sender for unending production of messages which are recurrently annihilated by either oblivion or disparagement.

Communication of this kind occurs in miniature in our most prosaic experience, as exemplified by the person whose attitude is, "You are not to talk. You are to talk when I tell you to," and by attempts at thought control by authoritarian parents.

Another variety of authoritarian communication is by means of heavy formulations, in which the speaker is the overweening intellectual authority.

One patient in a frenzy of arguing and of collecting bits of information in the futile attempt to prove his father wrong to his father, had hoped, by getting into technical studies, to get away from his father's indoctrination.

"I felt that I wanted a little sphere of my own. One thing I liked about my technical studies was that I could do my own thinking, and my father couldn't."

Disjunctive Communication. In disjunctive communication the predominant purpose is confusion, disruption, or divisiveness. Either sender or receiver acts to make the communication disjointed, literally "unhooked," in the direction of breaking down communication, changing authority roles. Sometimes it is playful teasing or a skirmish of wits, employing the disjunctive techniques but without destructive intent or effect. Sometimes the apparently playful skirmishing is defensive, arising, say, from anxiety, reflecting or spiraling into a state of confusion in the communicator. Disjunctive communication, when it is defensive, really signifies, "Don't annoy me, don't ride me; let me be." It may be one of the operations of resistance during psychotherapy.

The techniques involved tend to break up the line of reasoning or the flow of language. Introducing semantic confusion is a favorite method. Another time-tested means is the question—the "irrelevant, immaterial, impertinent" question which is curbed in the law courts, the pseudo-logical, heckling questions that are rampant in quarrels.

Gestures and mannerisms—crackling of the cellophane cigarette wrapper, jangling of a charm bracelet, etc.—may be used disjunctively in psychotherapy as an expression of resistance about an oversensitive area.

Pseudocommunication is a composite of dissimulation, simulation, and limitation of communication. Communication is seemingly, but not really, going on. There may be a sense

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of "double talk," of disparity amongst the several levels of communication.

Pseudocommunication is to be differentiated from noncommunication and from phony communication. In contrast to the former, a sense of relatedness to the other person persists, although communication may be guarded and restricted. In contrast to the latter, the intent to deceive or to set up a meretricious image or message is lacking. Pseudocommunication may or may not be sincere. Of itself, it is not hostile or destructive, though it may occur in a hostile context. Indeed, in some situations pseudocommunication is a kindness.

We all engage in pseudocommunication occasionally, sometimes out of respect for another when there is neither wish nor necessity for him to get involved in our personal feelings. Some of the social forms of gesture and conversation serve in pseudocommunication.

Pseudocommunication is often defensive. For instance, an anxious person, in his initial psychoanalytic interviews, may have recourse to social chitchat before feeling ready to get to the purpose of his visit.

Noncommunication may occur in an ostensible communication situation. A communicator experiences a sense of the other's lack of relatedness, in spite of a continuing verbal exchange whose explicit content makes sense. A not-unfamiliar and often distressing experience of noncommunication is the sudden sense that the listener is absent—that the interpersonal wire has gone dead.

Noncommunication may be experienced by a straining listener, whose attention is not relieved by a message, with a feeling of the most overpowering doped drowsiness—most distressing if the listener is an analyst and the noncommunicant a reclining patient!

This is to be distinguished from resistant communication in which the communicator sets up a sense of impasse by verbal or nonverbal means. With resistant communication, there is a vivid sense that communication is being pressed back, that there is an active rejection or denial of the free flow in the exchange.

The word "resistant," of course, brings to mind the problem of resistance in psychotherapy. The usage in the present context is denotational. In the usual clinical sense, resistance concerns a wider range of communication difficulty occurring between therapist and patient and entails consideration of the following elements—each participant's personality and communication pattern, the patient's specific anxieties and their origin, and the specific operations in the communication transactions.

Personality Disorders and Communication

The Hysterias

With *Studies in Hysteria*, published in 1895, Breuer and Freud[6] made two major contributions to communication in the field of psychiatry: first, symptoms have meaning; second, communication is the therapeutic operative force in psychoanalysis. The symptomatology of hysteria was a language to be decoded and translated back into words. The translation itself, and the release of affect associated with the translation, was the therapy. As Breuer said, "The excitement which is produced by very vivid and irreconcilable ideas finds adequate reaction in verbal communication."

CONVERSION HYSTERIA

In conversion hysteria, emotional disturbances are expressed by disturbed functioning of a part of the body in terms of its body-image; that is, the disturbed functioning is expressed in a resymbolization conceptualized as to how it functions. The sufferer himself does not recognize that the body experience is linked to affect and the affect to a contextual experience. The sufferer does not recognize that the symptom is a direct expression in body-language of a full interpersonal event, relationship, and experience, presented in the form of a charade. All that seemingly remains is its somatic symbolization. The force toward repression, some profound necessity for alienation from the self as an experience, is the powerful operative impetus.

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The steps between the original experience and the clinical picture of conversion hysteria are: (1) interruption of intrapsychic communication by repression; (2) some deletion of meaning from the unfortunate affect-situation relationship; (3) a persistent somatic symbolization of the affect-situation relationship; and (4) reinterpretation and reformulation of the somatic symbolization in terms of a local illness of the body; that is, there has been a series of resymbolizations. The meaning, as experienced in the sufferer's awareness, is not consonant with all the relevant facts. In other words, the meaning in awareness is false to the reality and the significance.

The symptoms in conversion hysteria may also operate for the sufferer in interpersonal communication. They are signs which are not only observed and interpreted by the therapist but are to be read in a certain way. The symptom also bears its own intended message, by nonverbal means, by the charade. Such interpersonal messages may be reproach, accusation, an appeal for pity, forgiveness, or help—these intricate operations all going on outside of full awareness of the patient. It is likely that the sometimes hostile response of those close to persons with conversion hysteria (including the baffled physician) is due in part to resentment of the manipulated message, the operations in the other communicator also going on outside of awareness.

The conversion of an unfulfilled emotion and desire for action into a symptom whose meaning and affect-content could be returned to awareness is illustrated by the following report of a patient seen by the writer in consultation and for brief psychotherapy.

Mrs. Tessie T., aged thirty-two, was a recent arrival to this country from Poland shortly after the Nazi occupation. She was the sole survivor of her family, having leaped from a freight train with destination Buchenwald. After her escape back into life, she spent eighteen months of the Nazi occupation lying cramped under the kitchen floor of her Gentile benefactors. She would emerge in the depth of night for her bodily needs, except when it was sensed that a search was imminent.

Beginning in the last months of this period, the symptoms for which she later came for therapy declared themselves—paroxysms of severe cramping pain in the hands, transitorily relieved by slow and full squeezing together of the hand muscles. The cramping pain persisted after her liberation and emigration to the United States.

No physical basis was found for the pain, which interfered with household duties, let alone gainful employment. In addition, she had severe occipital headaches and sleep disturbed by screams of terror.

The early goal of psychotherapy was to ascertain whether there was a clear personal meaning in the hand pain. She was encouraged to make movements with her hands which would relieve the pains. In the course of this somatic expression the patient recognized that she was strangling Nazis, that she was expressing her consuming rage and visualizing the Nazis with whom she had had experience. With the affect expression and the recognition of the symbol meaning of the hand pains, the symptoms did, indeed, greatly diminish, but not the screaming nightmares.

Anxiety Hysteria

In anxiety hysteria, anxiety is projected onto an outer circumstance—an object, situation, or event—which is believed by the afflicted person to account for his distress and becomes the object of his phobia. In other words, the basis for the anxiety is resymbolized by a reinterpretation of outer reality. The new symbol serves as a rationalization for the anxiety.

Hysterical Disturbances of Consciousness and Hysterical Dream States

These conditions may be considered a replacement of the reality of here and now by another world of time and place—and perhaps person—as what has existed either in past reality or only in fantasy. This switch-over is an autistic projection, which differs from what is generally included under the rubric of schizophrenia in the following two respects—the intactness and effectiveness of the hysteric personality, and the retention of adequate verbal and ideational performance.

In the hysterical switch-over, the "as if" takes over as a well-integrated play might do.

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It is as if life were resymbolized *in toto* by the other role which is played with the consistency of another self, and which replaces another constellation of traits and operations which, in turn, seemingly form a functioning self. The patient is able to manipulate fact, meaning, truth, interpersonal relationships and his (generally her!) own self in a full, integrated role.

THE HYSTERICAL CHARACTER

The hysterical character comes close to what is considered hysterical in common parlance. This personality type is remarkable for the use of emotionality and histrionics in interpersonal communication, and for the highhanded bending of fact and truth to her own purposes and to the distortion of meaning and significance for the other person—all of this very often with verisimilitude. Sometimes the histrionics carry over into acting out—beyond drama into deeds.

These devices have high communicative intent and make a powerful impact on the appointed audience. They become a method of expressive communication more important to the person than direct verbal literal communication. The kind of language favored may have great dramatic and emotional import, though the nonverbal expression by gesture, facial expression, and behavior may be preferred. The person of hysteric character doesn't linger on logic and verbal thought and formulation, for these would slow up the full sweep of the dramatization. In these respects the person of hysterical character is qualitatively opposite to the person of obsessional character.

If one can retain one's sense of oneself in the presence of a person operating in terms of her hysterical character, one may note in oneself a lack of empathic responsiveness, though the manipulations may be surprisingly effective in the hands of an expert.

The common factor in the hysterias appears to be the resymbolization of emotional experiences containing meaning, which is potentially within awareness, into somatic form.

The sequence of inner processes basically involved in hysteria is the progression from an intolerable emotional experience, with meaning which is potentially within awareness, to resymbolization of experience and meaning into other terms: in conversion hysteria, into somatization; in anxiety hysteria, into phobic resymbolization of anxiety; in hysterical alterations of consciousness, into resymbolization of one's sense of self; in hysterical character, into resymbolized acting out in the form of a whole, different, integrated personality. All these changes generally occur to the complete mystification of the afflicted person.

Obsessional States

PHENOMENOLOGIC CHARACTERISTICS

Regardless of the differing interpretations of the genesis and psychodynamics of obsessional states, there are a number of phenomenologic characteristics that are generally agreed upon. All agree that, "the obsessional state is classically a state in which there is great activity of thought" (Sullivan). All agree that there is retreat from feeling to thinking. "The compulsion neurotic, being afraid of his emotions, is afraid of the things that arouse emotions. He flees from the macrocosm of things to the microcosm of words."[9] It is recognized that his intrapsychic communication shows an imbalance between thought, language, and feeling states. His relationship to the outer world, his perception communication with the outer world, is also disturbed. Reich recognized that the obsessional character is structured on resistance, that it is character armor. In other words, in the obsessive character, a barrier to interpersonal relatedness is also interposed; that is, a disturbance in interpersonal communication exists.

VIEW ON OBSESSIONAL STATES FROM THE STANDPOINT OF COMMUNICATION

From the point of view of communication, the obsessed person flees from direct experience of feeling states by means of manipulation of intrapsychic communication. His efforts to delete feelings from his awareness and to shun the contextual situation and interpersonal experience in which his feelings arise are an ongoing pattern of inner life. He often

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experiences this way of life as a positive value, as an ideal of the inner life, which, regrettably, he does not achieve. The various compromise formations—substitutions, displacements—are further distortions of intrapsychic communication. By attempting to alienate affects from himself, to make them foreign bodies, so to say, he succeeds only in alienating himself, in losing the sense of his emotional identity.

The alienation of the self affects interpersonal communication intricately. One by-product of the flight from having emotional experiences is very often a repudiation of awareness of emotion and mood experiences of others, indeed, a flight from empathy, a denial of the emotional reality of others. Some of the symbolic private rituals of the obsessional state are an expression of the tremendous effort to control and redirect intrapsychic communication, to correct an unacceptable self-image. In the classic example of mysophobia, the washing is as though to achieve, by physical cleanliness, the subjective lost moral cleanliness, or rather, to undo the moral or sexual "uncleanliness."

The tendency of the obsessive person to construct systems of thought by which he thinks he lives, and which he often tries to enforce on others, is not infrequently associated with distortion of fact. This high premium on the person's own system of thinking and his imposition of it on others is reminiscent, in miniature, of paranoid thinking and system making.

In the obsessive character (Reich) the personality is organized to ward off the free emotional ideational flow with other people and within himself, an insulation which threatens his aliveness of spirit. For obsessive persons, the obsessional substitutions, says Sullivan, "are simply all-encompassing attenuations of contact which protect them from their abnormal vulnerability to anxiety."

The expressive communication of obsessional people—of verbal language, voice quality, gesture and movement, of the affect accompanying speech—is often experienced by the listener as dry and brittle, as though only the steel structure of thought remained. This communication profile is present to some degree in most obsessional people. Sometimes the affect of anxiety, irritation, anger, or impatience seeps through this steel structure; sometimes its only evidence is change in verbal pace, that is, an intensification of the defense against affect. Sometimes the principal sign is increased tensility and increased rigidity in the person and his communication.

An obsessive person has a predilection for the symbolism of logic rather than for the symbolism of sense imagery, to verbal fantasy rather than to imagery fantasy. "He intellectualizes," we say. Often the logic contains the little distortions of reasoning which are so frequent and banal that we are dulled to them and take them as common sense. They often are plausible rather than true and sound. The mesh of rationalization is often so firm and finely knit that it, surprisingly, often passes for genuine thought. The rationalization is actually comparable to a very mild delusional system, with a faulty frame of reference.

The patient does not get relief from airing his reasoning comparable to what is achieved in the ventilation of emotion. Indeed, this differentiates abreaction from emotionally toned obsessive reiteration.

He often lacks the language and the respect for affect. He does not necessarily lack affect, though his range of affect is often greatly restricted. He may say, "I felt bad" and not be able to be more descriptive.

The obsessive person tends to undercut a wave of feeling by taking brisk action. One patient who recognized this in himself, said, "I often plunge into decisions so fast I don't have a chance to experience what I feel."

Sometimes the narrowing of experience involves not only affect, affect language, but also sense perception. Several patients blanked out sight and hearing when confronted by the call for affect.

Often, the dreams lose richness of meaning, imagery, and affect; the dramatic quality diminishes. Instead, dreams are brittle, fairly prosaic statements in which the manifest content and latent content are surprisingly close. The reduction in imagery, particularly in the dream-life, is part of the denial of the autistic side of communication, with which the obsessive person often feels he dare not or cannot deal.

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It is not surprising that these people characteristically have great difficulty in psychoanalysis in genuine free association, based on emotion and subjective experience, and, instead, ramble on more in word associations. Sometimes the interview is prestructured. One compulsive patient, who had extreme difficulty in speaking in analysis without directive cues from the analyst, put it, "I try to prepare before I come. I feel as though I am taking an oral exam and I am not prepared for it."

The difficulty in intrapsychic communication, the overvaluation of the symbolism of logic, the paucity of imagery and affect, and the high premium set on illusory accuracy are experienced by the person as an emptiness and as anxiety about verbal communication. One patient said, "As if, if I don't have words, I have nothing." Indeed, the anxiety about achieving verbal communication is characteristic of obsessional people. "Conversation," said one patient, "is like waving a flag; it's my way of saying 'I am at ease.'" These disturbances may be so intense that the person experiences a sense of dissocation, a sense of cutoff within the self and from others. This cutoff differs from the usual schizophrenic dissocation by not seeming irrational or illogical to others and by not having autistic content either to his or the other's awareness.

Schizophrenic States

Schizophrenia is a montage of disturbed communication. Not only is communication seriously damaged in every direction—intrapsychic, perceptual, and interpersonal—and in its various modes, but its pattern varies with the different phases of schizophrenia. Indeed, the communication patterns give each of the phases its character.

The gap between the afflicted person and the professional people working with him is further increased by our tendency to understand communication predominantly in the mode of discursive logic. The patient's responsiveness to therapy depends more often on the therapist's reaching the patient than on the patient's ability to move toward us.

Dissociation, autism, symbolism of imagery and myth, discursive logic, nonverbal communication including body-language, and verbal language patterns are all of basic concern in the communication problems of and with schizophrenic patients.

COMMUNICATION ASPECTS OF AUTISM, ESPECIALLY IN SCHIZOPHRENIA

It was on the basis of autism that Bleuler, in his classical study, *Dementia Praecox or the Group of Schizophrenias*,[4] separated schizophrenia as a syndrome from other major psychiatric disorder patterns. Autism, said Bleuler, is the term applied to the "detachment from reality, together with the relative and absolute predominance of the inner life," which characterizes schizophrenia. He also made mention of autistic processes in normal experience.

One's autistic experience includes the store of private meanings, reveries, emotions, and formulations of experience which are difficult to communicate interpersonally. When one is absorbed in autistic processes, the communication with the outside world is diminished. To help us understand the inner world of the schizophrenic person and to remind us of the gradations between the well and the sick, Sullivan, in "The Language of Schizophrenia,"[16] described subtleties of process that are in every person's range of autistic experience. He emphasized not only the reverie processes but the experiential quality that prevails in infancy and very early childhood, and also the emergence of language with its autistic and socialized verbal meanings. He pointed out that when we mute the world about us by means of preoccupation, sleep, or fatigue, we submerge into the autistic mode.

There are, however, a number of respects in which the normal experience differs from the schizophrenic. We can, with a sense of freedom of choice, resume our usual communication with the world about us, which the schizophrenic person cannot do. The message coming from the autistic experience, when it is not processed for outside comprehension, generally is not directly interpersonal, nor is it so intended; an additional inner operation is necessary to translate the autistic into a comprehensible form, which the openly schizophrenic person cannot perform. We all must

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work out a balance between our autistic life and relatedness to the outside world, which, also, the openly schizophrenic person is not able to do.

The autistic life of the schizophrenic person contains characteristic experiences in communication which are experienced both intrapersonally and *as if* interpersonally. Some of these are "thoughts-out-loud" and hallucinatory experiences, affective experiences which are outside the experience in the subjective state we consider normal, difficulty in finding symbols and language for strange affective and ideational experiences, and breakdown in the competence of language and thought built up in the person's lifetime of maturation.

"Thoughts-out-loud" is the term that Jonathan Lang, a student of psychology who himself had experienced schizophrenia, suggested in his paper[17] for "hallucinoid, minimal automatic, sub-vocal speech."

These thoughts-out-loud are often experienced as coming from another authority, such as the Divine Being.[5] We may say that the authority of the self has weakened; the organizing activity of the psyche has become ineffectual. These thoughts-out-loud are reminiscent of inner language, a pattern of integrating thought and of communication with the self, which is characteristic of early childhood, but in the schizophrenic break in organization is experienced as "coming to him."[5] This overwhelming immersion in verbal communication with the self obliterates verbal communication with others.

In the calm-appearing autistic state, affective experiences nonetheless are going on, contrary to what often is the impression of the onlooker. Lang noted that he placed a high affective value on the experience of ideation as such (we might call it an erotization of thought), and that his affects were appropriate to the "hallucinary thoughts-out-loud."

In the agitated autistic state, the affective experiences—euphoria, terror, religious ecstasy, martyrdom, messianic benevolence—are outside of our ordinary experience. The universe is experienced with a sense of vast significance, of meanings not yet understood. To meet the mystery of the universe, the patient "tries to decipher the code by which one can communicate with the friendly forces without giving oneself away to the unfriendly. This code is sought in supposedly significant gestures."[5]

The hallucinatory experiences the schizophrenic person is undergoing are dissociative, fragmented communication within himself which so often he does not recognize as being his own productions. They are *as if* they were interpersonal. Characteristically, there is an unequal balance of power between the communication of the hallucinated others and himself; they shout him down, expressing their power by their insistent control of communication with him.

The "Change-Over" to Open Schizophrenia

The major dissociation which ushers in the autistic state of open schizophrenia is an assault on basic communication within the person and in his relatedness to the outer world. We might designate this transitional phase the change-over. It has a quality which is different from that in the established autistic state.

The person who has just made the change-over into open schizophrenia is beset by communication disorder. He has great difficulty remaining in active reciprocal communication with people and with life going on about him; his perceptions of the material outer world may be disturbed, and his perceptions pertaining to his own body and affective states sometimes are disturbed but sometimes are indicative of a disturbed state which is being reported accurately. The change in relatedness to the meanings and the significance of the cosmos has already been mentioned. Time and space are experienced differently from our usual mode. The change-over is a manifestation of disrupted intrapsychic communication, a weakened central authority of the self, a failure of the organizing function of the psyche.

In the panic state the patient is often aware of and distressed by the slipping away of reasoning and the collapse of communication and relatedness. He may make desperate efforts at holding onto the self and communication, such as phoning to distant persons across the country. A patient, Martha John, in the throes of

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her change-over, phoned the writer during the night and, in a penetrating whisper, said, "I have forgotten something. You know the secret I have forgotten." Patients in this panic may clutch and cling physically to a trusted person. This alienation from the self is often projected onto others. It is they who become unreal. This changed experience of people, the fragmenting of the self, and their projection externally account for some elements of symbolization in schizophrenia. Martha John, during the change-over, ran around shrieking: "The walls are falling; the walls are made of paper."

The patient may engage in symbolic acting out. The affects and what they mean to the patient may be performed symbolically as charades, as a kind of pun in action, which Martha John did in throwing things out of her bureau drawers. "I must put my house in order," she cried out.

Symbolic expression may be in the form of ritualistic and mysterious gestures, symbolic of magical wishes and efforts at control, whether of a hostile universe, or demonic beings, or evocative of benign power. These differ from the obsessional person's rituals, actions, or gestures, which take a far more prosaic and sensible-seeming pattern. The obsessional person is not as clearly aware of what the magical meaning is, which, indeed, may be present in his subconscious if the obsessional state is an overlay on schizophrenia.

The schizophrenic person experiences the symbolic meaning of his gestures in full emotionality. He may be able to verbalize what the symbolism is (if he still communicates verbally) but not the basic emotional necessity beneath the symbolized frame of reference.

General Statement of Communication in Schizophrenia

Though communication is intricately disrupted, disproportionate, and confused in the schizophrenic state, the afflicted person is active and involved in the universe of communication. The writer believes that, however deteriorated or regressed the schizophrenic patient may be, and however extreme his withdrawal, there emanates from him a sense of inner activity. This communication activity is, of course, not immediately interpersonal, not related to the ongoing world, but rather is self-contained in the autistic state, in which fantasied communication prevails, communication as an "as if." The exception may be when depression complicates the illness, for in depression the inner experience is that the drive to communicate has been eradicated.

The messages, verbal and nonverbal, may be incomprehensible to their receiver and to the sender; they may be intended to be incomprehensible, whether consciously or unconsciously. The messages may be intended to be understood but may fail of comprehension, either because they are garbled or because the receiver does not tune in on them. They range from utter confusion, to skillful distortion, to exquisite subtlety, perceptiveness, and accuracy.

The messages may be in verbal language, either predominantly in the form of logic or in the form of imagery. They may be in code words, by gesture in deliberately significant form, or in postures, attitudes, and movements that are unconsciously revealing. They may be assuming a role and acting the part. They may be in writing, speech having been given up, or by means of objects selected and arranged to convey significance. The nonverbal messages may be emanations of mood, apprehended empathically.

Schizophrenic persons may, particularly in the panic state, long for relatedness and a sense of being in communication with people. They also are afraid of having their psychologic privacy invaded and of being the recipients of enforced communication. This is particularly intense with the admixture of paranoid symptoms in the acute phase when patients express their fear, in delusional form, of being controlled by nonverbal, remote communication. It is a paradoxical polarity that the paranoid schizophrenic persons themselves attempt to manipulate and control communication by nonverbal "magical" means.

Before turning to the patterns of communication in the classic four phases of schizophrenia, let us consider how the individual modes of communication are affected in this most intricate disorder of communication. Since the relatedness to the world of reality is

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based on percepts, we will first discuss their functioning in schizophrenia.

Perceptual Experience in Schizophrenia

A percept, in the language of communication theory, is a "bit" of "information" entering the "receiving wires" (the sensory tracts) connecting the "central switchboard" to the outer world or the somatic inner world. In the more psychologic phraseology of communication, a percept is the first integration of sensation with "meaning" and pertains to some phase of material reality. Arieti[1] speaks of an additional element, the affective component of percepts. A percept is moment-to-moment self-reporting. Whether conscious or not, it has an influence on consciousness and is influenced by it.

Evidence of how another person perceives is not arrived at simply, for what we are granted, generally, is either a statement or behavior indicating a percept; that is, there is reporting and/or observing and interpreting. Obviously, verbal communication and symbolization pertaining to the percept introduce variables in our inferences about another's perceptual experience. These are among the factors that have made it difficult to ascertain whether what we infer as a percept in a schizophrenic person is true or false, whether it is a fault in the "receiving wire" or the "central switchboard."

The range of perceptual functioning in schizophrenia sweeps from the exquisitely accurate to an apparent absence. Perception may be sensitive and accurate even in the midst of delusional and hallucinatory activity. Twenty-three-year-old Millie was consistently clear in differentiating between her distortional experience and the evidence of her five senses. She said, "I know every sound in this house. I know the click of every door."

This accuracy of perception occasionally was resymbolized into distortion, and the steps of the distortion were clear. For instance, hearing the phone bell from another room, and judging, from the respondent, who the distant speaker might be, she would "imagine" their conversation and hear it vividly, apparently as "thoughts-out-loud," but she could distinguish between the actually heard and the vividly imagined. Sometimes her sense of the speakers as personalities enabled her to approximate the theme of the unheard conversation. Whether or not her inference was accurate, she was insistent and accusatory, imposing her frame of communication on the speakers and their conversation. This is an indication that the "feather-sensitive perceptiveness" of the paranoid schizophrenic person has something to do with focused selective attention, and there is evidence also that there is an accompanying selective inattention.

Sometimes the reporting of the percept is accurate, but the percept bears a faulty relationship to its stimulus; the person recognizes that the percept cannot be true, and the experience is delusional, that is, judgment and remembered experience are corrective. With intensification of the disruptive forces, judgment dwindles and the delusional orientation takes over.

For instance, Raymond, a young man with recurrent schizoaffective elations and paranoid trends, tested himself for improvement early in one episode by noting his percepts on looking at photographs in a pictorial magazine. Sometimes the faces wavered out of the page, coming alive and mocking him with their eyes, and he recognized that he was still sick; when they subsided into the page and became inert again, he "knew" he was better. In the height of his elation he did not challenge his erroneous percepts and delusional inferences.

Szalita[28] cites the experience of her patient who was aware that the wavering of the design on the ceiling in the therapist's office was a faulty percept and that his seeing it as an aggressive witch was his emotional response to the percept.

The percept and its report may be accurate but may pertain to a phenomenon outside our usual awareness. A communication difficulty arises when we interpret the patient's report as symbolic or metaphoric when, actually, it is a literal description. For instance, Millie would down inordinate amounts of soft drinks to assuage a "bitter feeling." We discovered that this behavior accompanied rage, which was close to her awareness and of which she

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experienced only an actual taste—dry, raw, and bitter—which was fluctuant during the day. On the other hand, the bizarre but accurate percept of a disturbed body state may be symbolized delusionally, as in the hypochondriacal pregnancy delusions of schizophrenia.

The perceptual experience may be a vividly remembered image percept, reactivated with hallucinatory force and significance. On some occasions of intense persecutory anxiety, Millie smelled stale blood, which, she claimed, harked back to her childhood when she came upon her mother lying on the floor with her wrists cut and bleeding. Sometimes a percept which was accurate to outer reality was integrated into Millie's prevailing mood. In terms of outer reality, she was overreacting, but not in terms of the feeling state. One day, entering an unfamiliar room, Millie stopped short and gasped; her glimpse of flimsy curtains hung on a precarious rod had given her a "shaky feeling." She then recalled her nightmare of the previous night—of walking precariously on a wooden bridge that was collapsing ahead of her. Thus the percept of the outer object was fitted into her inner life.

Similar to this experience of percept and affect is the inaccurate percept which is used not in its function as an indicator of reality but to support a projected affect or symbolization which has been pressing intrapsychically. This disparity has been studied by Beck in Rorschach tests of schizophrenic patients and interpreted by him as a misconstruction, a misapprehension, of the true forms of the stimulus.[2]

The imperfection of percepts may be a manifestation of the shrinkage of the power of the self, of the ego, so that the entire universe of things, becomes disproportionately powerful, while the reality of people fades. This disruption of percept, meaning, and experience throws the person back to childhood competence of perceiving, to the era before he had integrated his percepts with meaning and before he had learned corrective experiences for normal sensory shortcomings (such as occur in optical illusions). An example of such a defusion of percept and meaning is given by Sechehaye[24] in the following subjective experience of Renée's: "I noticed a complete loss of the sense of perspective. I sketched like a child. I got lost easily and could not orient myself spatially."

Some perceptual impairment in schizophrenic persons may be due to a shift in focal awareness, perhaps from being absorbed in hallucinatory projections. The patient may repudiate all conscious experience and cut off his perception relatedness to the point of submerging himself in catatonic sleep or stupor. In patients in the terminal phase of schizophrenia, Arieti has reported perceptual loss as the extreme outpost of defect, which he considers psychic agnosia characteristic of the regression.

From this general survey, it is clear that the perceptual states of schizophrenic persons are varied and variable. Some are not alien to "normal" experience, although infrequent or unnoted; others are bizarre but accurately communicated; still others are symbolized delusionally; and, finally, the most fundamental relatedness to outer reality may be damaged.

THOUGHT IN SCHIZOPHRENIA

The integrated functioning of both language and thought is disrupted in schizophrenia. Typically, neither language nor thought functions in the closely knit organized form with which we are familiar in our competent, mature intellection.

Since language is one easy indicator of how reasoning is proceeding, a discussion of reasoning involves a discussion of the correlated language. (To repeat a word of caution, language patterns do not entirely or accurately reveal the progression of reasoning. The operation of finding words for a felt logic or a felt reasoning is not the same and coextensive with the reasoning itself, as is shown in experience with inarticulateness, extreme fatigue, and expressive aphasia.)

One of the disturbances in thinking is the breakdown in discursive logical thinking; that is, thinking is not governed by the laws that are intrinsic for either things or the movement of ideas, and often it is not purposive and consistent with its own premises.

Arieti accounts for the disturbance in logical

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thinking as a regression to a less advanced level of mental integration, earlier phylogenetically and ontogenetically, in which other patterns of thinking and logic are characteristic. This pattern he designates as "paleologic," in contrast to the later and more advanced pattern of thinking which is in terms of Aristotelian logic. In the latter, he states:

> . . . only identical subjects are identified. . . . In paleologic thinking, on the other hand, the predicates lead to the identification. Since the predicates of the same subject may be extremely numerous and one does not know which one will be chosen by the patient in the process of identification, this type of thought becomes bizarre, unpredictable, individualistic and often incomprehensible.
>
> The inability to abstract the common quality leads to the identification of the two subjects.[1]

Arieti's hypothesis might apply to the following: A young woman, in an agitated panic state transitional to open schizophrenia, was persuaded to eat a cupcake. The word caught her fancy, and she perseverated on it, removing the cake from its fluted paper container and putting a cup into the paper as though it were a saucer.

The principle of paleologic is an accurate and illuminating description of the pattern of reasoning. Whether it is fully explanatory of the psychologic operations involved requires further study.

Typically, thinking in schizophrenia is not in the service of reality testing but becomes subservient to emotion and motivation, and this is one reason for its false logic and distortion of purpose. A seeming exception occurs in the paranoid style of logic, which uses reality and the forms of our logic in the service of the person's irrational, emotionally determined objectives, much as Captain Ahab used his ship and crew in his monomaniacal pursuit of Moby Dick. The perversion of the goal to which the logic and reality are put is, in a long-range sense, a failure of reality testing.

Verbal Language in Schizophrenia

Though one thinks of verbal language in its consensual, interpersonal sense, one root of language lies embedded in thought and in the competence of related skills of intellection. Its disruption in schizophrenia reflects damage to both intrapsychic communication and interpersonal relatedness.

Many schizophrenic persons, before their illness, have been particularly centered on verbal language, skilled in its use, sensitive to words and their nuances of meaning. Schizophrenic children, before the full-blown clinical illness has declared itself, often have been precocious in language, with a preoccupation and overinvestment in it. So the breakdown of language functioning in open schizophrenia is all the more striking.

In the autistic state, language may be fixated at any station from unformed phonemal utterances to well-phrased, recognizable thought and fantasy. It may be in the form of neologisms, of word-salads, or of expressions that are prophetically intoned and oracular in import. The psyche may be brought so low that the person experiences an inability to think in words, to form words. He may have an elaborate rationalization as to why he must not use words.

In the *Autobiography of a Schizophrenic Girl*,[24] Renée describes how far below the threshold of consensual language she found herself. She recalls her utterance, signifying, "Raité, Raité, was habe ich gemacht?" which, she says, was "sorrowing in my own 'language,' in the meaningless, recurring syllables, 'icthion, gao, itivare, gibastown, ovede' and the like. . . . Sunk beyond language, beyond thought, I reflected no more on the murder of Abel." It is also noteworthy that she had been absorbed in a timeless mythic theme, the murder of Abel, which symbolized an unrevealed personal theme.

The defusing of percepts and meanings often goes on to attack the innermost meanings of language. The mesh of meanings and words that has grown up around things as part of maturation and experience becomes a torn fabric. In Renée's experience: "When . . . I looked at a chair or a jug, I thought not of their use or function—a jug not as something to hold water or milk, a chair not as something to sit in—but as having lost their names, their functions and meanings; they became

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'things' and began to take on life, and exist."

This experience is strikingly the reverse of Helen Keller's in learning "water," the sound, for "water," the phenomenon.

An illuminating report of subjective experiences of the excited schizophrenic which involves language and meaning is given by Boisen:[5]

> Seeming incoherence is apt to be due to the very quickening of the mental life, to the tendency to accept as valid all the ideas that come surging in, and to the difficulty of keeping pace with the thoughts. In such states meaning outstrips symbol. Not only does the excited schizophrenic have to find new words to express the new ideas which throng in upon him, ideas for which the conventional language is inadequate, but he has no longer any language of which he is sure.

We may hypothesize that one psychodynamic for neologism and word-salad is this unstable and altered relationship between experience, meaning, and symbolization. Into the making of neologisms also enters the inability to follow a thought through; sometimes playfulness and teasing enter into the invention of new words, to bewilder the listener.

The schizophrenic person may use language in the patterns of the obsessive person, with literally meaningful verbal content and with meticulous syntax. Most strikingly, however, his language is highly metaphoric, overcharged with significance and with the private meanings which normally we submerge.

BODY-LANGUAGE IN SCHIZOPHRENIA

Body-language in schizophrenia functions in three dimensions: the signs by which we read the schizophrenic person and which are not necessarily linked with his communicative intent; the use of nonverbal body-language as his means of purposive communication; the experience of body percepts.

The signs are strikingly and highly characteristic in the varied clinical picture of schizophrenia. Posture, stance, movement, muscle tension, and facial expression give a wide range of information of the patient's inner state of emotion and of communication, including the following: his emotional attitudes, such as rage, anxiety, beatitude; the age at which he is experiencing or fantasizing himself; often the thought-content he is symbolizing; the degree of withdrawnness from the environment in autism or in catatonic stupor; his inner communication with hallucinated figures; and the change-over to stereotyping of gesture and facial expression from spontaneous expressive movements.

The symptom of stereotyping of gesture, facial expression, and utterance is particularly interesting as having a communicative quality in forme fruste, as being symbolic and expressive, though what the message is may be lost to the patient and mystifying to the onlooker. It has been suggested[9] that the stereotyped gestures are indications of emotion which is no longer intended for communication, remnants of intended communication, or substitutes for emotion. The stereotyping generally does not evoke in us the responsiveness that we experience to gestures which are in the full service of communication, partly because the meaning is not clear, partly because the communicative charge has been reduced. This diminished responsiveness of ours contributes to our sense of the uncanny in the patient and to our alienation from him, which is one of our obstacles in communicating with him.

That catatonic stupor has meaning to the patient on a high symbolic level is suggested by the experience with Millie, who had made several suicidal attempts and who, on several occasions, retreated into catatonic "sleep" for eighteen hours at a stretch. On her emergence from this state, she revealed that she had been almost overwhelmed by rage at the therapist (and on previous occasions at the mother) and by the urge to destroy herself. "Isn't it better to sleep for eighteen hours than to kill myself?"

Turning from the signs by which we read and occasionally understand the schizophrenic patient and which are not of communicative intent, we find a wide range of expressive activity which the patient does intend communicatively. The schizophrenic patient may express some of his longings for closeness by means of direct body-language. One young man in his late twenties, hospitalized for

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chronic schizophrenia some ten years, who was restricted to stereotyped verbal expressions, in several interviews with the writer moved his chair closer and closer until he was almost in direct physical contact. A patient in open panic may cling to someone as to a solid object in a storm. Sometimes the longing for closeness, sometimes the gamut of emotion from love to destructive rage, expresses itself in sexual behavior and intercourse.

The schizophrenic patient often uses gestures after giving up the use of words. His use of gesture, however, lacks the equivalence to word language, the clarity of meaning and the appeal to consensual experience, which, for instance, characterize the art of pantomime or the efforts of a foreigner to express meaning for which he lacks language. For the schizophrenic patient, the expressive function is impaired in both words and the wordlike use of gesture.

His gestures have true symbolic value, sometimes indicated by the annoyance, pleasure, or refutation he may express in his communication with the figures in his hallucinated world. His gestures may have specific meanings, as in an instance, reported by a colleague, of a schizophrenic girl who exposed herself to the therapist in what appeared to be a homosexual invitation.

Frieda Fromm-Reichmann communicated with schizophrenic patients by means of entering into a gesture interplay with them, expressing herself symbolically to the patient and experiencing a sense that mutual recognition and progression of exchanged meanings had occurred.

Other Varieties of Nonverbal Communication in Schizophrenia

Another variety of nonverbal communication that schizophrenic patients sometimes engage in, and which occasionally occurs in our general experience as well, is the use of objects solely to convey meaning symbolically. Millie gave the writer several gifts of little wishing wells that she had constructed. Raymond, in the course of a schizoaffective elation, came "visiting" the therapist with a little suitcase containing, among nondescript articles such as underwear, a length of rope suggesting a noose, which he took out, laughing, and saying, "Don't worry, this is not for suicide."

Some actions are highly symbolic though not necessarily transformed into ritual and stereotyping. Martha John kept throwing things out of her bureau drawers because, "I must put my house in order," in the context of referring to her personal life.

Some of the interpersonal actions and behavior have intended symbolic significance reminiscent of the communication by hysterical characters. This mode of communication, which may or may not replace verbal language as acting out, is particularly characteristic of the patients designated by Hoch and his associates as pseudoneurotic schizophrenics.

The schizophrenic patient's withdrawal into silence and inactivity may be the necessary condition for productive intrapsychic communication. David Rioch refers to a patient who, in the course of psychotherapy, retreated into silence and took to bed for several days—but was not catatonic—and, on emergence, reported that he had worked out one of his "problems."

Empathic Communication and Schizophrenia

Though his competence as sender and receiver of consensual communication, particularly verbal, is limited, the schizophrenic patient nonetheless is often extremely sensitive to affects, emotions, and personality qualities in those about him, as evidenced by later accurate reference to subtle events and experiences.

He experiences and reverberates to the moods of those about him—the anxiety, acceptance, rejection, resentment; he experiences vividly possessiveness, withdrawal, and manipulativeness. He senses the other person's genuine strength or his simulation of strength. He is sensitive and often surprisingly aware of the communication situation between him and others, especially with the therapist. He is particularly alert to the other person's pseudo comunication, clichés, or disproportionate reassurances.

Though we are all more subject to other people's moods than we acknowledge, the

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schizophrenic patient is generally as exposed to other psyches as a baby is, in the same diffuse, vulnerable way. This kind of sensitivity characterized a mute patient who wrote in her nightly letter, "You were so sad yesterday," after the therapist had been reflective and in doubt about the course of treatment. The alert, active, paranoid schizophrenic patient not only empathizes moods but picks up discernible subtle signs of behavior that he then weaves into his distortion.

In the other direction, *from* the schizophrenic person, particularly when he is quite absorbed in the autistic state, may emanate a powerful and uncanny mood, an effluvium of such frightening affects as anxiety, despair, rage, open panic, apathy, and unfilled longings for affection and sex, which are disquieting and often anxiety-evoking to others. Though direct verbal communication with the person in the autistic state may be seemingly unrewarding to one's efforts, he may be extraordinarily available to nonverbal empathic communication from the therapist—as Frieda Fromm-Reichmann has taught us—and, indeed, to the affect accompaniment of verbal communication.

Communication Patterns in the Four Classic Patterns of Schizophrenia

The four classic varieties of schizophrenic reaction are characterized by four basic communication patterns by which the schizophrenic person establishes a new, though sick, equilibrium. The new equilibrium serves to give him structure, to give him a mode of being, relating, and functioning. Whether these are earlier modes phylogenetically that once were normal but were discarded in our evolution, as suggested by Arieti, or whether these modes are intrinsically pathologic is a moot question.

The patterns of disturbed interpersonal communication in the classical categories of schizophrenia appear to the writer to be intensifications of faulty communication with which we all have experience in miniature. The large correlations of the classical clinical patterns and the patterns of communication transaction follow.

Catatonic State. In the catatonic state, not only is there absence of action but an almost total severance of communication to and from the outside world. Generally, verbal communication is given up, and the remaining communication is empathic and in body-language. There is some evidence of ongoing intrapsychic activity, as in Millie's coping with her acute destructive impulses in the "sleep."

Paranoid State. In paranoid schizophrenia, communication, whether in the symbolism of discursive logic or of imagery, is distorted. In some cases the person not only distorts communication but also imposes authoritarian control over communication and insists on formulating it in his own terms. Verbal communication may function competently as language but not as thought.

Verbal communication may be renounced, and dependence may be placed on autistically significant signs which are intended to be communicative but, since they are not consensually validated, are not communicative. A related phenomenon is the patient's conviction of his own power of nonverbal communication:

Carl, an artist in his early forties, in the change-over period of a paranoid schizophrenic episode, visited a friend who had been emergently hospitalized in a catatonic excitement and with whose wife Carl had been intimate. He gave the friend a special handclasp, reporting, "I wanted to show him I was mad, too. I know he got the message through my hand."

The person with paranoid schizophrenia is often afraid of having has thoughts read or influenced: Ellen, who was almost entirely mute and hallucinated and attended to "whispers" from behind closed doors, had a period of what amounted to sleep reversal. She wrote to the therapist, "I can hear people think during the day and that interferes with my thinking. I think better when they are asleep."

The paranoid schizophrenic patient may use code words portentously and mystically as references to an esoteric religion. Sechehaye's patient spoke of "The System"; Staveren's of "The Line." Both these patients gave every indication of longing to communicate with their therapists.

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Hebephrenic Reaction. In the hebephrenic reaction of detachment and "silliness," the person has set up delicate but drastic disjunctive operations in pseudocommunication, verbal language fragments, gesture, and expressive utterance.

The hebephrenic patient introduces what may be considered psychologic and verbal "noise," which serves to keep out messages from "normal" people. Sullivan has pointed out, however, that hebephrenic patients, habituated to each other on a ward, set up a tolerance for each other's presence.

Simple Schizophrenia. In simple schizophrenia, communication is very much reduced and constricted. It appears to the writer as being more uniform than in the other classic patterns, and involves the verbal mode, gesture, and expression of feeling state. The writer has experienced patients with simple schizophrenia as children who are to be seen but not heard.

Though considerable attention has been devoted to verbal language disorders in schizophrenia, in this incomplete discussion of communication we may close with Frieda Fromm-Reichmann's warning against the "over-estimation of the significance of understanding the contents of schizophrenic communication. . . . With the schizophrenic, unqualified thriftiness in content interpretation is indicated even more than with other patients. . . . The schizophrenic needs help in understanding the genetics and dynamics of his communications, not their content."[13]

The Depressive States

The present clinical categories of depression, with which a number of writers have expressed dissatisfaction, can be accounted for on the basis of two phenomenal elements which do provide consistency: (1) the mood experience and (2) the patterns of communication. The various personality defenses against depression modify the patterns of communication, which, while they deviate from the core experience, yet retain a central relatedness to it. The subjective experience of the depressive mood is the motif of all the depression pictures and is as central for considering depression as autism is for schizophrenia.

General Statement of Communication in Depression

To take full-blown retardation as the paradigm of depression, communication is massively impaired, with shrinkage and diminished activity in all dimensions. Imagery stops, the flow of ideas becomes slowed, emotion flattens. There is little giving or receiving of communication. Seemingly, the impulse to communicate is lost.

Retardation depression is the polar opposite to schizophrenia in respect to the quality of communication, and is opposite to the manic state in respect to the intensity of the drive to communicate with the outside world and people.

Instead of the typically exaggerated and sick activity of the autistic side of the personality in the schizophrenic person, autistic activity in retardation depression is seemingly diminished, with the exception of the final disruption of personality.

The favored symbolic mode in schizophrenia is imagery; on the whole (with exceptions in agitated depression), the symbolic mode in which the person with depression communicates interpersonally is logic. However, he often experiences imagery characteristic for depression but which he refrains from communicating to others. Instead of the schizophrenic person's involvement with communication, faulty and disturbed though it is, the person with depression experiences a diminished impulse toward communication and despairs of attaining it, though he longs for it. The person with the extreme of retardation depression is reduced to a vegetative deteriorating state, far more shrunken in communication on every level than is the patient with terminal schizophrenia.

The Relatedness to the Self and Subjective Experience

In the writer's clinical experience with the nineteen patients with psychotic and psychoneurotic depressions who form the basis of this study, some suggestive trends in their communication patterns emerge, despite differences in sex, age, occupation, associated symptomatology, and the specific syndromes of the

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depressions.* None of these patients was stuporous or completely out of touch at the time of his experience with therapy. However, when retarded, their verbal and empathic communication was seriously impaired and was a trial to patient and therapist alike. The following reports of subjective states were obtained after efforts to outmaneuver oppressive silences, and may cast light on the experiences and processes which progress to maximal severity among hospital cases.

Depressed persons, when encouraged to describe what they are experiencing, voice their awareness of themselves in imagery which is characteristic of depression.

The subjective experience often is one of being insubstantial to the point of being hollowed out. Mrs. Anne H. recalled her experience as she was slipping into a psychotic postpartum depression after a period of obsessionalism and agitation: "I almost believed that if the bathroom had life, my being there would make no impression on it, except as a ghost-like mass of flesh."

Mr. John J., whose depression was complicated by alcoholism, said, "Sometimes I feel I had just skirted a circle just out of my reach. It's almost a physical sense. . . . I feel hollow, like a crust of information."

This subjective sense corresponds to what we may interpret as an attenuation of the ego. It is also experienced as a sense of being out of relatedness, of alienation from the self and from others, of loneliness. The interference with intrapsychic communication is paralleled by a sense of noncomunication with others. This is illustrated in the following description by Mrs. Paula M., a very effective businesswoman whose long-standing depression had been kept well in hand until her early forties, when she made a serious suicidal attempt with barbiturates and required hospitalization: "I feel alone. In a room with people—yet I have a feeling like hanging over a crevasse, a deep ravine, and if only someone could touch me—but having their hands all over me would not make me feel it. I could still be alone."

We are prone to take the statements of the depressed person about feeling empty, not as the self-perception, which the above examples demonstrate, but only as self-derogation (which indeed is often added to the experience) and even as valid self-appraisal.

The depressed person is particularly afraid to experience emotions: Generally, the fear is of experiencing resentment and anger, but often it concerns pleasure, liking, and happiness as well. Though this self-distrust is not limited to depressed persons, it is they who have come close to deleting the experience totally.

Mr. John J. said, "I don't like to experience resentment. It is too unpleasant, because it's like a crime. . . . I felt anger, then limpness [at his father's interfering letter]. Oh what's the use. . . . It's a kind of detachment. Maybe that is why I feel empty so often."

Miss Ruth T., with depressions on and off for twenty years, had come to psycho-

* These nineteen patients with depressions consist of nine men and ten women, ranging in age from sixteen to fifty-five years. They were in therapy with the writer from six months to seven years, except one patient with whom there was no direct contact but whose therapist was supervised for three years. The occupations ranged from unemployed to school, household, business, various professions, and creative writing. Eight patients had been in psychotherapy for the same condition previously; these attempts at cure numbered as many as six.

Fourteen patients suffered from psychoneurotic depressions, five from psychotic depressions; there were no reactive depressions.

Three patients had been hospitalized for depression of psychotic intensity with serious suicidal attempts and had received electroshock. Two of these patients were involutional, the other postpartum. They came to the writer for psychotherapy immediately on discharge from the hospital, still retarded, with suicidal thoughts or fantasies but without any active impulses.

One patient had been hospitalized for recurrent hypomanic episodes which were immediately followed by depression. He began therapy with the writer when he was in a depression. His elated states were characterized by bizarre and delusional content, and the diagnosis shifted from the original one of manic-depressive psychosis to schizoaffective disorder.

One patient, who refused hospitalization and who had strong suicidal drives, had manic-depressive swings with agitation when depressed, with homosexuality, and alcoholic tendences. His condition suggested the diagnosis of schizoaffective disorder of psychotic intensity.

Two patients with psychoneurotic retardation depression were alcoholic, one moderately and the other severely.

One patient had psychoneurotic manic-depressive swings.

The depressions occurred in various personality types. A number of the patients with psychoneurotic depression had harbored suicidal preoccupations.

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therapy at the recommendation of her physician, because of increasingly severe headaches and muscle pains which, she feared, were due to trichinosis. In the course of therapy she was often silent and resistant. Concerning her reluctance to experience and to speak of feelings she said: "Feelings? feelings? I've been trying to unlearn feelings. If I had permitted feelings, I would have blown up with rage and frustration and I wouldn't get anything. . . . I don't want to go around crying. I have no words to describe it. . . . Never expect anything and you will never be disappointed. You might be pleasantly surprised."

The relatedness to the self in the interpersonal situation, even in psychotherapy, is revealed in the words of Mrs. Betsy P.: "How can I oppose something as frail as a feeling against what you say? My feeling has no validity against what you suggest for my good."

This dread of experiencing and communicating feeling has also been reported by O. Spurgeon English.[8] "'To live,'" said one of his patients, "'is like opening all my pores on a cold day and subjecting myself to exposure.'"

The person with retardation depression often suffers from diminution of reverie processes. He may be afraid of indulging in fantasy, or embarrassed to admit even to himself that he does. Miss Ellen C. said: "I want to get into the importance of fantasy all my life and the need to keep it hidden all my life. It's quite important to keep it hidden. . . . What occurs to me in thinking of the fantasies, the word 'ersatz' comes to me. . . . Now you see some of the curse is taken off ersatz." Her fantasies consisted of images of happier home life, of release from the illness and poverty that bedeviled the family.

Mr. John J. remembers being dreamy as a child, looking beyond horizons, and that he was shamed out of daydreaming by reproof.

Sometimes the person with retardation depression experiences the loss of imagery very regretfully, particularly people who have placed a high value on imagination and fantasy, such as creative writers. The remaining imagery tends to be restricted to patterns which are quite typical of depression. This will be considered in the next section.

At the most intense retardation the person no longer has the subjective experience that he might or might not choose to indulge in fantasy; imagery, fantasy, even dreaming, are attenuated almost to the vanishing point as conscious experience. Whether these processes are occurring in the depths of unconscious experience is still a matter of conjecture.

Mr. De L. said he had been encouraged to start psychotherapy because he was beginning to dream again and was hopeful that he had something to work with.

In contrast to the schizophrenic patient who erotizes thought and who experiences some emotions and fantasies in the never-never land of his autism, the depressed person does not achieve even fantasied fulfillment and becomes inarticulate not only to others but to himself.

Perceptual Experience in Depression

The perceptual experience in retardation depression, though significantly different from the schizophrenic experience, is more damaged than is generally realized, and we are as prone to misinterpret the one as the other.

In retardation depression, perception, which is seemingly accurate, is restricted, the meaning component is reduced, the affective component is bleached out. Zubin[32] notes the clarity and accuracy of language and of observation in retarded depression and suggests that the retardation itself helps in the accuracy. However, the precision and accuracy are at a high cost and dependent on severe limitations.

The depressed person often experiences the world with a sense of remoteness and clarity. He has a sense of physical distance and of being cut off which is not spatial but as though there were an invisible, alienating screen. Mrs. Anne H., for instance, described the onset of the retardation after a period of agitation, "Everything became dulled, toned down, the radio voices remote, everything hushed."

In contrast to the sense of the hush following the onset of depression, Zubin reported instances of the converse—depression ensuing on the sudden loss of hearing.

Pure culture depression unaccompanied by other malignant trends has been observed in per-

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sons who are suddenly deprived of their hearing by war-injuries or other accidents. The sudden removal of the background noises which give the normal hearing a continuous feeling of being alive brings about sadness and grief and a feeling of the *world being dead* [italics mine] even in individuals who were otherwise apparently not prone to depression.[32]

Such experiences suggest that there is a deep, reciprocal relationship between loss of perceptual awareness of the world and depression, perhaps depending on the cutoff in the sense of relatedness to the world.

The perception experience, that the world lacks substance, indeed that the world lacks people, is so frequent in depression as to be characteristic. Mr. Martin R., returning from a holiday in Europe to his workaday world in New York City, suffered an accentuation of his long-standing psychoneurotic depression. He described the grayness of the experience, a sense of "huge buildings, devoid of people."

Not only are sounds reduced, particularly the sounds meaningful of man's presence and functioning, but the awareness of people is reduced, both as physical objects in space and as personalities.

This is strikingly illustrated by the case of Mr. Robert S., with depression of many years' standing, sometimes with suicidal impulses, who also complained of difficulties in his highly skilled and demanding work situation as executive. Though he voiced his depressive ruminations freely, there was a paucity of description of any people in his contemporary life at home and at work. Interestingly, his Rorschach responses were completely devoid of human figures, another example of the simple subtractive defect of perception in retarded depression.

The restriction of the field of perception also involves subjective physical percepts, indicative of a changed relationship to the body. This disturbance is seldom voiced spontaneously. For instance, Mr. Martin R., sitting vis-à-vis the therapist, hand grasping ankle, was silent, depressed, and seemingly resistant. He was encouraged to describe his experience of the moment in terms of his mood and of his body. He said, "I have the sense that I am composed only of my left finger tips and the anklebone on which my fingers run. My mind is a blank."

Mr. Harry U., who was motivated for psychotherapy partly because of difficulties in establishing intimate relationships, in addition to his long-standing depression, complained of a cottony taste, and recalled his depression at about the age of eight, as "the dreary cottony feeling in which I am lost and wandering about." As this young man's condition improved, he took singing lessons (a good commentary on his efforts to regain communication) and noted, "I felt fine; enjoyed standing, enjoyed the way the soprano was hitting a high note, went 'zoom' with her. Gee, it was wonderful."

So far the examples have been those of simple subtraction of perception. Occasionally, however, the percept is faulty, perhaps a distortion of experience, perhaps a faulty interpretation. Mrs. Betsy P., prone to agitation rather than to simple retardation, would experience her arms as being so heavy and inflated they could swoon away, the same feeling as in a faint and delirium that she recalled from her preadolescent depression.

The perception defect in depression often bears a relationship to the drive to repress, to manipulate awareness, that is, to what is after all a voluntary tampering with communication.

Mrs. Anne H. said, "[I had] a lifelong tendency toward voluntarily making my muscles rigid to achieve relief, sometimes pleasure, and sometimes an avoidance of pain."

Miss Ruth T. reported on one occasion the interplay between mood, repression, body experience, and perception "I have two moods. I feel cheerful and with tension, and also sad and impatient with myself. This resistance I would like to get rid of. I can feel tension in my shoulders, arms, back of neck and my legs. My legs are twisted around the chair."

In the privacy of her home when she felt this way, she had come to accept her mood of depression and would allow herself to weep. "After a time I say to myself, 'Well, you can't spend the rest of your life weeping' and I

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snap out of it; I blank out. Then I find it hard to concentrate on reading. Sometimes I get up in front of the mirror and square my shoulders and say 'Buck up!'" to which the therapist commented, "Maybe squaring your shoulders has something to do with the pain in your neck and shoulders."

Sometimes, with the restriction of perception of the outer world and of the world of emotion, what remains in awareness is the perception of inner somatic experience. Mrs. Anne H. recalled the efforts to cut herself off from outer reality in her childhood depression: "I really was more conscious of my bodily discomfort than of what went on around me. . . . Then, as often before and afterwards, it was as if standing still and trying to cut off perception of outside stimuli, I could 'hear' more clearly what was going on inside of my body . . . (like rumbling in my stomach, or the beating of my heart)."

Such perceptions of visceral experience reverse our usual experience, in which outer perceptions dominate over the inner ones. The predominantly visceral experience, when verbalized, suggests hypochondriasis to the therapist. Indeed, sometimes the depressed person resymbolizes the experience and himself interprets it hypochondriacally or delusionally. The patient who experiences "heavyheartedness" or the difficulty in breathing frequent in depression, coupled with his sense of a nihilistic universe, often becomes anxious about heart disease and seeks medical help in terms of that self-diagnosis and not for the depression.

It is quite significant that, with the lifting of the depression, the restriction of perception is also removed. Mr. Charles J., a novelist suffering from depression and a "writing block," noted with delight the return of sensory clarity and perceptivity: "Everything smells better and clearer and more interesting. I walked through the streets sniffing odors."

Symbols and Imagery in Retarded Depression

Symbolization in retarded depression bears significant contrast to the schizophrenic pattern. The symbolization of the universe, for instance, is destructive, but openly so and impersonally. There are no mysterious forces that play baffling, promising, threatening games. There may be an austere, waiting, depriving deity. In agitated depression the hostility of the universe is a vivid and central experience. Miss Ellen C's symbolization, which she referred back to the span between age five and thirteen years, was, "I felt God must be very angry, just like my father. . . . A very powerful punishing Person and you really couldn't get away with anything."

Even in the meanings projected onto the universe, there is the tendency to reduction to the monolithic, in contrast to the heightening, multiplication, and varicgation of meanings in schizophrenia.

The images that come to mind in depression often symbolize the depression itself—the barrenness of life, emptiness, loneliness. The depression may be symbolized by a concrete image or in imagery capturing the mood. Mrs. Anne H. had a recurrent visual image: "The Great Stone Face—I see a wind howling through this dead face."

The image may be symbolized in a figure in a dream. Miss Ellen C. dreamed of being taken to a house called "the Maw." Her association was that "in the Maw" signifies the maw of depression.

Sometimes lines of poetry are cherished by the depressed person as speaking for his mood. Mr. John J. said, "My favorite image is from 'The Mauve Decade,' 'The children struggle briefly and languish in the cool tide of rectitude.'"

Imagery may be projected onto the physical world, as an altered perception of the physical world and may be a projection of the barrenness of the inner life, of the retardation itself. This has already been discussed in the section on the perceptual experience in depression.

The depression may be symbolized in terms of holidays of special significance to the group or society and to which the depressed person adds his more personal intensification; for instance Yom Kippur, the Day of Atonement, with its solemnity, its reminder of sin and reform, its recall of death of near ones, the

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cessation of busyness, arouses echoes in depression. The major high holidays, such as Christmas, symbolizing warmth and family closeness, intensify the sense of loneliness for many depressed patients.

Summer vacations, with the dream of being free-roving, of finding new friendships, are often experienced with intensification of loneliness if the person has difficulty in making quick vacation relationships. Sometimes when the vacation is over, without significant change in the person's life, the depression intensifies.

The image may be a projection of the sense of dirtiness, of being refuse, of being "crapped upon." Sometimes the symbolization is in terms of the person himself, how he symbolizes himself; sometimes the symbolization is in terms of the surroundings, or even of a significant person.

Edith D., a seventeen-year-old girl with a depression of moderate intensity precipitated by a catatonic episode in her nineteen-year-old sister, said to the writer, "I feel such garbage. I'm nothing. How can a seventeen-year-old girl have anything worthwhile to say to you?"

Miss Ellen C. often dreamed of toilets overflowing with feces; she often felt she had been "crapped upon."

To the writer's observation, the period during which such imagery may be revealed is associated with a drabness in the patient's appearance as well as in spirit, the skin tone dingy beyond simple pallor, the hair and eyes lackluster, the stance dejected. With improvement, the skin tone and hue improve, and the imagery of refuse is replaced by the imagery of food, aliveness, and growth.

The symbols in depression tend to be concrete—concrete in terms of things, both in actuality and as imagery. For instance, Mrs. Grace P. dreams of a purse. In dreams, the auto has been a surprisingly frequent symbol—its power and mobility are the refutation in wish fulfillment of the lack of power and the staticness of depression. Of course, this generalization does not exclude other significances.

Those prone to retarded depression have difficulty in accepting the validity of intangible symbols. In psychotherapy, these persons have great difficulty in working with dreams. For example, Mrs. Betsy F., a writer on scientific subjects who was interested in developing her capacity for writing fiction, said, "I still have trouble in accepting that something is a symbol for something else. It seems too tenuous to apply. When I tell a dream I hear my father sneering at it, 'How can anyone say anything about anybody from dream content?' "

Or, dreams have a monotonous quality. Mr. De L. had a recurrent dream of wandering through a deserted house, one after another of empty rooms.

The dream quality may be highly imaginative and with considerable movement, indicative of destruction, particularly if any tendency to agitation is present. Mr. John J. several times dreamed of wandering among dangerous rocks on a stormy coast.

Occasionally, a dream expresses the dread that communication is impossible, and that the dreamer is helpless. Mrs. Paula M. dreamed that her mouth was sewn together and that she was struggling to talk. She awoke and found herself testing her mouth. She commented, "In the dream I could hear voices, but I couldn't make myself heard and made only sounds."

With the stirrings evoked in psychotherapy, the patient often experiences not only a sense that dreaming is activated but also more favorable imagery.

With the lifting of the depression, imagery returns. Indeed, in the writer's experience one of the heralding symbols is the symbol of rebirth in nature, of growth of trees, new leaves.

Mr. Harry U., as his mood of depression gave way to zest in living, in going about and meeting people, said, "Trees are soft, green, round. Trees when you lie under them and look up at the sky are especially nice. They always move a little and generally there are little clouds—and green, of course. The green of trees is always very soft."

THOUGHT IN RETARDED DEPRESSION

The functioning of both language and thought is disturbed in retarded depression. Since the language style is quite prosaic and

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familiar to us, the alteration demands little attention. However, the alterations are serious in deep depression, and anxiety-provoking or discouraging to the afflicted person in masked depressions.

The change is more complicated than the slowing and deletion of thought which is part of the staticism of depression. Freedom and flexibility of thought diminish, though with masked depression the person may be effective as far as the world can see. He may be aware of these difficulties in thinking before they are discernible to others, and may experience a loss of spontaneity. The loss, first subjectively, then objectively, affects originality of thinking, nuances of thought, richness of association of ideas—a very unhappy loss for individuals who place a high premium on intellectual activity. Achievement in the face of this difficulty, which occasionally occurs, is at the cost of unbelievable effort and mental labor.

Mr. Tom K., talented and experienced in his field, complained in the course of a fairly intense depression with fluctuations between agitation and retardation, "I have difficulty in assembling ideas. I have a detached feeling about work. First I have an idea strike me and then I feel I couldn't possibly do anything with this without reading on this and on that. And it ends up with forgetting the idea and I can't see how I got to make the point. I can't concentrate and I can't follow an idea through." Actually, his professional accomplishment was considerable at this very time, though he got no sense of its reality.

The subjective or the overt retardation of thought contributes to the self-doubt of depressed persons, which may be part of their self-image outlasting the clinical manifestations of the depression. Such experiences are often voiced, "I am stupid," which is taken to mean simply self-disparagment, but it is more than that, or rather, it starts as a frightened self-awareness of sluggishness and restriction of thinking.

Partly by accentuation from the diminution of imagery and partly from the person's loss of sense of self, thought, in retarded depression, emerges in remarkably logical form, though the reasoning is not sound in itself. Indeed, thought and discourse may be cast in a form about as impersonal as a Euclidean proposition. The logic, however, is inappropriate to the communication situation, to warmth of interpersonal relationships, to subjective experience of emotion. This logical style is often used defensively, or out of a feeling of inadequacy, and impedes communication.

Thought and the defensively used logic in retarded depression are defective not only quantitatively but qualitatively in that they are used nihilistically, as part of the rationalization to support the status quo of depression. The patient will set out to prove with the heavy artillery of his reasoning why he is doomed to fail, why nothing is of any use, particularly psychotherapy. He will set out to prove why it is fated that he die soon, backing his thesis with, perhaps, references to heredity for conditions in which, at most, its role is conjectural.

Dr. E., on learning of his father's cerebral thrombosis, anticipated vascular damage for himself, probably coronary thrombosis. "After all," he said, "I'm forty, I breathe more heavily. My father was a robust man. I have been very robust myself."

This kind of reasoning invokes large, impersonal, and generally immeasurable forces, and suggests an equivalence to the depressed person's characteristic relatedness to the universe as implacably destructive. His tendency to build the case against himself—whether in terms of personal worth, intelligence, or hopelessness of therapy—tends to convince the therapist of the validity of his charges. Unfortunately, both therapist and patient often become victims of this negative rationalization, which increases the difficulty for the therapist to be effective in treatment.

Another reason the depressed person leans so heavily on logical form for his inner life is his need for structure as a subtle kind of supportive exoskeleton. Since feeling and emotion are not trusted and understood, formal reasoning carries the greater weight.

Miss Ellen C., in pressing the therapist for "help," recognized that she was pressing for structure, for explanation and formulation that she could add to her stock. She said, "I am puzzled at the way you work. . . . You must

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have method. You must have a method, a philosophy. . . . I need structure." She recalled the importance to her of two college professors and said, "I got a sense of structuring knowledge that somehow helped in an inner kind of structure. . . . I am getting some structuring from you."

VERBAL COMMUNICATION IN THE DEPRESSIONS

Among the important considerations in verbal communication in the depressions are: (1) the subjective experience associated with the performance of verbal communication in itself; (2) verbal communication in terms of language style and syntax, the favored mode of symbolism, and content; (3) relatedness and responsiveness in terms of the communication situation; and (4) articulation.

These aspects reflect accurately the different clinical pictures of the several depression syndromes. Except for the subjective experience, they are directly observable and provide the observer with signs of the patient's state. Articulation, strictly speaking, is a specialized form of body-language, but it lends itself to discussion with verbal communication.

In the classical retardation, the voice is heavy, inert, of narrow range in pitch, monotonous, and hesitant. The language style tends to be unremarkable and of good syntax, though perhaps in sentence fragments and limited in variety. The content is restricted and unimaginative. Responsiveness is slow, but, on the whole, appropriate to the communication situation.

In agitated depression, the voice may be rasping and low-pitched, but articulation is brisk and fairly rapid, tense, with considerable range of pitch. The ideational content reflects the kind of agitation; it may be prosaic or sweepingly nihilistic, fantastic, or accusatory. Responsiveness may be quick and pertinent, or the current of speech may carry the patient away from genuine contact with his auditor.

In the hypomanic state, typically, articulation is vigorous, sometimes with self-aware eloquence. Voice and verbal content are diversified, with the familiar flight of ideas, which seem to be quite well related to the communication situation, especially at the beginning of the response, and then depart from the other communicator. (For a worth-while study, see Ref. 21.)

In addition to the subjective experiences of retardation of thought, the depressed person is distressed by difficulties involving words, articulation, and availability for communication. For example, Mr. Harry U. said, "When I get depressed, the words become like bricks loosened from the wall and tumbling down."

Miss Ellen C. often complained of feeling inarticulate, though the only discernible difficulty was an occasional hemming and hawing.

Often, indeed, as with thought, the competence recognizable by external standards is far greater than what the person experiences subjectively. He may experience a sense of being cut off in his verbal responsiveness though, to his awareness, he is making every effort to find words and to articulate. Dr. E. talked of feeling in a "peculiar state of vacuo. . . . I had the feeling I couldn't hear if another person spoke."

Sometimes the person cuts off out of a refusal to receive messages which he experiences fairly close to awareness. His concern is that they enter his mind and push his thoughts around. Miss Ruth T. observed that when someone speaks to her she hears him but holds the idea in abeyance to see if she wants to receive the idea, and meanwhile she keeps on thinking her own thoughts. She noted that she slows up verbalizing, first her own and then the other person's, as a way of controlling the situation.

Although the depressed person often speaks in finalistic formulations, he distrusts any one else who does. Mr. Harry U. would cease hearing the therapist as soon as abstracting statements were made, or statements that to him suggested the "shoulds" and "oughts" of proper behavior. Mr. John J. referred to his wife's "literalness."

Sometimes, out of his past difficult communication situations, the depressed person evolves his language style to serve his need for guardedness—though at a cost. Mr. Harry U. felt that if he made laconic, impersonal, noncommittal statements he could not be shouted down, but that people could only differ with him.

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Often the feeling of being cut off in communication is extremely disturbing, and were it not associated with making syntactical sense, the quality of intense anxiety would suggest schizophrenia. Mrs. Betsy F. described her experience in arguing, which she was prone to when agitated: "I had a feeling it began in my head first with the words while I was talking, and the words were spinning around and then words came in from the outside, upside down and swirling. . . . I felt the tears and I couldn't get my breath. . . ."

The depressed person often anticipates a lack of understanding when he speaks in terms of emotion or imagination. Dr. E. would say, "I don't expect that you know what I mean."

The depressed person may lack the vocabulary to express emotion, which contributes to the discontinuity between his emotion experience and his verbal expression. Dorothy, a young woman with depression and moderate alcoholism, said, "What I feel on the inside and what I say on the outside have nothing to do with each other."

This discontinuity between subjective experience, particularly of emotion, and verbalization makes verbal communication between the depressed patient and the therapist difficult and discouraging.[3]

Many of the statements the depressed person makes have the form of a logical tautology, formulation sentences. "Well, that's how it was," Mrs. Paula M. would say with finality, immediately after making a flat statement about herself.

Miss Ruth T. often cast her statements in the following pattern: "I want to talk about what we talked about last time. I think that's a good thing to talk about."

This particular style of language lends itself to being used defensively. It is not intended for the thought to move forward or for emotion to be entered in any depth. Often, these formulatory sentences are intended to silence the other person, particularly if he is asking questions.

The depressed patient tends to rely on stereotyped, fairly conventional expressions, clichés, and formulas, more heavily than is usual and in interesting contrast to the neologisms of the schizophrenic patient. The expressions may be steretoypes of his own oft-repeated statements, an epigram gone stale, masking the fact that freshness of feeling and of thinking is missing. For instance, Mr. John J. regularly referred to his wife, with the same mannerism of seeking words and in the same words, as "a baby-face with the soul of a barracuda," without fuller description. These stereotypes may serve as props in verbal communication, as cover for the retardation of thought and language and for the reluctance to experience affects and emotions.

Sometimes patterns of social forms are relied on not only to conceal the person's lack of fresh thinking but as a safe style of discourse. Dorothy, for instance, was given to verbal social formulas which obscured all her communications, both interpersonally and in the analytic situation. She had long ago discovered that they formed a safe way of relating to her younger sister.

Body-language in Retarded Depression

The signs of retardation depression are the familiar ones of restricted movement, dejection, and the quality of physical slump. Many depressed patients attempt to mask the depression, to convey a sense of competence or good spirits, by means of "bucking up" in an exaggeration of "good posture," with increase of the inspiratory chest position.

Gesticulation is generally reduced, but, though it is restricted, it may be used with emphasis. The facial expression may be rigid—perhaps noncommittal, perhaps amiable. With a profundity of depression, the facial tone may be slack. The look of alertness and the sense of relatedness to the milieu are attenuated. Actual alertness and awareness of the changing physical surroundings may be quite keen in a moderate retardation depression. By and large, symbolic communication through gesture and other body-language is diminished. The longing for closeness is expressed by physical moves.

Occasionally the patient does intend someone significant, such as the therapist, to become aware of his depression, of how sick he is, how helpless he is, how impoverished for affection he is, by permitting his dejection and depression to become obvious, perhaps with underscoring. Several of the depressed patients

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in the writer's experience, for some little while, would communicate with sad glances to convey what they feared words would not.

The patient often is afraid of accepting the warmth he longs for; often he is afraid to give physical affection. To a marked degree, several young mothers who were depressed—and even after the clinical depression had lifted—were threatened by the need of their young children for cuddling and tenderness.

Mrs. Betsy F. experienced her robust and longed-for baby as a drain on her, not only for nursing, but for his clinging to her in the first months of his life. She felt threatened by any appeals for tenderness.

O. Spurgeon English noted that his patient with depression "did not want to nurse her child because she did not want to be touched."

There often is a discontinuity between body closeness and the emotional experience in sex. Mr. Harry U. said, "When I have intercourse there is a male in this having intercourse. But it is a personless person. It is practically not I. It is somebody who isn't paid attention to."

The depressed person sometimes feels lost if he does not have the expressive movements of the other person to fixate on, to orient toward. Mr. Martin R. said to the therapist, "That I can't look at you means I can't get inspiration from you—watching your reactions. That is why I always try to pace myself to the person I am addressing and it is like I would be entirely in a void, completely on my own—there is no road map—large open fields without any direction. It's sort of lonely."

Empathic Communication in Retarded Depression

Seemingly, the depressed person is deficient in empathic communication. In contrast to the schizophrenic person, he is not perceptive of nuances in the nonverbal communication of others. There is some indication that this reduction is complex, depending on the retardation of perception, a lack of relatedness as receiver, and a lack of drive as sender. This deficiency of empathy makes psychotherapy difficult in its own right and is burdensome to many therapists.[3] Though the sense of an empathic exchange is diminished in therapy with depressed patients, they are distressed by noncommunication, by involved syntactical constructs, and by dejection or depression. This suggests that some empathic experience is nonetheless going on.

A Note on the Manic State and on Agitated Depression

The manic patient, state Lewis and Piotrowski, "absorbs the world around him passionately," whereas the hyperactive schizophrenic "more or less ignores the world." The manic patient, however, despite his verbal flow, does not relate to others as receiver of their communication, and he tends to impose his verbal communication on others. In these respects his interpersonal communication is faulty. Nor does he subject his thinking or language to the scrutiny of judgment—a defect in relatedness to himself.

In agitated depression the person is absorbed in a nihilistic preoccupation which cuts him off from free relatedness to the world, other people, and himself. Whether or not his verbal production is accelerated, it is hardly a free exchange with others; the symbolism, whether expressed in subjective or projected terms, is nihilistic.

In both the manic phase and agitation, empathic exchange is diminished, perhaps even more than in simple retardation.

Acknowledgment to the depressed patient with moderate retardation that some of his difficulty involves communication often makes him more available for communication. Exploring his communication difficulties often also mobilizes relevant experiences from his past. Coping explicitly with his communication difficulties reduces both the patient's and the therapist's sense of helplessness and unproductivity.

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CHAPTER 47

STUTTERING

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STUTTERING, AS A SYMPTOM, may be defined as a disturbance in the smooth flow of speech owing to tonic and clonic spasms involving the functions of respiration, phonation, and articulation. Tics and spasms near to or remote from the speech mechanism are frequently associated.

The term "stuttering" is commonly used to describe repetitious speech, and "stammering" to describe hesitant speech. The two are often used interchangeably, but, according to the derivation, stuttering stands for labored, difficult, hesitant speech with resultant defective conversation; stammering refers to defects of articulation and should never be confused with stuttering. Stammering depends on performance; stuttering depends on emotional disturbances.

Stuttering is a highly complex syndrome. It has a multiple etiology, combining morphogenic, chemogenic, neurogenic, psychogenic, and socioenvironmental factors, and has often, and properly, been called the disorder of many theories. Specialists in practically every field of medical research and treatment, seeking to cope with this problem according to their individual findings, have but added to the complexity and confusion. Only by approaching the problem from a dynamic and holistic point of view, with emphasis on the total organism involved, can we hope to understand its nature. To be effective, this approach must concern itself with the affliction less as a speech disturbance and more as a manifestation of the feelings, attitudes, and responses implicit in the crucial speaking situation.

¶ Theories Concerning Genesis of Stuttering

As a speech defect, stuttering has been recognized as a problem from time immemorial. That it has a history dating back at least to ancient Egypt, we know from certain symbols said to have been found in the hieroglyphics. It is mentioned in the Bible and by ancient philosophers. Moses is reputed to have been a stutterer. Aristotle, Aesop, Demosthenes, Virgil, Erasmus, Charles Lamb, and in our time, Sir Winston Churchill, King George VI, Somerset Maugham, Gary Moore—all have been so afflicted.

The genesis of stuttering was originally as-

sumed to be physical. Hippocrates held that it was due to a "dryness of the tongue"; Aristotle laid it to too thick and hard a tongue; Francis Lord Bacon attributed its cause to coldness and moisture of the tongue. Physicians used to reason that, since a stutter is a disorder of speech, it must, of necessity, be caused by some abnormality in the speech tract. Santorini, the Italian anatomist, believed that two holes of abnormal size located in the middle region of the palate was the causative factor. Morgagni, regarded as the founder of pathological anatomy, rejected this theory and inclined toward the belief that the hyoid bone was the most likely cause. The idea that the tongue was the basis for defective speech was so firmly fixed that, by the middle of the nineteenth century, European surgeons were rivaling each other in being the first to improve on operative techniques. In 1841, nearly two hundred cases in France alone submitted to the operation. At the end of the year, a cry of warning went up, and those who had tried the experiment had the courage to admit themselves in error. Present-day organicists differ from those of earlier times as to what *is* the causative factor; today, the organicity is related to the complicated neurophysical aspects of the entire speech tract.

Some researchers attribute psychological factors to the *modus operandi*. The modern theories of stuttering are too numerous to cite in any one particular chapter, and the following are just a few of the more predominant psychological evaluations.

1. Blanton[11] believes that psychological factors are the primary causes of stuttering, and the fear states of the stutterer prevent the cortex from exerting control over the organs used in speech. The cause lies in the emotional conscious and unconscious mind of the stutterer. Stuttering is the symptom of the emotional difficulty, and the physical symptoms can be explained neurologically.

2. Coriat[12] applies Freudian principles to the psychoanalytic theory of stuttering:

> Stammering is a psychoneurosis caused by the persistence into later life of early pregenital oral nursing, oral sadistic and anal sadistic components. The term "pregenital" refers to the organization of the sexual life of the child during the early infantile period before the genital zone has assumed a dominating role. In cases of stammering, these various pregenital tendencies can be definitely observed when attempts are made to speak, and they also appear in characteristic oral nursing and oral cannibalistic dreams, showing that the stammerer has not overcome these pregenital impulses in the course of adult development.

3. Greene[16] places the individual who demonstrates stuttering speech in what he terms the "stutter-type group." The individuals in this group are characterized by a basic tendency toward excitability and disorganization, an exaggerated capacity for response to stimuli, and a relatively high potentiality for the spread of emotional tension. Their mental and physical activities are continually being disturbed or inhibited because of uncontrolled reactions. This disturbance is manifested by arrhythmia or hesitancy, not only in speech but in many other forms of psychomotor activity.

4. Froeschels[13] calls stuttering "dissociative aphasia." He believes that there is a disturbance of the thought processes, a deficiency in word finding and sentence formation and, later on, an interference between the ideas which the patient wants to utter and ideas of existing difficulties. At the onset the causes are largely physiological in nature (because about 80 per cent of children pass through a short period of syllable-repeating), but, as time passes, psychological reactions develop which may be considered a form of psychoneurosis. Froeschels finds considerable evidence that the affliction is linked up with subconscious volition, the will to stutter.

5. Karlin[21] believes that stuttering is basically due to a delay or a slower progress of myelinization of the cortical association areas concerned with speed.

6. Solomon[24] uses a sociopsychobiological approach: "Stuttering, as a clinical syndrome, is a specifically conditioned personality, emotive behavior, and speech disorder in the struggle for integration and equilibrium during social speaking."

Attempts to arrive at the genesis of stuttering through physical examinations, laboratory and

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biochemical studies, and psychological testing have not proved specific. Neurological examination in the average stutterer reveals no evidence of peripheral neuromuscular involvement or of any pathological disturbances of the speech organism. Electroencephalography has also been proved to be nonspecific for any stutterlike pattern. It has merely shown that the stutterer is characteristically an awkward, tense individual, suggesting deficiencies in motor integration. More than often this incoordination appears to be related to emotional disturbances rather than the resultant of any correlated cortical disturbances.

The question of organ or symptom choice in stuttering is a most difficult one to answer. It is my feeling that it arises primarily from a combination of organic and psychological factors occurring at approximately the same time. These factors or disturbances are: (1) the suggestion of the presence of constitutional factors which predispose the stutterer to emotional imbalance in general and to motor and speech disorganization, and (2) the added stress placed upon this organic instability by parental and cultural restrictions, prohibitions, and taboos specifically related to the areas of speaking and self-expression.

¶ Facts and Characteristics Concerning Stuttering

Some of the common facts and characteristics that have been determined in regard to stuttering are as follows:

1. The incidence of stuttering amounts to about 1,300,000 in this country alone, 15,000,000 in the world. It has been placed at about 1 per cent of the general population, roughly half of whom are children. Stuttering has no respect for social or economic status, religion, race, or intelligence.

2. The question of sex distribution in stutterers remains as yet in a controversial state; males are from four to eight times as frequently affected as females.

3. Though there are no hereditary facts found in stuttering, we do know that there is a familial tendency. Stuttering does appear in families with some history of stuttering more often than in those of nonstutterers.

Despite the lack of any strong evidence pertaining to the inherent causative factors in stuttering, there is some suggestion of the presence of constitutional factors which predispose an individual to emotional imbalance in general and to stuttering speech in particular. There also appears to be some predisposition in people who stutter to an original motor disorganization, since stuttering children are observed to be more awkward and less adept at acquiring motor skills than is the so-called normal child. This observation has been corroborated in a study made by Berry[10] of the developmental history of 500 stuttering children as compared with 500 normal children. She found that the children who stuttered were definitely retarded in acquiring motor skills. They were retarded in learning to walk, when compared with the nonstuttering children, and "also showed a serious retardation both in the initiation of speech and in the development of intelligible speech."

4. The question of handedness in stuttering has also been one of considerable controversy. Its premise was originated by Orton.[23] Briefly, it postulates the presence of a speech center in each cerebral hemisphere, one of which centers is the dominant one. Either owing to a lack of development or as a result of the reversal of the handedness (the center of which is closely linked with that of speech), the dominance in the one speech center is lost. Then the two centers have the same influence, resulting in hesitating speech.

5. Other characteristics noted include relatively high incidence in twins and in family history of twins, relatively high incidence of sinistrality and ambidexterity, and slowness in speech development.

6. Relating to the actual content of the stuttering itself, we find that 10 per cent of words are stuttered, that stuttering lasts usually less than two seconds, and that repetition of initial sounds, prolongation of initial sounds, or exaggerated hesitancy to speak are common. Also, in this same context, there are associated parakinetic reactions such as eye closure, nostril dilation, and slight breathing abnormalities.

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7. Finally, stuttering is found to be reduced in repetitive reading, reading in chorus, and in singing.

Though so much has been concluded in regard to stuttering, it still remains a perplexing problem. One of the chief reasons for this confusion is the revealing fact that no two stutterers are alike in make-up or development. Where research is sorely needed, and may aid to clarify and shed more light onto this clouded issue of stuttering, is in the study of personality development.

¶ Psychodynamic Patterns in Stuttering

Any workable hypothesis concerning the understanding of the nature of stuttering must take into account the organism as a whole. So-called symptoms of neurosis are not essential constituents, but they develop as an outgrowth of the neurotic character structure and can be understood only on that basis. Stuttering is to be considered as an expression of anxiety, which results when the protective structure of the organism in a neurotic process becomes threatened and disorganized. Goldstein[14] refers to this as the organismic approach. He states that not all deviations of behavior are directly related to the underlying defect, but some are the expressions of protective mechanisms which the organism utilizes against the disastrous consequence of the defect.

To better understand the nature of stuttering, one should make an attempt to understand the neurotic trends in the individual stutterer's character structure, with its particular functions and consequences to his personality and way of life. Emphasis should be directed less on the symptom of stuttering, much more on the underlying forces which drive the patient to stutter, and, finally, on the feelings, attitudes, and responses in the crucial "speaking situation."

Early Childhood and Parental Influences in Stuttering

The soil from which the individual who stutters grows and develops is similar in nature to that in other forms of neurosis. It differs mainly in regard to the quality and degree of the individual responses and experiences to the particular environmental background.

Individuals inherently tend toward self-realization and constructive individual growth. Given the chance and a more or less healthy soil, a child can grow to become apparently normal and can fulfill his growth possibilities. Basically, the soil must contain a feeling of genuine warmth, love, and respect. A child needs to feel that he is wanted, loved, and needed; he needs a sense of belonging. If these conditions are lacking, then a state of emotional stirring is generated in the child, which is felt as difficult to understand or accept. He may thus be rendered weak and insecure. This can easily be the focal point around which his difficulties, with increasing further frustrations and disappointments, originate.

The reasons why a child does not receive adequate love and warmth at this stage of development may lie in the parents' incapacity to convey them, because of their own problems. This may be expressed openly, in the form of hostility toward an unwanted child; in a detached, disinterested, and aloof manner; or camouflaged in the form of an oversolicitude or the self-sacrificing attitude of an "ideal" mother.

In the stuttering child, disturbed parental and environmental factors which begin at an early age—usually between three and four years—result in the weakening of the child's ego and generate basic anxiety, with accompanying feelings of helplessness and hostility.

As a result of the early age at which such a child feels himself threatened, he will, because of an already weakened emotional state, be unable to organize his inner forces in sufficient strength to restore order to his disorganized personality.

Finally, as a form of safety and protection to this altered ego, neurotic trends and defenses are developed which, because of their contradictory nature, create further conflicts. This is usually the origin of the primary manifestations in stuttering.

The following are two brief illustrations of various combinations of parental settings in stutter-type environments:[6]

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Johnny's family on both sides were of German-Polish descent, middle class. He is an only child born through a forced marriage due to an illegitimate pregnancy. His mother is a large, heavy-set, domineering, and perfectionistic individual. In her own family constellation she played a minor role, being constantly oppressed and pushed into the background by her own mother and older sister, who was the family favorite. Johnny's father played instead a detached, aloof, and indifferent role, succumbing many times to his wife's demands in order to avoid too many arguments or friction. As a boy, Johnny was in constant fear of being punished in not being able to live up to his mother's absolute and perfectionistic demands. She exposed him to a domineering form of overprotection, as she dictated and charted every possible move he took. Onset of stuttering began at the age of 9.

Tony was born in a poorer Italian section of Brooklyn in 1927. Both parents were Italian, born in Sicily; they had migrated to this country because of social and economic goals. Tony was the only boy in a family of five older sisters. There were eight pregnancies in all, two of them ending in miscarriages. Tony's father felt angered and hostile each time his wife gave birth to a female child. He would rage at her for her incapacity to bear worth-while children, and felt insignificant as a male in the eyes of his relatives and neighbors. He is further described as being aggressive, domineering, controlling and as an arrogant, vindictive tyrant. Because of his own cultural background he strongly held to the dogma of male superiority. When Tony was born, his father shut his barber shop for a week and the home became a temple of worship and festivity. His "Christlike" son had been born, and no longer had he to hang his head in shame and humiliation. Tony's mother, on the other hand, is described as being self-sacrificing, oversolicitous, and martyrlike in her suffering role. Tony's life had been charted and dictated ever since his birth: he was to become a successful doctor, lawyer, or dentist. The intense pressure of the unattainable goals forced upon Tony from an early age resulted in his beginning to stutter at the age of 8.

In the foregoing illustrations, though there may be some basic similarities between the cases, there appears to be no definite difference from those factors found in backgrounds of other neurotic developments.

The Onset of Stuttering

The onset of about 90 per cent of stuttering occurs under the age of ten, and the majority of these cases start in the first five years, when the first major social adjustments begin. Orton[23] divides the onset of stuttering into two periods, one beginning at the period of speech learning (two to three years of age) and the other at the time of writing (six to eight years of age).

It is at about the age of three that the average child begins to show enough meaning in his speech to have his parents pay attention to what he is saying and how he is saying it.

The onset of stuttering in childhood may be precipitated by any experience which, in an emotionally inadequate child, generates anxiety and fear. Such traumatic experiences are fright, accident, illness, operations, forcible conversion from left- to right-handedness or a tense and worrisome home environment. The element of fright as a situational traumatic experience plays the most prevalent role. The most common experiences of this type are being frightened by the dark or by lightning; receiving severe punishment at the hands of a domineering and stern parent; being frightened by a dog or some other animal; being chased or mobbed by a gang of "tough boys"; being yelled at by an angered person; being thrown into water for the first time; and being caught in the act of masturbation by a parent.

The following examples are illustrations of adult stuttering—individuals whom I've studied—with known precipitating factors beginning in early childhood:

N.H., a 35-year-old male, was the product of a domineering, stern, and rigid mother and an alcoholic father who had little time to spend with his children. The family environment was one of constant friction and quarrels. At an early age he was subject to nail-biting, temper tantrums, and nightmares of "being beaten up." His eldest brother was his constant and only companion, the one in whom he confided and whom he respected. At the age of 8, while chasing his brother

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through the streets while playing, he saw his brother struck by a truck and instantly killed. Involuntarily, following this tremendous psychic shock, he began to stutter.

A.D., a 33-year-old male, was left-handed since birth. Both parents were described as being vigorous, intolerant, and demanding. There is a history of a brother and a maternal cousin who stuttered. There was a constant fear of not meeting his parents' demands and of receiving some forms of punishment in consequence. As a child he wet the bed and had frequent nightmares of "falling off tall buildings or of floating off into space, without being able to come back to earth." At the age of 5, he was forcibly threatened to be converted from left- to right-handedness, and subsequently he stuttered.

The above cases are not meant to be examples of cause-effect relationships in stuttering. They have been cited to illustrate conditions in which emotionally disturbed children can be prone to feel threatened in the face of overwhelming anxiety-provoking situations, and, as a result, give expression to their fear in the speaking situation.

Disturbed Communication in Stuttering

In our particular culture, language is considered the chief medium of communication. Through it we express our opinions, feelings, attitudes, and actions. The earliest conflicts of a child are expressed in his communications, both socially and verbally, to his parents and to the outside world about him. Where other children can pass through the primary stages of communication and early development fairly comfortably, the stutterer, because of his emotionally crippled position, is much more prone to anxiety.

Speech is the human's most complex and finely balanced muscular activity. Because of its complicated nature and its numerous nerve areas and muscle groups which require almost perfect coordination and harmony, speech is extremely susceptible to disorganization and nonperformability during periods of emotional tension. At such times, the lines of communication are thrown out of gear, the nerve messages go astray, and we find distortions and definite emotional disturbances in the area of verbalization. It is, therefore, in his speaking that the stutterer experiences the most destructive threats to his basic security and identity.

Free-flowing and spontaneous speech obtains mostly in an environment of parental warmth in which the child feels himself accepted. Hesitancies in speech will first appear in response to parental prohibitions and restitutions. Although nonfluent speech or hesitancy in younger children may be fairly normal,* tense parents who are perfectionists will often find this hesitancy alarming and will tag it as a stutter. Once the child has been so labeled, his position becomes unique in that there is set in motion a chain reaction of worries, anxieties, and preoccupations which will be a source of grave concern to both child and parents. Since language is the chief medium of communication for a child at this time, it is also the area first affected when the protective structures of the organism are threatened and anxieties result.

The speaking situation normally used to convey an idea, express a feeling, or ask a question now becomes a self-assertive, self-conscious act fostered by emotions of hostility and fear. Simple social situations in which speech is required now unconsciously become a testing ground for possible social combat, and the hesitation that results from the conflict between the rational impulse to speak and the irrational fear of speaking becomes crystallized into a stutter. (Psychologically, this is the same process which characterizes occasional stuttering in both child and adult.)

At first, the child, except for the expression of some subjective feeling of tension, awkwardness, or slight muscular incoordination, is unaware of the seriousness of his affliction. However, the threats and apprehensions of his anxious parents will soon make him conscious that, when he speaks, he is doing so differently from others and thus is something of an oddity. He soon begins to feel inferior to other children—peculiar and self-conscious. When, in due course, he enters school, the

* Most children normally repeat 40 to 50 times per 1,000 words spoken.

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added stress and competitive atmosphere in which he finds himself involved will only further cripple his personality. As additional emphasis is placed in terms of presupposed dangers and threats in speaking, speech, which is ordinarily not a conscious effort, will be identified, for him, with his fear of making those funny hesitant sounds and of finding himself rejected by his playmates.

Once the child becomes conscious of his speech and passses from the phase of simple, loose, repetitious speech (primary stuttering) to forcing and compulsively straining his verbalizations, he enters into what is known as "secondary blocking." He now becomes terrified at the mere thought of speaking, and this is intensified as the situations increase in number. In addition, a change in his outward expression and a marked difference in his attitudes toward speech take place.

As his fears increase and he becomes more conscious of his blocking, the child now discovers that, to compensate for his speech difficulty, he is in need of further defenses and means to conceal it. He attempts to find actions and rituals to avoid difficult words and thus begins the hopeless task of substituting. At first, as Gottlober[15] states:

> . . . this works, but soon he fears the word he is using for substitution and it is not long before he runs out of synonyms. Then the "starters" begin, sounds or acts which he thinks will help him to begin talking. He snaps his fingers, stamps his feet, clenches his fists, screws up his face or whistles. Each trick has its few moments of effectiveness and then helps no more. But he continues using them just the same and the ritual that precedes even a single word soon may take from a few moments to more than a minute to complete. He has never seen himself talking or trying to speak, but he is painfully aware of many of the devices he is using. He has felt them in twisted and overcontracted muscles and they have been pointed out and laughed at or mimicked by jeering, teasing friends and sometimes even by his own loved ones. In time he stops trying to talk almost completely and withdraws from the playground and other human contacts.

Stuttering, which is but an outward expression of anxiety in conflict, is secondary to an unhealthy personality development and is manifested specifically and implicitly in speaking where lines of normal verbalization and communication are disturbed.

In the confirmed or adult stutterer, on the other hand, we find a much more pronounced development of the neurotic structure and additional complex attempts at neurotic solutions in which the stuttering habit has become a means of externalizing conflict. A fundamental aspect of the whole personality, the function of speech is both verbal communication and the expression of an individual's interpersonal relations. The syndrome of stuttering must then be considered as a problem involving both interpersonal and interpsychic aspects of inner conflict. In this, the symptom in itself is due primarily to the struggle of the stutterer to keep together as a whole the warring aspects of his personality. In this way, stuttering manifests such attempts at solution as the afflicted one utilizes to maintain his psychic unity in the process of achieving self-realization and holistic integration.

Secondary Manifestations of Stuttering

Many stutterers feel that they are set apart —different; that although others too have their problems, they are at least better able to cope with and live with them, while they themselves are more obviously crippled because their speech defect is something they canot hide. They will further rationalize this line of thinking by admitting that, while those who are victims of migraines, asthma, stomach ulcers, and so on *do* suffer, they are able to conceal their troubles generally, whereas stutterers must put up with an added burden in the way of social criticism and judgment. As a result, those so afflicted feel themselves entitled to special conditions and privileges from a society which should be obligated to make allowances for the stuttering difficulty.

Some stutterers, embittered, will blame a way of life where such gadgets as telephones, dictaphones, and other means of verbal communication make speaking a "must." According to them, others more fortunate should take over for them in speaking situations which may give them bad moments—the others

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should answer the phone, make the necessary verbal requests, supply all necessary data and information, and give their complete and undivided attention to the stutterer when he speaks. The reasoning here is that "since you know I stutter, you should help me by making an all-out effort to understand me when I speak and so protect me from embarrassment and ridicule."

The stutterer may know realistically that he has stuttered for years. He knows too that in certain situations he has always found it difficult to speak. Nevertheless he blindly refuses to accept his shortcomings and feels compulsively driven toward speaking flawlessly rather than just settling for speaking with some degree of improvement.

The stutterer has a strong sense of dependence upon words as the sole means for communicating his thoughts and reactions; he feels at a disadvantage in the speaking situation, and so his whole concept of the act of speaking becomes confused and defective. And while within himself he may feel compelled to use the right word at the right time, yet he will rebel against any form of outside coercion, be it explicit or implicit. In any reference to a thing or an object as he speaks, he will give himself little freedom or choice in his use of words, so driven is he to be perfect, exacting, and absolutely correct in all of his communication. Since he invariably thinks of the speaking situation as controlling him and not of his being in control of it, he will resort to many forms of neurotic solutions to help him cope with his difficult and precarious position.

The stutterer plays with words, changes them about, makes substitutions, and may even, if he finds the going difficult, create his own vocabulary. Emotionally under pressure, he feels he must be master of his own language and that, by one device or another, he should be able to make it suit his own particular needs. He may become annoyed, however, if his listeners do not understand the meaning of his cryptic verbal communications, his coined words, his gesticulations, his unfamiliar pronunciations. At still other moments when speech is difficult, he will attempt to save himself by filling in gaps with falsities, absurd rationalizations, or even obvious distortions. If questioned as to the validity of his remarks, he is seemingly offended at his listeners. Actually, what he experiences under these circumstances is rage at himself for not having reinforced and foolproofed his magic solutions. Had he not failed to bluff his way through to a convincing performance, his defenses could not have been penetrated. So here again, this neurotic stutterer reveals his blind faith in himself and his compelling dependence on his maneuvers and duplicities.

The various bodily movements and contortions used also carry with them a sense of implied ritual. The pressing of both hands against the body, the blinking of the eyelids, the placing of the palm of the hand over the mouth—these are but a few of the many bodily "magic" gestures used in stuttering. Each has its specific and all-powerful meaning for a neurotic need at the moment of conflict.

As a whole, these are unconscious attempts to hold together whatever is disruptive and chaotic at the time. Most stutterers, oddly enough, feel that they should and must hold together their disorganized personalities, and so they will even go so far as actually to pinch themselves into a semblance of spontaneity, and will struggle to cover up their deficiencies by changing words to suit their fancied needs and to blot out of their awareness—and that of their audience—any apparent weakness or discrepancy in their idealized image of themselves. Rarely do such devices succeed, yet, in trying to understand the stutterer, it is most important that we constantly keep in mind the tremendous neurotic pride invested in these solutions. The stutterer neither can nor dares to give them up; he cannot lose faith in them. Without them, he will experience himself as being lost, a nothing, prey to the onslaught of his waiting self-hate. Only through a slow unveiling and resolution of his conflicts as a whole will his reliance on these neurotic props be abandoned.

Most stutterers are in constant dread of being defeated as they speak. Even before they begin, they are overwhelmed by the fear of not being able to initiate the utterance of a

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single word or sound. Threatened, they will anxiously whip up and distort the facts or the actualities until they regard the situation in the light of a calamity and doomed to failure. They say to themselves "I won't even be able to open my mouth," "I can't do it—I know I shall stutter," or "I shall be paralyzed with fear." They fear ridicule, criticism, and embarrassment not as self-recrimination but as coming from the outside and from others. Since they are driven compulsively toward the achievement of perfection in speaking, their main emphasis is directed not in terms of what they want to express but on how they will appear before others when they speak, on how they will finish up in terms of the audience's reaction. Owing to their profound sense of inadequacy, each new attempt at speaking becomes a testing ground for their actual existence.

Speaking, as a result, becomes a conscious process. Constantly at odds with himself and tortured by almost every attempt to express himself verbally, speaking, so habitual a function with normal persons, is for the stutterer an ordeal which fills him with panic and a sense of disaster.

In social or job situations, the stutterer is compelled to protect himself from exposing his speech difficulty by constantly avoiding the necessity for speech. He will go out of his way to avoid lengthy conversations, have others answer the phone for him, will seldom ask for directions, will restrict his spoken desires—anything rather than to encounter verbal friction.

What the stutterer fails to recognize in himself is his need to comply, his fear of aggressively disturbing and intruding upon the privacy of others. Should he ever dare to interrupt another who is talking, he will immediately become involved in anxiety over his boldness and will begin to stutter. What might perhaps be a healthy and perfectly normal act on his part will suddenly have become one that is aggressive and presumptuous. And, as with any unconscious attempt toward expansiveness, this will threaten his protective structure to the point that what he actually experiences is now an overwhelming sense of going to pieces, of crumbling.

Still other stutterers use expansive attitudes to cover up their shortcomings in their life situations. They will brag about the advantages they, as stutterers, have over average speakers. They take a peculiar destructive delight in showing how cunningly they avoid difficult situations by using their stuttering not as a crutch but as a powerful excuse device. Some will take great pride in identifying themselves with stutterers such as Churchill or Somerset Maugham who have accomplished so many great things.

In his interpersonal relationships, the resigned type of stutterer sees to it that he maintains his emotional distance from others. Although he may appear to have many friends and acquaintances, he rarely becomes emotionally involved with anyone. Many have even withdrawn physically into an isolated, inconspicuous existence. They never marry and, by avoiding most social contacts, manage to live very much like hermits. Some go to the extremes of avoiding buses, restaurants, or other public places where they run the risk of having to speak in order to communicate their wants to others.

It is also true that the man or woman who stutters is a chronic hesitator in other areas of his life. Stuttering, with all its blocks and hesitations, almost always represents the localized and externalized expression of a general state of indecisiveness and wavering. Before attempting to speak, the stutterer procrastinates and anxiously thinks about what he will say, how he will say it, and when. Since he cannot be spontaneous in his choice of words and speech must therefore be a conscious act, he is extremely cautious and perfectionistic in what he communicates. Even when he is quite certain that he knows what he wants to say, his self-doubts grow, and he will be forced back into a position of indecisiveness and further hesitations. In the end he finds himself in the dilemma of either offering passive resistance and refusing to say anything at all or of involving himself by pushing himself into the speaking act. Or he may externalize this and persuade himself that others are coercing him into doing so.

As a result of these many conflicting tendencies, he will grow more entangled and

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rebellious, more anxious and hostile and trapped, and this will lead him inevitably to a state of constant confusion and a chronic stuttered speech.

The stutterer is therefore unable to find relaxation, enjoyment, or an inner contentment. The tremendous expenditure of energy implicit in a conflicting ordeal of this sort is bound to leave a person frustrated, hopelessly resigned, inert, and exhausted. Spontaneous initiative is either paralyzed within him or is short-lived, as all his attempts at constructive effort are thwarted or diverted. The energies which might have been utilized to achieve positive direction toward his goals must be consumed in his efforts—negative ones—to release himself from the opposing forces of his neurotic conflicts. But by a progressive resolution of his inner struggles and by carefully worked-out changes, the stutterer may in time —and often does—overcome his conflicted self and so arrives at a rewarding and healthy state of self-realization.

¶ Treatment

Psychotherapy

In a problem as complex as stuttering, any attempt toward treatment should be composite in nature. Adequate therapy should include investigations of a medical, social, psychiatric, and re-educational nature. Stuttering is to be considered not as an isolated disorder of the speech mechanism but as an outward expression of a more basic character disorganization. Any effective treatment must also be directed toward helping the individual to understand his particular neurotic difficulties with their neurotic solutions and to arrive at some resolution of the underlying conflicts. It must also include a rehabilitation of his entire speech mechanism.

The goals in treatment have changed considerably from those of our forerunners. Today, the emphasis is away from symptoms as the prime expressions of underlying disturbances and toward the treatment of the total personality, the whole man. This holistic approach involves not only the individual's disturbances in relation to others but the nature and importance of intrapsychic processes. Our responsibility is to help the stutterer not only to overcome or alleviate his stuttering but to find himself as an individual—to release those energies now bottled up in his neurosis toward self-realization, capacities for creative work, better human relationships, and assumption of responsibility for himself.

A detailed presentation of treatment in stuttering cannot be given in one chapter, so only the basic principles and methods of effective treatment are mentioned here. Aside from the preventive and educational procedures which are of value in all disease entities, treatment in this particular context will be undertaken from a combined psychotherapeutic and speech technique.

Since stuttering usually begins at an early age, treatment, too, should begin as early as possible. For therapeutic purposes we can distinguish two phases of stuttering—primary and secondary.

Primary Stage

In treatment during the primary stage (five to ten years of age), when the child is less cognizant of and anxious about his speech problem, the approach is mainly one of treating the parents and, through them, removing unfavorable environmental influences. The prime objective is to be able to give support and yet aid the child to lessen the degree of his inner turmoil and conflicts, to attempt to arrest the disorder, and, if possible, to prevent perpetuation of the problem into the secondary stage or into confirmed stuttering. The parents or parent surrogates of the stuttering child are made as aware as possible of the many workable means available to ease the demands made upon their children, and how these same pressures can lead to stuttering. An ideal situation, it goes without saying, would be one where either or both of the parents could be encouraged to enter into treatment themselves, to help them work through some of their own most disturbing emotional problems, which, in turn, would better the child-parent relationship. Where this is not feasible or is met with resistance, treatment of parents must assume the form of specific instructions. These instructions are directed toward (1) avoiding making the child feel unique or different from others,

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avoiding making him "speech conscious," and especially allowing him to develop a sense of freedom of expression through speech and a feeling for an independent choice of words; (2) improving the general health of the child; (3) balancing his environmental tempo, with the removal of some of the more exciting and disturbing tension factors; (4) encouraging in the child a sense of confidence, responsibility, mutual love, and respect; (5) working toward a sense of coordination and rhythm in the child's personality as a whole; (6) encouraging the child to mix freely with other children and especially with members of his own family; (7) encouraging more constructive methods of discipline; (8) enabling the child to grow at his particular pace and helping him find his own potentialities and creative capacities; and (9) establishing a feeling of real love, warmth, and mutual belonging in the family unit. Though these goals may seem to be so comprehensive as to be difficult of attainment, even partial achievement of them can aid the stuttering child in his later struggles toward self-realization.

SECONDARY STAGE

In the secondary stage of stuttering (eleven to nineteen years of age), the stutterer is now consciously aware that he has a speech difficulty and is particularly affected by what others think of him. This adolescent or adult stutterer develops a keen sensitivity concerning his affliction and is easily affected by criticism and his own particular shortcomings. Treatment in this stage, in contrast to that of the primary stage, consists primarily of a direct approach. The individual's problems are tackled directly, and the aim is toward personality and speech reorganization.

Once the primary objectives are established and a plan of approach is decided upon by the therapist, more feasible and productive therapeutic work can begin. In accordance with the original premises of this chapter, especially that of promoting self-realization, it is important to recognize early in the therapeutic process the various resistances and blockages which are keeping neurotic processes going and simultaneously are interfering with healthy growth. Since we are primarily interested in helping the patient find himself, we must remove those obstacles which obstruct his growth, interfere with his real self, and cause him to feel alien to himself and to others. The following precepts are, I believe, most worthy of attention.

1. Encourage the stutterer to begin and continue treatment.

Doubts and feelings of doom have become fixed in the minds of those many stutterers who have gone from clinic to clinic, from specialist to specialist, or have been subjected to so-called "miraculous cures." When these unfortunates are initially interviewed for what they may feel is another new and futile attempt, among the many others, they are often skeptical and cautious. They have little real incentive for receiving help in the solution of their problems, and a difficult area of resistance is set up. The therapist must therefore give a great deal of himself by way of encouragement.

It might be well for the therapist to give his patient some pertinent information concerning his own professional background and his experiences with psychological problems, particularly the problem of stuttering. Then he should try to ease the patient's doubts and anxiety about himself by relating to the patient in a firm but sincere, warm, open, and consistent manner. He can reassure the patient further by saying something like: "Yes, I have no doubts about being able to help you with your problems, provided you are ready to cooperate with me. If you help pitch in, I'm sure we can do the job together."

2. Remove those resistances which are perpetuated by the individual's disturbed productivity and intellectualizations.

Besides the stutterer's hesitations when speaking, he presents similar inhibitions and blocks in the quality of his productions. The stutterer blocks with his whole organism—his feelings, attitudes, beliefs, and actions.

The stutterer thinks highly of "wisdom" and "intellect." His thinking is usually in terms of absolutes. His responses are purely on an intellectual level. His own inner fear of feelings forces him to seek logical and clean-cut answers to his problems. Seeking his conflicts at a distance, he tries to compartmentalize and ration-

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alize many of his shortcomings and opposing tendencies.

Progress in treating a stutterer is often slowed by the fact that his associations are usually not free and spontaneous in quality. The patient must be made aware of this blocking agent early in his treatment, so that a more real, down-to-earth atmosphere may be promoted in the therapeutic situation.

Of course, the actual stuttering symptom is one of the blockages in productivity. The therapist struggling to remove the symptom itself and not working with the total character structure is easily caught in a tangle of intellectual discussions on the presupposed cause-and-effect correlations of stuttering. What the stutterer is trying to express when he speaks, especially when he stutters, must be kept in mind. The therapist must intercept and decode the messages the patient sends by the way he presents himself in speaking, his hidden meanings, feeling tones, anxieties, inhibitions, hesitations, and especially his own word jargon.

3. Alleviate disturbances in the therapist-patient relationship.

The stutterer's use of magical claims creates a formidable obstructing force in the therapeutic relationship. The patient externalizes his own feelings of magic onto the therapist and endows him with superhuman powers impossible to attain. The therapist is a magician, he feels, who can easily and effortlessly rid him of his dilemma. In order to place himself in a position less threatening to his neurotic solutions, the stutterer may use his affliction, with its distractions and its rituals, to keep his therapist off guard. The therapist must therefore and nevertheless maintain a balanced, firm, and consistent position as well as his superior status. The patient secretly and truly desires this, despite his seeming to fight the therapist's firmness and consistency. In this way only will the therapist ultimately receive the stutterer's real respect and regard and be able to give his patient a sense of security.

4. Relieve the stutterer of his fears regarding any disturbance to his neurotic status quo.

The stutterer lives in constant dread of having his protective structures invaded or removed, with its accompanying terror of crumbling and psychically going to pieces. His need for mastery, particularly in the speaking situation, causes feelings of self-hate to develop when his pride values in this direction are undermined. The stutterer cannot face his conflicts squarely or bear their related anxiety. He therefore quickly retreats by pleading helplessness and having abused feelings. As he feels the situation becoming more desperate, he will adopt more strategies with his last area of refuge—that of avoiding conflict entirely. By resigning himself to a state of pseudo-unity, he is able to save face in at least part of the struggle.

It is very important that the stutterer begin to see himself less as "just a stutterer" and more as a human being despite his stuttering. He can be helped to feel more hopeful and on firmer ground and, conversely, less resigned and frustrated. His anxiety and the threat to his "lofty position" being lessened, he will then be able to take a stand in relation to his conflicts and have the courage not only to face himself as he really is but also to change.

Specialized Speech Techniques Used in the Treatment of Stuttering

Recently, among those directly associated with the speech field, there has been a reaffirmation of the point of view that, essentially, stuttering is a learned form of behavior not necessarily associated with basic neurotic personality or atypical neurology. The objective of this particular group of speech therapists has been one of working directly with the speech difficulty. Among the objectives of the techniques used here are the following: (1) to weaken the forces which tend to maintain and strengthen stuttering; (2) to modify and decrease the severity of the stuttering blocks by eliminating the secondary symptoms of stuttering; (3) to help the stutterer to speak, even though he stutters, in a relatively easy and effortless fashion rather than to avoid fears and blocks; and (4) to help the stutterer in an over-all adjustment to his environment.

At this point only a few of the better-known speech techniques used in speech clinics today will be mentioned.

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VOLUNTARY STUTTERING

Voluntary, or intentional, stuttering is based upon the psychological principle of negative practice. The stutterer is trained first to do intentionally what he has been doing involuntarily and unintentionally, so that he may gain control over a habit which has been controlling him. The stutterer (Berry and Eisenson,[10] p. 288) must learn to stutter intentionally, at first repeating his complete spasm with all the associated mannerisms. He is also encouraged to try to feel as he does in his involuntary stuttering. Aids in this procedure are the use of a mirror, which he can use to observe himself as he stutters; imitating another stutterer who, by prior arrangement, has agreed to imitate him; or attempting to imitate how he himself sounds by listening to a tape recording of his own speech.

When the stutterer has reached this stage and becomes efficient at self-imitation, he is ready for his next step in voluntary stuttering. He can now learn to repeat his evocation and be able to modify it in one or more respects decided on in advance. Normally fluent speech is not the immediate goal in this technique; rather, it is the control of stuttering through modified stuttering. Even if he feels beforehand that he can speak without stuttering, the stutterer is encouraged to pretend or fake stuttering—but to do so in a way different from his usual manner of stuttering. Finally, he is further directed to stutter easily, without struggle behavior, without blocks, and without tension, if at all possible. The objective in this form of therapy is to aid and influence the stutterer to modify and weaken his own stuttering pattern and to substitute for it a more fluent form of stuttering.

DIFFERENTIAL RELAXATION

Differential relaxation requires that the stutterer be able to relax one set of muscles which are to be used in a voluntary act, regardless of how tense other muscles may be. In stuttering, for instance, the major group of muscles employed are those which involve the articulatory mechanism. In the beginning, the stutterer is taught differential relaxation by encouraging an unconsciously produced tense articulatory position. He is directed to press hard, even harder than he does involuntarily, in the articulatory contact for a *t*, and to then relax the contact while he exhales so that a *t* may be produced. Following this, and soon after, the stutterer is asked to make the slightest possible contact necessary to produce a *t*. Once he can do this for one type of sound, he is given exercises to practice on other plosives, continuants, nasals, and affricates—until they are all learned. The stutterer, in this practice, has achieved his goal when he can imitate "bogey" words and feared articulatory acts with relative ease.

ADAPTATION

The last speech technique to be mentioned here is that known as "adaptation." Johnson[20] and some of his associates employ the technique of repeated readings of the same material to demonstrate that the incidence of stuttering is reduced with successive readings. The underlying theoretical premise for this approach is that the occurrence of stuttering in the first reading dissipates sufficient anxiety so that there is less stuttering in successive readings. Since this has been found to be true in practice, Johnson and his colleagues feel that the use of this technique can demonstrate to the stutterer that, in some situations, his severe nonfluencies can be quickly reduced and relative fluency of utterance attained. In so doing, the speech situation is changed from one conducive to stuttering to one usually conducive to relatively fluent speech.

Conclusion

Since stuttering, in this particular context, is being considered as a problem involving the whole person, it would seem to follow that the most suitable form of treatment should consist not only of vocal exercises and suggestions but of treatment of the whole personality as well.

In the final analysis, as the stutterer slowly finds himself progressing toward self-realization, he will tend to discard his neurosis and all that it implies—including stuttering. The length of time in treatment varies from individual to in-

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dividual, depending upon such factors as age, severity of the stuttering symptom, degree of neurotic involvement, familial and environmental conditions, etc. It can vary from one year in a young child to several years in the adult. Finally, the main criterion for evaluation depends not so much on the complete elimination of the stuttering symptom in itself as on the total growth of the individual himself, in terms of what Karen Horney[18] advocates when she says,

. . . it concerns all that is involved in self-realization. . . . it means striving toward a clearer and deeper experiencing of his feelings, wishes and beliefs; toward a greater ability to tap his resources and to use them for constructive ends; toward a clearer perception of his direction in life, with the assumption of responsibility for himself and his decisions. . . .

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CHAPTER 48

SYMBOLIC REORGANIZATION IN BRAIN INJURIES

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THE CONCEPT OF CHANGES in symbolic organization as modes of adaptation to stress is based on formulations of the relationship of language and behavior found particularly in the works of Edward Sapir,[65] G. H. Mead,[34] Benjamin Whorf,[81] and Karl Lashley.[28] It becomes increasingly clear that language is not simply the label placed on already formed perceptions, thoughts, and feelings, but that the symbols we use are a product of a pattern of interaction in the environment. What we see or hear is the result of a process of selective perception and generalization which, to a great extent, goes on outside awareness. Sapir has pointed out that the physical aspects of a stimulus are only points in a pattern, and take on form and meaning by reason of their place in a total pattern of relatedness. We hear the melody rather than the individual notes, and a different set of notes may sound the same, provided they bear the same temporal and spatial relationship to one another. The color blue would have no meaning in a world where everything was blue; the quality of blueness takes on meaning only against the background of other colors.

Furthermore, the manner in which we structure the environment is determined in considerable degree by cultural orientation. The reality we perceive is not a universal one, for participants in different cultures classify the environment differently. For example, among the Navaho Indians there are color terms equivalent to our white, red, and yellow, but none corresponding to black, gray, brown, blue, and green. To the Navaho, blue and green are the same color and, most important, are *felt* as the same color. If they are seen as different, it is in the sense of varieties or shades of the same color. Whorf has suggested that even our space, time, and matter organization of the universe is influenced by the grammatical structure of our language.

In language we not only classify the environ-

ment but express a relatedness in it from which we derive a sense of reality and a feeling that things are what they are. The fashion designer, with his puce, mauve, beige, etc., is not only designating colors as he sees them but identifying himself with a particular cultural group. On a broader scale, let us take an expression such as "the exotic East." This is a term for which meaning and feeling derive largely in the context of Western social values. The people of India or China do not feel that their country is exotic, nor do they regard themselves as being of the East, except by reason of their orientation to Western culture. Yet the person who uses the expression, in so far as he does think about it, believes that he does so because East is East and it *is* exotic. The reality that we experience has been called by Sapir a "social reality" and the feeling of the reality of one's experience is related to the degree to which the symbolic representation identifies one with the values of his culture.

Sapir has offered a classification of symbolism into referential and experiential, or condensation, types. Referential symbols are those designations and classifications of the environment on which there tends to be arbitrary and universal agreement and which primarily serve purposes of communication and reference. This type is exemplified by numbers, letters, the Morse code, and systems of flag signaling. Experiential symbols are those which seem to express a particular emotion or feeling, such as a prayer, a vow, the password of a fraternal order, and most gestures. Actually, it is difficult to find symbols that are purely referential or purely experiential, as both features are usually present in some degree. In a referential sense, the American flag denotes territorial sovereignty, while experientially it may be associated with feelings of patriotism and security. These feelings are not determined arbitrarily by the symbol but depend on the particular situation and the degree to which the person is related in his society. One is apt to be more aware of the referential aspect rather than the social aspects of language. The religious worshiper, for example, regards the feelings of faith, love, fear, or reverence derived from prayer in terms of communication with a deity rather than in the way the symbol identifies him with his cultural values. He is quite unaware of the interaction in the environment and *feels* the symbol not as language but as the very essence of reality.

Changes to more experiential types of symbolic organization may occur in situations of stress. Examples are metaphors, prayers, vows, proverbs, humor, slang and profanity, and superstitions, to name several in the verbal sphere. All of these involve a shift in the level of interaction in the environment. Thus, in a certain situation, the breaking of a twig may be a sign that someone will be hurt. One may seek the solution of a problem or accept the truth of a statement by restructuring it in a proverb such as "where there is smoke there is fire." Now this is manifestly untrue. Yet the speaker gets the *feeling* of truth and a resolution of his doubts by reason of the altered pattern of interaction (as compared to the referential aspects). In humor there is a similar relationship between the referential and experiential aspects of language. In this chapter we shall present certain delusions as adaptive processes. When a patient claims that his food is poisoned, he may be saying, in effect, that people don't like him. But he says it in this language because using the symbol gives him a *feeling* of well-being, anger, martyrdom, righteousness, or what not, derived from a relatedness in the environment in terms of the cultural value, food. Here the delusion is quite analogous to the use of food in religious rituals, to various customs and manners concerning eating, and, in the verbal sphere, to metaphors, homilies, and vows about food.

¶ Classification of the Material

The type of stress that will be considered is that which occurs with brain injury and physical incapacity. Here the stress is very great; the patterns are striking and enduring and, as compared to neurologically normal persons, less susceptible to change in the course of study. Rather than sharply divide organic from functional, it should be recognized that changes in brain function occur with any type of stress, although our methods of study are still inadequate. The principles to be outlined apply not only to states of physical incapacity associated

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with brain damage but to psychological stress as well.

The material will be presented in its neuroanatomical, neurophysiological, psychodynamic, and social and cultural aspects. It will be classified in terms of the motivational concept, denial. This forms a unifying category for many seemingly diverse forms of behavior, and the data can be brought into line with clinical syndromes already familiar, in some degree, to the reader. The approach also lends itself to a classification of the environment in spatial, temporal, personal, and somatic aspects. The various denial syndromes may be grouped into verbal and nonverbal forms and explicit and implicit types. Verbal patterns will be described under the headings of explicit denial, confabulation, paraphasia, reduplication, and amnesia. Nonverbal patterns are designated as inattention and withdrawal, mood changes, and altered sexual behavior and behavior related to other physical activities.

¶ Verbal Patterns of Denial

Explicit Verbal Denial (Anosognosia)

Explicit verbal denial has been described in the literature mainly in the form of denial of blindness and hemiplegia, referred to as Anton's syndrome and anosognosia of Babinski, respectively. Actually, patients may deny any type of physical incapacity, when studied under the conditions to be specified, and cases have been reported of enduring denial of aphasia, deafness, involuntary movements, diplopia, ptosis, urinary and fecal incontinence, paraplegia, and loss of a limb or an eye. Phantom limb may be regarded as a transitory form of anosognosia, which may become enduring under the conditions of brain function to be specified. An interesting form of anosognosia occurs in the toxic encephalopathy following severe burns, where the patient denies he has been burned and disfigured. In Paget's disease the patient may disclaim any knowledge of his osseous deformities. Where several disabilities exist, such as hemiplegia and blindness, any or all may be denied. Patients may disclaim ownership of an affected member of the body, attribute it to someone else, or displace it into space. Thus patients with a paralyzed limb may say that it belongs to the nurse. A woman brought to the office by her daughters told the doctor to examine them as *they* were ill. Another claimed that her paralyzed limb was lying on her bedside table "like a set of false teeth." In states of partial denial, patients may admit the existence of some of the manifestations of illness but attribute them to some trivial cause or blame them on the actions of someone else. Thus patients will say that they cannot move an arm because it is sore from a hypodermic injection.

Along with physical incapacities there is denial of events or situations of traumatic import. Patients with self-inflicted wounds of the head deny not only the shooting but the existence of the problems that led to the act. Following craniotomy and prefrontal lobotomy there is frequently denial of the operation.

Patients with complete denial are bland and affable in interviews, and there are no signs of clinical anxiety. There is a general lack of spontaneity, and, as a rule, patients talk only when spoken to. Apart from interviews they appear dull and inactive, but in the expression of the denial they become animated. There is a conspicuous absence of the "catastrophic reaction" described by Kurt Goldstein in many patients with brain disease. Patients with incomplete forms of explicit verbal denial often appear paranoid, as they may admit some of the manifestations of illness but attribute them to the actions of others or claim that the injured part of the body belongs to someone else. However, markedly euphoric, manic, and highly paranoid reactions are much more apt to occur in patients without explicit denial, as will be described in a later section (see p. 975).

Often, a patient will deny his incapacity in one form of language and admit it in another. It was this observation that initially turned our attention to the matter of symbolic organization rather than consideration of the phenomena as manifestations of specific neural defects or as equated with psychological or physiological drives such as the "wish" to be well. Thus a patient complains about the "hammer-

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ing and sawing" done on his head but denies having had an operation. Patients may admit not moving their limbs but deny that they are paralyzed. They may deny or "forget" having sustained an injury but describe the identical accident as having occurred to someone else. Even though patients deny being ill in any way, they accept medication, submit to operations, and carry on the ward routine in a manner not different from other ill persons.

Patients with explicit verbal denial of illness had previously shown certain characteristic patterns of behavior. These, in particular, concerned health and work. They were reported by relatives as always having denied illness, seeming to regard it as a form of weakness or failure. The maintenance of health was regarded as a personal responsibility tied up with self-esteem. They were apt to put off going to doctors and excuse or rationalize the manifestations of sickness. They were described as conscientious, compulsive, responsible people, and these attitudes were especially exemplified in attitudes toward work. For such people, health and work were ethical values. Through social relationships involving health and work, they gained a sense of "being." When ill or unable to work they were isolated and, through lack of a relatedness, did not derive such a feeling of self. Thus the manifestations of illness are not felt as "real" or as a part of one's own experience when they are not elements of a pattern of social relatedness.

Patients with paranoid forms of explicit denial, in which the manifestations of illness are recognized as existing in some degree but are blamed on others, show some of these personality characteristics. There is the same compulsive drive and need to deny illness. The paranoid group, however, had previously expressed their needs and feelings in a more "physical" fashion. They did not use words as magically, and their attitudes toward illness had been those of open fearfulness and resentment rather than having been verbally expressed in negation, rationalizations, justifications, clichés, and homilies. Thus, patients in the paranoid group might say that they did not go to doctors because they couldn't stand the sight of blood, or smells, or injections. Whereas the patient with complete verbal denial was apt to be concerned with ethical principles, the paranoid person sought perfection more through physical attributes, particularly those relating to physical appearance, masculinity and femininity, cleanliness, and particular food and bowel habits. He was much more apt to react in situations with physical displays of force and violence.

Confabulation

The negation of illness is commonly accompanied by confabulations and delusions (see footnote, p. 968). Many of these are seemingly designed to amplify the denial, minimize the traumatic implication of the illness, and explain away the manifestations. Thus the fact of being in the hospital is ascribed to "visiting a sick friend," "a run-down condition," or "a check-up." A man who had shot himself through the brain, leaving a spherical skull defect, said that he had "tripped over the cat and hit my head on a golf ball." Other patients, both men and women, said they had come to the hospital to have a baby. Some patients, while admitting the existence of incapacities, told stories of activities transcending their limitations. One of these was a young soldier who, following a head injury, was left with a paraparesis, dysarthric speech, and some intellectual deficit. He admitted this defect but confabulated that he had graduated from automotive engineering school and had been a vocalist in a seventeen-piece band. A number of these stories of the past were in themselves true but were used in a context where they served the purpose of a confabulation.

Other confabulations do not seem to deny illness but, taken in a referential sense, even magnify the disability. Thus one man said he had been blown up in an atomic explosion. Here the confabulation is a metaphorical or allegorical representation of current problems and disabilities. For example, one patient became blind after a craniotomy for a brain tumor. When asked what his main trouble was, he replied "I was slugged and rolled in a blind alley." Another officer had sustained a head injury in Korea when the jeep in which

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he was riding overturned. He was left with a weakness of his right upper extremity, a mild dysphasia, difficulty in reading, and an inability to write. For many months in the hospital he persisted in a confabulation that he had been an intelligence officer bringing in suspected Communist security risks and had been hit by an enemy shell. He would continue with a long rambling account of having written everything down so that any jury in its right senses would be sure to convict, and how "red" the suspects were. In the story the terms "intelligence," "writing," "security," and the homonyms "read" and "red" came up repeatedly. When it was appreciated that the patient was talking about his own problems of intelligence, security, reading, and writing, the importance of including these seemingly irrelevant details became apparent.

Another aspect of confabulation is that it identifies the patient with significant cultural values of his experience. Like explicit denial of illness, it is a means of establishing a relatedness in the environment whereby the patient derives a feeling of reality and being, and avoids isolation and nothingness. For example, in a military hospital, paratroopers who have sustained head injuries in automobile accidents frequently admit the injury but confabulate that they have been hurt while jumping. Personality study of these subjects indicated that their feelings of esteem and belonging had derived mainly from membership in the paratrooper group. A confabulation such as "the parachute got fouled up" not only symbolizes the patient's predicament but gives him a sense of identity.

Some confabulations, such as the ones about the Communist spies and the atomic explosion, may seem bizarre, yet, from the standpoint of language, this content is highly conventional and popular. This aspect is borne out by the generally banal and colloquial character of the language. Thus, a patient with a subarachnoid hemorrhage said he had gotten a headache while "waiting for a streetcar." After a craniotomy another woman claimed that she had been "hit by a Mack truck." Such clichés are important forms of socially organized language. One of the most amazing features of language is that an element which in one context is catastrophic may be a form of adaptation to stress in another.

CONFABULATION ABOUT CHILDREN

A particularly interesting illustration of the correlation of the content of confabulations and delusions* and patterns of social relatedness is found in stories concerning children. The patient may talk about nonexistent, or "phantom" children, or actual children. Frequently they are said to engage in the same activities or have the same disease or injury that the patient himself has. Or patients talk of their own fears and feelings of helplessness in terms of a "child" being mistreated, neglected, raped, kidnaped, or killed. A twenty-one-year-old soldier had suffered a head injury which had left him with a moderate weakness of both legs. Throughout a long hospitalization he had a great deal of difficulty with the doctors and nurses, who, he felt, rejected him. Following a period of marked aggrievement, he was a week AWOL from a week-end pass. On his return he gave as the reason for his tardiness a story about his daughter (the patient was childless) having contracted poliomyelitis. He described with a great show of feeling how his "daughter," aged three, had developed paralysis of her legs. He said he had taken her from hospital to hospital, and all of them had turned the child away, thus expressing his own aggrieved feelings.

It should be pointed out here that in ascribing an injury to a child or, for that matter, to anyone else, the patient is not releasing "hostility" or gratifying a previously unfulfilled wish. Nor is he now expressing long-repressed feelings toward some sibling. Rather, he is talking about himself and his problems in language which has particular meaning for him. People who confabulate about children are those who have formed their most significant social relationships either by taking the role of a child or placing others in it. Some are characterized by informants as "childish," "immature," and "dependent," while others are described as

* Confabulations are differentiated from delusions in that the confabulation is limited in respect to time, place, and person, whereas a delusion, in this sense, is timeless and limitless.

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having been dominating, controlling, worrisome parents, wrapped up in their children's lives. They seemed to have achieved comparatively little sense of personal identity in any transaction other than that constituting a stereotyped, highly conventionalized parent-child relationship. Many of these patients seemed to have lived for the symbolic forms themselves, to perform through themselves or others the ritual of the "good" or "bad" child.

Disorientation for Place and Time

The forms of denial and confabulation that have been described are regularly accompanied by patterns of disorientation for place and time. The work of Paterson and Zangwill has shown that disorientation is not simply a manifestation of confusion but occurs in orderly patterns. In the acute stage of brain injury, verbal identification may occur. Here the patient says that he is in X hospital *and* some other place, such as an apartment. In the stage of misnaming, the patient uses euphemisms as "a prison" or "repair shop" or "convalescent home" or "restaurant" or calls the hospital by the name of some existing or nonexistent hospital. When an existing hospital is used, it is generally a hospital close to the patient's home or one where he has previously been for some comparatively trivial illness. Sometimes the name given to the hospital symbolizes the patient's feelings about his illness and the hospital. A woman with a tracheotomy and a paraparesis said she was in the "Fresh Air Roller Skating Academy," while a woman studied at Mount Sinai referred to the hospital as "Mount Cyanide." Almost invariably, the name given bears some similarity to the actual place as "Mount Sinai Restaurant," "Mount Morris Hospital," or "Mount Sinus Hospital."

In the pattern of displacement, the patient names the hospital correctly but places it elsewhere. The erroneous location is usually close to his home or place of business. One man put the hospital in a town where he had lived ten years earlier. Some patients name and locate the hospital properly but greatly reduce the distance between the hospital and home. A young soldier insisted that the hospital in Washington was only ten miles from his home in Detroit. Some patients could point out the location of hospital and home on a map but still condensed the distance. It is not infrequent for the patient to be oriented in one context but not in another. For example, a young soldier from Detroit, on the day that he was expecting a visit from his family, was able to give the air-line mileage and their expected time of arrival while maintaining that he was only ten miles from home.

The confabulated journey commonly appears after the patient, in the course of recovery from a brain injury, has apparently attained full orientation. This is a statement by the patient that he has taken a trip from the hospital, as having gone home the night before or having gone shopping. One man, a patient at Mount Sinai, told of how he had spent the morning "skiing with fifty beautiful girls at *Mount* Holyoke College."

Disorientation for time of day and/or date appears at some stage of illness in patients who show disorientation for place. In disorientation for time, the patient uses his own experiences as the index of time of day; the patient "confuses" night and day and morning, afternoon, and evening. In a control series of patients hospitalized for diseases not involving the central nervous system, tested in a similar fashion, patients might make mistakes of several hours, but the errors never extended across a mealtime. Disorientation for time of day was commonly observed after a patient had been sleeping. A boy, after awakening from an afternoon nap, was indignant at getting spaghetti for breakfast. Another patient tested in the morning insisted it was afternoon because "I was up all morning." Whereas another invariably gave the time as 7:00 P.M. "because that's when my daughter comes to see me." When patients were first tested, they were not permitted to look at a large wall clock in the ward. However, it was found that when temporal disorientation was present, it made little or no difference whether or not the patient could see the clock. Even though he could read it correctly, he would persist in his error. One patient when approached in the morning would be well oriented for time. In the after-

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noon he would name the hour accurately but claim it was morning because "I was sleeping" (during rest hour) "and I never nap in the afternoon." It is evident that the patient has an altered pattern of interaction in the temporally defined aspects of the environment. He uses his own experiences as the index of time.

In disorientation for date the patient usually gives as the date a time in the past antedating the time of his illness. If he gives the month correctly, he is apt to name the wrong year. There, he is particularly apt to make a mistake in one digit as 1948 for 1958, or 1957 for 1958. There seems to be just enough of a mistake to make the answer wrong.

It is important to regard these types of verbal disorientation as symbolic patterns rather than as absolute defects in memory or perception. Disorientation for place should be distinguished from visual-spatial agnosia and from topographical disorientation where the patient has difficulty in finding his way about and cannot make a geographical plan. Similarly, disorientation for time should be separated from the ability to tell time. Perceptual and memory deficits may be present in the absence of disorientation, or disorientation may persist after disturbances in retention are no longer present. The persistence of disorientation, even though the data for correct orientation are readily available, is striking. One officer, for example, regularly crossed out the Walter Reed inscription on his stationery and substituted Fort Sill, a post where he had served for several years. The disoriented patient usually gives his faulty answer promptly when asked, while the patient who proves to be oriented asks questions to define the situation, such as did the examiner mean the room, the building, or the hospital. Actually, we feel a patient can be disoriented only if he *knows*, at some level of his thinking, where he is. As in confabulation and humor, the experiential symbol takes on meaning only against the background of the referential aspects.

In cases of brain injury where there is progressive clinical improvement, the way in which the same symbolic element is integrated into various patterns may be observed. A patient, on admission to Walter Reed, said he was in "Coolidge Memorial Hospital" which he located in Georgia. ("Coolidge Memorial" was a condensation of Cooley-Dickinson Hospital and Coolidge Memorial Bridge, places near his home while he had been stationed in Georgia.) In the stages of reorientation he successively located "Coolidge Memorial" in North Carolina, Virginia, and Washington, D.C. He then located the hospital accurately but called it "Walter Reed Memorial." He introduced the correct name by remarking "They say it's Walter Reed." He then stated that he had been told that a friend who had been injured in the accident had been in "Coolidge Memorial." This was given up but, through the remainder of his hospital stay, he maintained that he had a "feeling that there must be a Coolidge Memorial Hospital somewhere."

Paraphasia or Metonymy

This symbolic pattern involves an altered mode of interaction in the environment in terms of misnaming objects. The patient selects single aspects of the structure or function on which he bases his designation for the entire object. Thus a hypodermic needle is called a "tiepin," a head bandage a "turban," and a wheel chair a "spinning wheel." The misnamed objects are those which related to the patient's particular problems, mainly those of illness and hospitalization. Thus errors are made when he is shown a syringe, straw, tongue blade, or thermometer. Objects of comparable complexity and familiarity which do not concern illness are much less frequently misdesignated. Sometimes the name assigned to an object expresses the patient's feelings about himself, as in the case of an electronics engineer who had sustained a severe head injury and called an electric light bulb, an object in the non-illness-connected category, a "used-up radio tube." Paraphasic misnaming may be elicited during formal testing and in conversation. Ordinarily, the patient does not seem aware of any error and repeats it despite correction.

Closely related to paraphasia is the phenomenon in which the patient talks about himself in the description of some object.

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People injured, say, in an automobile accident, when asked what happened to them, tell how the car "only got a scratch" or how the car "got its top stove in." One man, apparently minimizing his accident, said he had fallen out of a "small aeroplane." The principles exemplified in disorientation and paraphasia may be applied to certain neologisms and condensations. One man referred to the hospital as a "curable place"; a woman, following a craniotomy, mentioned her "aching watch." A patient who later became aware of his subdural hematoma and memory loss would talk of his "embree" (hemorrhage plus memory).

Reduplication

Reduplication for Place

In confabulation, disorientation, and paraphasia, the designation of the event, place, time, or object has both referential and experiential aspects, whereas in reduplication these aspects are separated. In reduplication for place, the patient names and locates the hospital correctly but states that there is another place of the same or similar name to the one that actually exists. The patient says that there are two Walter Reed Hospitals. Although the "two" hospitals may have the same name and even the same personnel, there is usually some difference that is significant in terms of the patient's problems. For example, the patient may say that the "extra" hospital is close to his home, is a "convalescent place," or differs from the "original" only in that no surgical operations are performed.

Temporal Reduplication

In reduplication for time or event, the patient states that an event or experience of the present has also occurred in the past. He may state that he has met the doctor previously in his home town or that he has gone to school with the nurse. A patient awaiting a craniotomy for an intracranial aneurysm insisted that he had been in the hospital a year before and had had the identical operation performed. It is generally impossible to separate temporal reduplication from reduplication for person, nor is it important to do so aside from purposes of definition. Patients with reduplication are apt to show it for place as well as time and person.

Reduplication for Person

In reduplication for person there is, in addition to an existing person, another of the same or similar identity, or an actual person is assigned another role.

A patient claimed that on alternate days his nurse's mother took care of him. A patient, recovering from encephalitis and concerned with her intellectual ability, claimed that the doctor had been her instructor in college. Another example of reduplication is that of a mediocre former pugilist who misidentified a decrepit elderly patient as a champion fighter. The person who is chosen as the subject for misidentification may be one who has an identity or disability comparable to that of the patient himself and/or one whose identity must be denied, as a doctor. Another factor, of course, is that the misidentified person looks somewhat like the person he is purported to be. It is of interest that the patient usually picks out only one or two people to serve as vehicles for the reduplicative misidentification or delusion.

The introduction of a fictitious person is another form of reduplication. In describing the "extra" person the patient is, in effect, talking about himself, as has been illustrated already in discussing confabulations about children. In telling of an automobile accident, the patient adds an extra person to those actually involved. He may say that this person was uninjured or that he was killed. Often the same delusion or misidentification in which a patient alludes to himself at the stage of greatest impairment of brain function is applied to someone else in the course of recovery. One man, who was markedly withdrawn and depressed, first said that he had been killed in an accident and later claimed that his brother was dead. Patients also talk of things happening to someone else which, even though true, are used in a context which expresses feelings about themselves. Thus a woman with a hemianopsia, when asked about her condition, told of how her son had lost his eye in a hunting accident. The "extra" event, person, or place is a condensed symbol of a type of relationship in the

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environment whereby the patient gains a sense of identity and talks about his problems.

The content of the reduplicative delusion can be correlated with past experience. For example, a woman, the mother of twins, a boy and a girl, claimed that she had two sons, Bill (the name of her son) and "Willie," in addition to the daughter. She had been a woman with a good deal of drive and ambition for a career, which was unrealized because of her household and family responsibilities. She had hoped to see them realized in her son and had been greatly disappointed when he rebelled at her rather controlling attitude. She had been particularly hurt when he had changed his name. In the reduplicative delusion she stated that she hadn't seen "Willie" since Christmas (the onset of her illness) but that she had heard that he was convalescing from some illness. She mentioned that "Willie's" clothes were home in the closet and that "Willie" had not changed his name, in contrast to Bill. When the course of her illness (cerebral metastases) took an obvious downward trend, she expressed great concern about "Willie," saying that he must be very sick. The patient who expressed the idea that his nurse's mother took care of him on alternate days had previously achieved identity through a mother-daughter relationship. He was described as very doting toward, partial to, and suspicious of his daughter, dependent and demanding with his wife, and promiscuous with other women. As his illness progressed, he became increasingly physically dependent on his wife to bathe and feed him and developed the delusion that his daughter had been raped by a homosexual.

Reduplication of Body Parts

In this form of reduplication the patient says that there are one or more additional members of the body, such as two heads, three arms, or four legs. The portion of the body that is reduplicated is invariably one that is disabled in some fashion. A patient who says he has an extra left arm usually has a left hemiplegia, the one who says he has four legs will have weakness or some other incapacity of the lower limbs, and patients with two or more heads have had a head injury or craniotomy. Also, reduplication for parts of the body is associated with some other form of reduplication, as for time, place, or person. The patient may say that the "extra" limb has nothing the matter with it or that the "extra" head has not had an operation. As in the other forms of reduplication, the phantom member may symbolize an interpersonal relationship. A nurse with a hemiplegia said that the "extra" arm belonged to her friend, also a nurse. She described the arm as "heavier, thicker, and darker" than her own and "hard-working and well-used." The friend was a large, physically powerful woman who had literally taken care of the patient for many years.

Déjà Vu Phenomenon

This may be regarded as a transient form of temporal reduplication, and the principles of reduplication may be applied to some understanding of both *déjà vu* and the closely associated panoramic memory. Repeated *déjà vu* experiences may replace reduplication when there is improvement in brain function and the new neural milieu will not sustain the enduring form. In the *déjà vu* phenomenon, which may occur as a component of a convulsive seizure and in neurologically normal people, there is a feeling that the present experience has occurred before. In the panoramic memory the person pictures a scene of his past life, usually in vivid detail. They have in common the heightened sense of reality and the exquisite feeling of familiarity. One patient had, as an aura of her seizure, the feeling of lying in her room as a child, listening to the flies buzz. Another, prior to becoming unconscious, would be "reminded" that he had seen the same object long ago. Another patient would state that the scene that he was observing was one that he had also experienced back home, but with certain differences. These differences appeared to symbolize many of his present problems. He had had two unsuccessful operations to relieve his seizures and was awaiting a third with anxiety. He would look at a two-story house on the hospital grounds and state that he had seen the exact house at home, but with three stories. Shortly after the second operation he had a seizure in which he recalled

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a scene in his childhood, but, instead of the road being its usual color, it was purple and red.

Amnesia

Amnesia is not ordinarily considered in terms of symbolic organization but is regarded either as an "organic" memory defect or as a manifestation of repression. Yet a study of a large number of cases of amnesia following head injury shows that it is a form of language in which the patient denies or otherwise represents his problems and expresses a relationship in his environment.

When a patient says that he does not remember his accident or his operation, he is talking about his accident or operation. While no patient who has had a severe head injury remembers the actual impact and generally has some retrograde memory loss, if he is socially related he soon learns what has occurred. When asked what happened to him, he answers appropriately. The amnesic patient, on the other hand, even after he admits the fact of an accident, will preface his answer with "I don't remember but they say . . .," indicating a feeling of noninvolvement.

The amnesia is usually highly selective, patients stating that they could not recall outstanding events of their lives. One young man had been in a car accident in which he had sustained a severe head injury and a radial nerve paralysis. He was a high-school football star and could not remember ever having played football or attending high school. In the amnesia, he expressed concern over his intellectual ability and the ending of his football career. When the amnesia cleared after several weeks these problems were stated in more referential fashion.

In the amnesia the patient not only talks of his problems but talks about them in the symbols that have been his main sources of social relatedness and personal identity. Thus, soldiers may not remember having been in the Army. One officer had a selective amnesia for having gone to West Point. In reviewing the background of such patients, one finds that they are usually career soldiers whose main bases of prestige and sense of belonging are tied up with military service. Frequently a patient will volunteer an amnesia which, from a referential standpoint, may be quite trivial. A sergeant complained that although he knew his grade of sergeant he could not remember actually receiving it. One patient volunteered that he was unable to recall who had won last year's batting championship. The amnesic content, however, becomes significant when it is learned that, prior to his injury, the patient had hoped to become a professional ball player.

The last thing that amnesic patients say that they remember is just as significant as the amnesia itself. This "last memory" may be fictitious or true, but in either case it serves to represent the patient's problems and expresses a relatedness. Thus one man who had broken both legs in a parachute jump had as his last memory "standing up in the plane." Others recall "being home." Another, who was confined to a wheel chair because of disabling fracture-dislocation of his hip, recalled "sitting at the foot of a mountain in an old broken-down car." It is of interest that, as the clinical condition improves, the "last memory" changes. Shortly after obtaining crutches this patient had as his last recollection prior to his accident "pulling into a garage and having a clutch repaired."

¶ Nonverbal Patterns of Denial

Inattention and Withdrawal

These may be regarded as forms of implicit nonverbal denial which occur under the same conditions of altered brain function as the other symbolic patterns described. Thus, instead of verbally denying paralysis, a patient with a hemiplegia ignores his paralyzed limbs. If ambulatory, he may neglect to place the affected arm in a sleeve or habitually not wear a slipper. Some patients do not look toward the affected side; others disregard the whole side of space, paying no attention to objects or people in one half of a room, and fail to respond to questions when approached from that side of the bed. In eating, patients may

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take food from only one side of a tray. In looking at a picture some patients neglect figures on one side even when, in the case of a hemianopsia, the picture is placed in the functioning visual field. The selective, motivated character of the phenomenon is indicated by the fact that patients never ignore a part of the body that does not have something the matter with it. In some cases the patient does not respond to stimuli over the affected half of the body, giving a picture of hysterical hemianesthesia.

Withdrawal may be regarded as bilateral inattention. It ranges from states of lethargy and sleepiness to the clinical syndrome described by Cairns, Oldfield, Pennybacker, and Whitteridge as akinetic mutism. This is best described by saying that the patient acts dead. He lies mute, often with closed eyes, does not respond to questions or stimuli, rarely moves, and does not eat. In most patients, however, there is a selectivity of response in which they do not answer questions about hospitalization and illness or reply in a dysarthric fashion, while speaking clearly in other contexts. Others "answer" stressful questions with yawning, coughing, or grimacing. Some patients speak to a relative but not to a doctor. The akinetic state may be interrupted by outbursts of restlessness and violence.

Because of the marked restriction of verbal communication, it is difficult to evaluate other aspects of behavior. The predominant mood, however, is one of depression with some paranoid features. One patient asked her husband if she were dead and if she would be buried.

A review of the premorbid behavior of withdrawn patients indicates that symbols of sleep, death, and violence had been habitual modes of adaptation to stress and important channels of social relatedness. One patient, during the course of a right fronto-temporoparietal glioblastoma, showed akinesis, inattention to a left hemiplegia, pain asymbolia, selective muteness and dysarthric speech, and episodes of violence. He was described as having reacted to difficulties in the past both by becoming depressed and withdrawn and by going into rages in which he would strike people, throw things, and threaten suicide. In answer to the interview question as to how patients acted when they were upset, such answers as "She'd give you the silent treatment" and "He'd never argue, just clam up" were obtained.

Many of these patients had shown an attitude of silent suffering toward illness. One woman had been treated for back trouble and swollen ovaries and, although seemingly in pain, never complained and refused to wear a brace, which had been prescribed. The family felt that she did not complain because she did not want to worry them. When not well, she shut herself in her room. A son had died of poliomyelitis ten years previously, and since then she had not mentioned his name. As a girl, her way of showing resentment had been to lock herself in her room, and when she did this, the family worried that she would commit suicide. Another pattern of adaptation shown by patients in this group was the exhibiting of tragic, ludic,* behavior concerning illness and death. A girl who developed a marked akinetic syndrome had been told as a child that she had heart disease. She was fond of clutching at her chest in a mock attack and, as a nursing student, she terrified her friends by seeming attempts to jump out of windows. Another woman with a severe withdrawal reaction had developed dramatic fears of cancer and tuberculosis and germs.

There is an unusually high incidence of chronic illness in the families of these patients. This is a source of added stress and seems to predispose to the use of the symbolic content described. A soldier who said he had been killed attributed his accident to having been blown up in an atomic explosion. In an interview with his mother, she described him as a very quiet boy with rare episodes of violent temper; then she dwelt at length on how devoted he had been to her through her many illnesses. She detailed how he was almost stillborn and subsequently listed a blood clot on her heart, numerous operations for female

* This term has been used by Jean Piaget to describe the play, imitative, and pretending aspects of behavior in children.

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trouble, a lung abscess, coughing up blood, etc. She went on to tell how a doctor had said, following a previous injury, that if her son ever got another blow on his head it would kill him. Her conversation was sprinkled with expressions like "worry myself to death" and "fit to kill me." Here the patterns of social interaction whereby the patient derived his concept of self seems to have been composed predominantly of symbolic representations of death and violence.

These symbols are used in a way comparable to those of funerals and mourning customs where the black dress, slow step, and hushed voice serve as imitations of death. Symbols of violent death and suffering in religious ritual furnish the content of a pattern of interaction in the environment in which the individual derives his feelings of truth, faith, and belief. The greater the stress, the more intense may be the feeling. That symbols of death and destruction may serve as modes of adaptation to stress has long been recognized. Aristotle in his account of tragedy said that one may be purged of feelings of fear by the imitation of some deed of horror.

Mood Changes

The behavior of patients with euphoric and paranoid attitudes will be described from the standpoint of symbolic adaptation. Changes in mood also involve other patterns of interaction such as those relating to food, sex, money, and behavior best described as puerile.

Euphoric and Paranoid States

A euphoric response appears to be an implicit form of denial of illness when the patient responds to a question about his condition with a laugh or a joke. Some patients show hypomanic behavior, with much clowning and horseplay. At times it is difficult to separate euphoric from paranoid behavior (or, for that matter, from depression), and it is, in part, a matter of the observer's own involvement in the situation as to whether the content is euphoric or paranoid and a laugh is a gay or sarcastic one. Thus, one patient on entering the hospital claimed that he had been beaten up by his wife. Behavior is often melodramatic in a comic or tragic fashion, and the adjective "ludic" quite aptly describes these aspects. Following a craniotomy, for example, a patient expressed no concern as to its outcome but went into an amusing (?) denunciation of the financial rapacity of his neurosurgeon. Dramatic expressions of resentment and affection were common and often intermingled. In one sense this behavior is contradictory or a manifestation of ambivalent feelings. From the standpoint of adaptation to stress, it is a form of implicit denial and a means of gaining a sense of identity through the selectively organized interaction. Thus, the patient who denounced the surgeon had himself been a highly successful businessman for whom money had been the main source of prestige and focus of social relationships.

There is also a great deal of physical identification with people, particularly doctors and nurses. Patients poll-parrot words and imitate gestures. They may answer the greeting "How do you feel?" with "How do *you* feel?" While being examined a patient may take up the reflex hammer or the pin and make an imitative gesture.

There seems to be a great need for physical contact. Patients insisted on being handled, fondled, and touched in some way. There was much noisy, puerile behavior and exposure and conspicuous incontinence of urine and feces. Patients might call for a urinal, then wet the bed before it arrived, or use it and spill the contents, followed by the patient being changed, handled, powdered, etc. In the verbal sphere many of these patients express confabulations and delusions about children. One man maintained that he could get well if he could get a certain laxative not in the hospital formulary. When, after much entreaty, it was obtained, he refused to take it. Others interact in terms of food, developing tremendous appetites or becoming finicky and demanding in their eating habits. Complaints of pain are common, in contrast to the behavior of patients with explicit denial or inattention and withdrawal. This group of patients are a trial

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to the nursing staff and are much more apt to be considered disturbed and psychotic than are those with other forms of adaptation.

SEXUAL BEHAVIOR

The alterations in sexual behavior prominent in this group have many ludic aspects. Patients charge that they are being kept in the hospital because someone has immoral sexual designs on them. When questioned about disabilities, patients respond with sexual banter. Illness is attributed to too much, too little, or a certain type of sexual activity. The manner in which altered sexual behavior serves as a mode of adaptation may be illustrated in the case of a woman who received a course of electric convulsive therapy for pain in her neck associated with the neck-torsion deformity of dystonia musculorum deformans. On admission to the hospital, she seemed anxious and secluded herself because she was ashamed of her bizarre posture and gait. After the seventh treatment she walked about openly stating that people were looking at her because they were sexually interested. She charged that some sailors had come into her room, drugged her, then knocked her on the head to take advantage of her sexually (shock treatments were preceded by an intravenous injection of Amytal Sodium). She also developed a reduplicative delusion about another patient who had a plaster cervical collar and expressed the idea that this woman "needed a boy friend to straighten her out."

Patients in this group had previously shown certain habitual patterns of social relatedness which differed from those of people who, under comparable conditions of brain function, expressed verbal denial or were withdrawn and depressed. The outstanding characteristic appeared to be the great degree of emotional identification with other people. Such adjectives as "affectionate," "excitable," "sympathetic," "sensitive," "jealous," "worrisome," "shy," and "dependent" were commonly used by relatives. This, of course, does not mean that the patient was "dependent" in any absolute sense; rather, this was a term in which the relative structured the relationship. Also, the patient's behavior seemed to conform to the cultural stereotype we have of dependence. As a group, they seem to have been very responsive to the attitudes of other people, with a need for tangible evidence that they were liked or esteemed.

Great importance was attached to the physical aspects of expression and appearance. Laughter and tears and other conventional representations of happiness and sorrow were common. One young man had grown up feeling liked by people only if he appeared happy, cheerful, and unworried. There was much preoccupation with looks. One man, for example, was fond of saying that if he were taller and had good teeth he would own the world. Many of the patients seem to have been very conscious of smells and tastes.

The use of particular symbolic content, such as sex, food, and money, under conditions of altered brain function can be correlated with the way these symbols had been integrated into patterns of social relatedness in the past. For example, patients who showed clinical aberrations in sexual behavior had habitually placed great emphasis on sex. They were described as concerned with sexual attractiveness, flirtatious or prudish, and sensitive to sexual implications in personal relationships. One woman was particularly exhibitionistic and coquettish during her hospitalization. She was a former actress, with many admirers and affairs, and was described as having been vivacious and temperamental. Other patients with similar behavior in the hospital were considered as having been extraordinarily prudish. In all cases the patients conceived their interpersonal relationships in sexual terms.

Another aspect of the social background was the tendency to classify the environment in sexual stereotypes, particularly popular ones of masculinity and femininity. Thus many male patients had felt that to be a man, sexual conquests, or reports of them, were necessary. The fact of belonging to one sex or the other had been regarded as a basis for certain character traits as, 'You can't trust a man." Some women seem to have attributed their problems to the accident of sex or to have blamed some man for them, and it was of interest that they frequently developed delusions about men changing into women.

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¶ Conditions of Brain Function

The symbolic patterns that have been described were present in enduring fashion in patients with structural brain damage studied clinically, electroencephalographically, and anatomically. In these cases the lesions are those which, by reason of rapid development, central position, diffuseness or multiplicity, or association with increased intracranial pressure or subarachnoid bleeding, produce generalized, usually bilateral, slow-wave electroencephalographic activity. The pathology involves the centrencephalic system rather than any specific cortical area or discrete projection system. Pathological conditions include infiltrating gliogenous and multiple metastatic tumors; acute vascular accidents, particularly with subarachnoid bleeding; cerebral lacerations; and toxic-inflammatory and disturbed metabolic processes. While any lesion which displaces the ventricular system may be associated with enduring denial of the types described, the optimum milieu is furnished by lesions of the diencephalon and midbrain and aneurysms of the circle of Willis. Such patients manifest the various denial syndromes most clearly because they do not have the gross defects in perception and symbol formation, such as aphasia, found in cases with cortical damage. The requisite neural milieu is also provided by bilateral prefrontal lobotomy and the effects of usually four or five electroshock convulsions.

Despite the presence of this pathology, lesions of the centrencephalic system do not cause denial per se. Other patients with comparable lesions showed little change in symbolic expression, according to the methods of study used. Nor can one predict the clinical syndrome on the basis of a knowledge of the pathology and the electroencephalographic record alone. In individual cases, however, the correlation of changes in behavior with the development of diffuse slow-wave electroencephalographic rhythms is often striking. In the progression of a brain tumor, for example, during the stage where the electroencephalographic record is normal or focally abnormal, a patient may be anxious and worried about his illness. With the appearance of a diffusely slow-wave rhythm, he becomes euphoric or offers a bland denial of his problems.

When recovery from the brain injury is rapid, as in instances of encephalitis, trauma, subarachnoid hemorrhage, or the successful removal of a benign tumor, a clinical picture comparable to the abstinence syndrome in drug withdrawal may appear. Here the patient becomes extremely agitated, may hallucinate, and becomes depressed. There is, thus, the paradox of an improvement of brain function and an apparent worsening of the clinical state.

In most cases, the abstinence reaction does not appear, but instead confabulations and delusions are superseded by other symbolic patterns. These include accounts of the illness of other people and references to their own condition in terms of what doctors, nurses, or their relatives did or said. Patients may become obsessively preoccupied with trivial ailments, past or present. Vows and resolutions about the future are common in this stage. Some patients use humor at the points in the interview where disorientation or confabulation was formerly elicited. When these patterns of language supervene, clinical anxiety does not appear.

It is evident that there are many types of explicit denial, disorientation, confabulation, paraphasia, amnesia, withdrawal, ludic manifestations, and altered sexual behavior that occur as responses to stress at various levels of brain function. In barbiturate intoxication the patients deny staggering gait and dysarthric speech. In anoxia there is denial of failing capacities, while states of euphoric denial are seen following cortisone administration. People with normal brain function deny the existence of cancer, venereal infection, or pregnancy, while the Christian Scientist denies the very existence of disease. Whatever the level of brain function, there is a relationship among the degree of stress, the situation in which the behavior is being studied, and the personality or social background.

¶ Applications

The formulations that have been made may be applied in many areas of neurology and

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psychiatry. They are most relevant to the relationship of behavior to changes in brain function, where they indicate the need for study not only along anatomic-physiological lines but in psychodynamic and social and cultural contexts. A great deal of current thinking equates certain aspects of behavior with functions of the brain more or less localized in particular areas, either anatomically defined or distinguished by physiologically measurable properties. For example, patients with explicit denial or euphoric responses are commonly regarded as showing "loss of insight," and the lesion is usually localized in the frontal lobes. The implication is that there is a function, "insight," residual in the frontal lobes. Such a "function" is what Lashley has termed a pedagogical abstraction and is simply a version of the patient's behavior. It completely ignores the highly selective and motivated character of the behavior and the fact that the patient may show excellent judgment and insight in areas that do not concern his problems. Similarly, explanations for altered sexual behavior have been that the brain lesion has caused a "release of repression" or a "loss of moral sense." Here, one confuses socially inherited concepts with physiological functions. A review of some of the theories of anosognosia points up the need for a multifactorial approach.

Theories of Anosognosia

In the literature, anosognosia has been generally regarded as a disturbance of body scheme. This is conceived as a three-dimensional image of the body represented in one parietal lobe or its connections. When this localized region is destroyed, the patient becomes unaware of the existence of his limbs or those parts of the body which are represented, apparently in a manner comparable to cortical motor and sensory representation. We have found the body-scheme hypotheses inadequate in many respects. First, anosognosia, as with hemiplegia or blindness, does not occur as a unitary phenomenon but in association with other changes in symbolic organization such as disorientation or reduplication. Patients deny not only physical disabilities but *anything* that they feel is a problem, and one would have to construct an incredible mosaic of functions in which parts of the body, their diseases, and various traumatic situations would be represented. No matter where the lesion is placed, many patients with such brain damage, and even with hemispherectomy, do not show either explicit denial or inattention. The hypothesis quite ignores the role of premorbid personality factors.

A more psychodynamic approach involving motivational factors has been taken by others. Goldstein pointed out that denial in itself is a psychological mechanism present in normal persons. He felt that the greater the defect, the greater the defense. Sandifer stressed the motivation of the patient to be well and interpreted denial as a means of avoiding a "catastrophic reaction." This view equates denial with a psychophysiological process or drive rather than considering it as a form of symbolic organization and does not take up the cultural, social aspects of motivation.

Prefrontal Lobotomy

The observations are also applicable to a hypothesis of the action of somatic therapies, particularly prefrontal lobotomy, and the shock therapies. These have in common the factors of added stress and altered brain function. Following bilateral prefrontal lobotomy the matter of success or failure seems to be one of the type and duration of the symbolic reorganization that occurs. If the patient explicitly denies his operation and the problems that led to it, or if he speaks of them in a euphoric fashion, then the operation is regarded as "successful." If his adaptation is in the form of lethargy and withdrawal, then it is "unsuccessful."

Electric Shock Treatment

In electric shock treatment, therapeutic improvement likewise depends on the creation of an altered milieu of brain function, in which new patterns of symbolic organization occur. It should be remembered that "therapeutic improvement" is only one category of behavior that can be correlated with other aspects. In

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one series of patients treated with electric shock treatment for intractable pain, symptomatic relief, that is, denial of, cessation of complaints of, and apparent indifference to pain, occurred only in those subjects who showed patterns of disorientation, paraphasia, and reduplication.

In a group given electric shock treatment for psychiatric illness, it was found that, after four to six treatments, the intravenous injection of Amytal Sodium elicited patterns of denial and disorientation in the improved patients, while in the unimproved group such a response rarely occurred even after many more treatments. In ordinary clinical interviews the patients rated as improved showed such language patterns as denial, reduplication, changes in tense and person, clichés, and stereotyped expressions and used evasion and withdrawal to a much greater extent than an unimproved group. Studies of the relationship of personality and social factors to therapeutic improvement are in progress.

The scope of this chapter does not permit a discussion of the symbolic patterns associated with the most common type of altered brain function—sleep. Nor is there space to consider how children use confabulation, paraphasia, reduplication, and other types of symbolic organization as modes of adaptation to stress, or to discuss the role of these symbolic patterns in forced social isolation such as "brain washing." It is hoped, however, that the data will call attention to the need for new viewpoints in psychiatry in the study of symbolic processes as a whole.

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CHAPTER 49

LANGUAGE AND PAIN

Thomas S. Szasz

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NOWADAYS, WHEN PSYCHIATRISTS address themselves to problems which relate to the body, they speak of the "psysomatic aspects" of the particular phenomenon. Thus, it has become conventional to speak and write about the psychosomatic aspects of cardiovascular dysfunctions, of peptic ulcer, or of pain. The terminology of "psychosomatics" is used—and I wish to underscore this since it has, apparently, not been appreciated—in psychiatric considerations of bodily (or so-called "somatic") symptoms. Contrariwise, psychiatric considerations of nonbodily ("mental") symptoms, such as phobias or character disorders, are never referred to with the adjective "psychosomatic." In order to maintain symmetry, the medical study of mental symptoms should also be labeled "psychosomatic." An examination of the present state of affairs in medicine and psychiatry will show, however, that this is not the case. In the first place, there is no such thing as a medical study of a phobia or a character disorder, and for good reasons, as will be discussed later. Secondly, while a medical inquiry into other (overtly) mental symptoms—such as hallucination, depression, elation, etc.—is possible and extant, the approach is not usually referred to as "psychosomatic."

¶ The Problem of Pain in Medicine and Psychiatry

"Psychosomatic Medicine": the Mixed Language

As I have thought about the problem of pain, it has become increasingly apparent to me that the expression "psychosomatic medicine"—and the concepts so denoted—are a hindrance rather than a help to us.[8] While it is true that I myself have used this terminology in years past, I now believe that we can do better without it. The reasons for this point of view are set forth and documented in detail in my book *Pain and Pleasure*.[10] They are, in the main, neither novel nor original, and I shall state them here only briefly.

My thesis is simply that medicine and psychiatry possess separate objects of study and utilize different methods of observation. Moreover, their concepts, hypotheses, and inferences

are expressed in different languages. They thus complement one another but are otherwise unrelated and, very likely, unrelatable. Accordingly, we may regard medicine as one language, psychiatry as another, and psychosomatic medicine as a mixture of two (unrelated) languages.[12] Using this metaphor (although this is much *more* than a metaphor), it is readily apparent that a mixture of, say, English and Hungarian would result in a mixed language that would be no improvement on either, and would, indeed, be less useful for almost any conceivable purpose than either one alone.

Some workers, well aware of the methodological differences between medicine and psychiatry, still consider the "psychosomatic approach" a useful one, understanding thereby a separate use of both methods and a combination, in the mind of the observer, of what has been learned. I do not see how anyone could object to this conception of psychosomatic medicine. At the same time, I think it should prove to be extremely difficult, if not impossible, for anyone to put this conception to actual use in a clinical situation. For, when faced with a patient or professional colleague, one is usually placed in the position of being addressed in either one or the other idiom. One must therefore either respond in the same language, or else one may choose to make the language in which one has been addressed explicit (that is, make a metacommunication). Thus one may raise the question of its possible inappropriateness for the problem at hand. To illustrate: An internist, confronted by a hypochondriacal patient whose body on physical examination appears to be healthy, may respond in one of the following ways. First, adhering to the idiom in which he was addressed, he might say that he could not find any bodily disease. (The patient may, of course, persist in his habitual language and proceed to consult another physician.) Secondly, the physician may add to the previous statement by suggesting that there may be some other, nonbodily (personal) trouble in which the patient finds himself and about which he expresses himself in this (hypochondriacal) way. (We are not concerned now with the patient's possible responses to this communication, nor with certain other communications which the physician might make in this situation.) The latter example illustrates a metacommunication, that is, it is a communication *about* the patient's communication (to the physician).

Among the several alternatives from which the physician might choose in such a situation, there is one other response worthy of comment. This is the response which is made in an idiom other than that in which the physician was addressed. As an example, the physician might say something like this to a patient who is worried about hypertension: "Well, your blood pressure is a little bit high, but I do not think it is important. I think maybe what worries you is . . . (whatever it may be) your job, wife, etc. . . ." The psychosomatic approach currently in vogue seems to me to predispose to this particular type of patient-physician dialogue. Switching and mixing languages is usually (though certainly not always) undesirable for both theoretical clarity and therapeutic practice. I shall have more to say about this subject in connection with its specific bearing on the problem of pain.

The Language of Medicine

Medicine, as I use this term in this essay, denotes the science and practical application of various disciplines which use the physicochemical method. The object of these disciplines is the body as a physical "thing" or "machine." This can be contrasted (not, however, for purposes of praise or condemnation!) with the psychiatric frame of reference in which the object of study is man as "person" or social being. One of the most eloquent exponents of the point of view to which I subscribe is J. H. Woodger, to whose book, *Biology and Language*,[11] I refer the interested reader for further details. Following a differentiation between the physical and psychological sciences and languages, Woodger, in fact, suggested that each of these are themselves mixed languages and may be subdivided further as follows:

Returning after these explanations to our original theme, it will, I think, be clear that we have

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to deal not with two languages but with *four*: first, the language of the physical sciences which speaks exclusively of physical objects; second, the language of sensible objects. The statement that this yellow sensible object is more orange than that one would be an example of a statement belonging to this language. Third, we have the person language, to which such statements as "Tom loves Mary," "Tom is trying to remember his telephone number," belong. Fourth, the community language. By way of example, I may quote the opening paragraph of Tolstoy's *Anna Karenina*: "All happy families resemble one another. Each unhappy family is unhappy in its own way." That is a possible zero-level statement in the theory of families or medical psychology. To this of course belong statements in the theory of government and of law. Most of the statements in our daily newspapers belong to person language or to community language or to both. Now in a natural language like English all these languages are hopelessly muddled up. The first is the most easily sorted out, although its syntax and semantics are by no means so well known that it is impossible to talk nonsense in it without being found out. But with the others there is chaos (Woodger,[11] p. 270).

We have trouble enough in the languages of medicine and psychiatry. In "psychosomatic medicine," the chaos of natural English is augmented and glorified. But let us focus our attention on medicine. The language of medicine is comprised of the first two languages listed by Woodger. It deals (1) with physical objects, for example the consolidated lung of pneumonia, and (2) with sensible objects, for example "physical pain" (namely, "It hurts more here—in the right lower quadrant of the abdomen over an inflamed appendix, than it does there—say, in the left flank"). The therapeutic methods used in medicine are likewise physical or chemical, such as surgical procedures or chemical agents.

The word "pain" is used as a noun or an adjective in the language of medicine. We may ask how it is used and what is its meaning. A detailed exposition of its many meanings is an important part of the study of medicine, especially of anatomy, physiology, and neurology, but we shall not be concerned with that subject in this essay. We shall have to be satisfied with a few general comments which call attention to certain characteristic features of the use of the word "pain" in the language of medicine. These characteristics are the following:

1. Pain is a sensation. By this it is meant that there is a relatively constant and predictable relationship between sensory input, or stimulus, and the resultant pain sensation which it is thought to invoke. For example, a burn, a fractured ankle, or a ruptured appendix are all regarded as causing pain essentially irrespective of the sort of person who experiences these injuries.

2. The structure to which pain points as a referent is the body as a physicochemical machine. This statement is, in part, redundant, inasmuch as all sensations refer, by definition, to the body (in the sense stated). It is worth while to make this explicit in this form, however, because it underscores the fact that the word "body" here denotes a public or physical object (versus the patient's concept of his body or a fear of its injury).

3. The intensity or reality of the pain is verifiable by the observations of physicians (or other examiners). This notion is inherent in the usage as described in (1) and (2). In other words, the patient's complaint of pain is checked by the physician on the basis of his examination of the patient. If he finds no structural lesion or dysfunction—and worse, if the pain is not accompanied by its usual physiognomic signs—he may then entertain doubts about whether the patient really has pain. In other words, this matter is viewed on the model of a physical experiment. The patient's assertion of pain is the observation that is to be verified—or falsified—by repetitions of the observation by other observers. The other observers are other physicians. If a lesion is found which is considered consistent with the complaint, the patient's assertion is regarded as having been verified. If no physical disorder is found, the patient's claim to pain is contested. It is regarded as a disproved hypothesis, false and "unreal."

The value of this approach, and of this physicalistic use of the word "pain," is as

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evident as is the value of the physical method in physics itself. The diagnosis of all painful illnesses of the body rests, in fact, on this method of approach which properly occupies the diagnostician, the neurologist, and the surgeon. Yet, just as the value of this method is clear whenever the physician is confronted by a problem posed by a disordered physico-chemical machine, so the uselessness of it is equally evident in those situations in which the bodily machine is functioning properly.

It may be argued that usually one does not know in advance—that is, before performing the proper physical examinations—whether the body is or is not disordered. This is true. What remains to be emphasized, therefore, is that with those patients in whom the physical studies fail to reveal bodily disease, persistence in the medical mode of inquiry becomes fruitless and cannot be justified—as it usually is—by watchful vigilance for the early signs of an as-yet-undiscovered illness which is about to manifest itself. While we may all have such undiscovered ailments, there is much reason to doubt that this type of (excessive) vigilance is of benefit to the patient. Such vigilance serves primarily the needs of the physician unless, of course, it coincides with certain psychological needs of the patient, as, for example, in cases of hypochondriasis.

The Language of Psychiatry

By psychiatry I refer to what the British call, perhaps a shade more accurately, "medical psychology." These terms denote the science and practical application of those disciplines which use the psychological method and language (in a medical setting). Their object is man as a social being, his development, social identity, self-concept, and his relationships with his fellow men. The idioms appropriate to such discourse are what Woodger aptly called the "person language" and the "community language." According to Woodger[11]

> . . . medical psychology is really a branch of sociology, especially the sociology of families . . . [which] needs no dualistic language in the ordinary sense of that phrase . . . (p. 301).

And further he stated that:

> Words like "psycho-somatic" are only invented to heal a breach which need never have been made. I have maintained that medicine has no need for a dualistic language (in the usual sense) and would be better without one. If we use person language we can see that medicine is involved in the sociology of family life and that the so-called medical psychology deals with problems arising from the difficulties of living together under one roof of persons related by the parental or some derived relation (pp. 317–318).

Other scientists and philosophers (of science) have expressed the difference between physics and psychology in somewhat different terms. All emphasize, however, the need to maintain, as much as possible, homogeneity of language and to avoid jumping—particularly when such jumping is done unwittingly—from one level of abstraction to another. The confusion of languages with their respective metalanguages in the same discourse is, of course, but another form of language mixing.

Russell[8] emphasized the public character of the objects with which physics deals, as for example, the burst of a rocket, in contrast to the private character of psychological data, such as a dream. This distinction is particularly germane to the over-all problem of pain. Medicine (as defined previously) deals with pain only as public datum. I summarized this earlier when I stated that pain denotes a sensation which refers to the body (as a physical object), and which may, further, be verified or falsified by other observers.

We are now in a position to summarize the characteristic features of pain as this word is used (or should be used) in the language of psychology (psychiatry).

1. Pain is an affect. By this it is meant that the personal, including social, characteristics of the individual experiencing pain are regarded as the most important objects of observation (data). For example, even in a case of so-called physical pain, such as usually occurs with a perforated appendix, the experiencing ego's orientation to the body (as a psychological object) is the conceptual framework for the understanding of pain. This point of view adds

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nothing, of course, to the medical view in the simple everyday occurrence of this phenomenon. In this instance the two pictures, so to speak, overlap completely, and no interesting difference between them is therefore visible. This difference shows up, however, in those much rarer instances in which the patient suffers this catastrophe without pain. A similar but even more dramatic example is that of serious self-mutilation, in which patients remove parts of their bodies without experiencing pain. The medical language fails here completely, and at the same time the value of the psychological language can be vividly demonstrated.

2. The object to which "pain" points as a referent is the body as a psychological object. Instead of "psychological object," one may say "personal object." Using Woodger's example of a statement in person language, "Tom loves Mary," Mary is a personal object for Tom. Mary is therefore a different person (different object) for Tom, who loves her, and for Jim, who does not. Even our everyday notions of psychology take cognizance of this fact. The importance of this otherwise trivial observation lies in the contrast between it and the nondifference—for several observers—of Mary's body as an object of medical study. To sum up, in psychological language, pain denotes a private affect which refers to an equally private object, namely, one's own conception (conscious and otherwise) of one's body.

3. To speak of the "verification" of the pain by other observers is meaningless in this idiom. An affect, or experience in this sense, is a primary private datum and as such can be neither verified nor falsified. William James[5] stated it this way: "Sensations are forced upon us, coming we know not whence. Over their nature, order and quantity we have as good as no control. They are neither true nor false; they simply are. It is only what we say about them, only the names we give them, our theories of their source and nature and remote relations, that may be true or not" (p. 160).

This nonverifiability of pain as an affect has the utmost practical bearing on the use of this word in the communicational pattern between patient and physician, and particularly between patient and psychiatrist.

In this chapter I shall endeavor to present a brief exposition of the psychology of pain, that is, our knowledge concerning pain as private datum, its development, organization, and communication.

A Psychoanalytic Theory of Pain

The Language of Psychoanalysis

The science of psychoanalysis began under the auspices of nineteenth-century neurology. Its objects and method, however, were consistently psychological. It is not at all surprising, therefore, that the language of psychoanalysis is a mixed one. The impurity of its idiom has persisted to this day, although it should be noted that there has been a persistent trend toward abandoning the neurological-physiological components of the language and an increasing adherence to a purely psychological idiom. This has been most noticeable, and most successful, in those areas of psychoanalysis which deal with so-called purely mental symptoms or phenomena (for example, defense mechanisms, dream interpretation, etc.). The mixing of languages has continued in its most flagrant form in connection with writings about so-called somatic symptoms (for example, psychosomatic theories). Among the latter, pain has been a prominent example, so much so that until recently this phenomenon was hardly considered to fall within the domain of psychoanalysis, unless it was first labeled "psychogenic" or "hysterical." Elsewhere, I have presented a psychoanalytic theory of pain, in a purely psychological idiom, and what follows is a condensation of this material.[10]

Anxiety and Pain

The very adequate theory of anxiety in psychoanalysis makes it a logical model for our approach to the understanding of pain. Both anxiety and pain can be considered as affects. We shall thus discuss our views concerning pain by comparing them with our views of anxiety. Pain and anxiety, and other affects as well, have different meanings at different stages of ego development. The situation will first be

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considered as it exists in the case of the adult ego.

The primary meaning of anxiety for the adult ego is that of a warning of "danger ahead" (Fenichel,[2] p. 43). What is the nature of the danger that the ego signals with anxiety? Freud[3] considered this question at length in *Inhibitions, Symptoms and Anxiety* and concluded that the danger is that of losing a needed object (originally the mother). We can interpret pain analogously as a warning of the danger of the loss of a part (or the whole) of the body.

What evidence is there for this assertion? Suppose we are cut, bruised, or burned on some part of our body. In so far as the ego is aware of this event, it will experience pain. However, pain is not only a response to a danger—that is, to an injury of the body; it may also be looked upon as a signal warning of the threat of still further injury. Injury, in the examples mentioned, consists of disruption of the continuity of the skin and the loss of tissue. Pain as a signal warns against still further damage, which may be conceptualized as loss of a part of the body. The protective reactions that pain evokes—for example, withdrawal of the part involved or the emergent need to put the injured part at rest—are in harmony with this interpretation.

Schur,[7] in a recent paper, reformulated Freud's concept of anxiety as follows: "The ego evaluates the danger and experiences some shade of anxiety. Both the evaluation and experience act as a signal to induce defenses" (p. 32). According to my thesis, this reformulation would apply in so far as the ego is oriented toward personal objects. When the ego is oriented toward the body, it evaluates the danger and experiences some shade of pain. This concept thus leads us to the problem of the nature and outcome of the defenses that are induced by pain.

The meaning of pain cannot, however, be limited to the danger of body loss. Reflection about clinical observations points to another group of phenomena associated with pain. These phenomena are superficially dissimilar but are alike in that they all have to do with a relatively excessive degree of stimulation of a variety of different organs and tissues. Indeed, in so far as excessive stimulation is perceived by the ego and is experienced by it in relation to the body, it is felt as pain. Thus, we experience too-intense light or excessive sound as painful, the feeling being referred to (that is, experienced in relation to) the respective bodily parts. Similarly, certain processes in internal structures, particularly in the hollow viscera (gastrointestinal and genitourinary tracts) and in the coverings of some organs (liver capsule, dura mater) are related to the experience of pain in terms of overstimulation. In these situations the anatomical parts in question are accustomed to a certain range of change in their dimensions, as for example, the distention and motility of the intestinal tract associated with the ingestion of food and with digestion. When the upper limit of these stimuli is surpassed (which occurs with excessive distention or excessive peristalsis), the reaction is pain; whereas cutting or burning of these structures is not perceived at all. Likewise, organ capsules mediate changes in the size of the organ which they enclose. Here, distention, stretching, and vascular changes cause pain. We conclude that in each of these instances the pain experience is related to the specific (normal) function of the body part in question.

To summarize, the ego evaluates the danger in its relationship to the body and experiences some shade of pain. The meaning of the pain can be divided into two large groups. First, pain indicates the danger of the disruption of the continuity of the body and the danger of losing a part of the body. The term "body part" here denotes a picture of the surface of the body or an appendage—in other words, body parts which are cathected as objects and which accordingly can be lost (detached). This concept may include functions (such as vision, hearing, etc.) which may be lost, but which are not structures in the anatomical sense of the term. Secondly, pain is a reaction to and a warning against the danger of excessive stimulation. This meaning of pain applies to those parts of the body which are within the outer covering, at some depth from the surface. We are, of course, familiar with these two categories of danger (that is, loss and excessive stimulation) in connection with the meaning of anxiety.[1]

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The Development of Pain

Ideas about the origin and early development of any aspect of the personality are, of necessity, speculative and hence much less readily verifiable than constructions concerning the adult. It was for this reason that I started with the adult situation and left the reconstruction of early development for later.

Once again the interlocking nature of the concept of ego and affects makes it advisable to re-examine our view of early ego development before turning to the question of the nature of the early affects of pain and anxiety. Authors differ about the way in which the primitive ego comes into being. According to Fenichel[2] (p. 36), "The sum of the mental representations of the body and its organs, the so-called body image, constitutes the idea of I and is of basic importance for the further formation of the ego." Thus, in this view, the earliest ego-states consist of bodily feelings. Here the ego is regarded as an entity. The same thought may be expressed in terms of the ego's relationship to another system: The ego's first object is the body, and this relationship is experienced in terms of (bodily) feelings.

The formulations of Hartmann, Kris, and Loewenstein[4] follow similar lines. They suggested that the mental apparatus evolves from an undifferentiated matrix. Instead of viewing the ego as developing from the id, they consider that both the id and ego evolve simultaneously from a common matrix. This was an important departure from the older view, because it was the first operational formulation of the origin of the ego (that is, ego can be said to "exist" only as it interacts with the id, and vice versa).

As I have previously suggested, we can, on the basis of object-relationships, subdivide the object world into two parts: the body on the one hand, and people as objects on the other (leaving inanimate objects out of account for the present). From this subdivision naturally arises the question of which of these objects, if either, is genetically earlier. This question is difficult to answer on the basis of reliable observational material. The *a priori* likelihood seems great that this question will be resolved in the end by an answer of simultaneity. Nevertheless, after voicing these reservations, I favor the idea that the body as an object is more important for the early ego than are people as objects.

The following argument is advanced in favor of this assumption. We surmise that it is the perception of stimuli from objects which brings the primitive ego into being. Moreover, we know that the satisfied infant is an infant asleep, and that during this early sleep he can be said to be without an ego. Awakening and awareness must first arise in connection with predominantly painful (that is, unpleasurable) perceptions, such as physical injury at birth, hunger, thirst, or cold. These unpleasant stimuli arise, of course, from the infant's body, and, in this sense, the primitive ego's first object would be the body (of the self). I must hasten to add, however, that this is not what I mean when I say that the body is an object of the ego, since, in the example cited, the knowledge of what constitutes the object (the body) is only in the mind of the adult observer. To the infant, both ego and object must be vague and undefined.

What remains to be emphasized is that, in the foregoing view, supremacy is given to those stimuli that appear to be most intense and prolonged (and these originate from the body) rather than to those that are most rewarding or necessary for survival (that is, stimuli originating from the mother). Heretofore, in psychoanalytic theory, the latter have been greatly favored over the former.

For the sake of simplicity and brevity, I will consider the ego's relationship with objects at three levels of development only and will indicate the nature of pain and anxiety pertaining to each. The many transitional stages between these three are not germane to our present inquiry. The first stage of ego development (age unspecified) is the familiar one of the differentiation between ego and nonego. There is no differentiation between objects. The affect pertaining to this stage of development is best described as undifferentiated pain-anxiety (or unpleasure, unlust). The next stage, perhaps occurring between four and nine months, is

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that point in development at which the infant knows the difference between his own body and the person(s) who cares for him. (The ability to distinguish between mother and father probably follows shortly thereafter.) With the beginning of this differentiation, we can speak of the ego as oriented to the body or to objects (mother). Accordingly, primitive pain-anxiety becomes differentiated into pain (in relation to the body) and anxiety (in relation to objects). Finally, the third stage is that of the adult ego. The overdetermined meaning of both anxiety and pain, at this developmental level, has already been discussed. It may be noted now that pain and anxiety may also appear as defenses, each one against the other. Illustrative of this is the so-called hysterical or hypochondriacal pain which, if successfully dealt with in analysis, will be replaced by anxiety. Conversely, stoical patients with rigid defenses against illness and pain will often experience anxiety in connection with bodily ailments as a defense against feeling pain.

Pain Situations

Another way in which the problem of the different meanings of pain may profitably be aproached is by scrutinizing the personal and social situation of the person experiencing pain. This mode of analysis is complementary to the developmental one. Although the two overlap, each provides us with distinct insights into the problem of pain.

The One-Person Situation

The situation here is that of a person experiencing pain who may or may not actually be alone. In any case he does not communicate his feeling to anyone—to anyone, that is, but himself. In terms of communication, the situation is that of a message being sent from the body to the ego. The word "body" here denotes whatever is so recognized by the ego. It refers to the person's concept of his body, which may be at once sophisticated and primitive, inasmuch as numerous concepts (or images) of the body may be unconscious. Thus, a physician, for example, who may have a scientific concept of his body on a fully conscious level of functioning, may also harbor repressed, primitive ideas. This is analogous to the way in which his conscious ideas and feelings about his wife might differ from certain views of her which he might have repressed, or which he may have transferred to her from others, and which he may have therefore never actually (consciously) experienced. Moreover, the concept of "body" will usually be something rather vague in infancy and more definite in adulthood. In any event, unless there is a more or less clear-cut split of the ego into experiencing and observing parts, there can be no question, in this situation, of validating the pain. This is so because there is only one "observer," and he is the same as the "experiencer." In this situation, therefore, all pain is "real" ("organic," "bodily pain"). Most of the pain that we feel or of which our patients complain can be understood best as to its experiential meaning by assuming that it is of this type.

Validation is possible, however, even in this situation, as noted above. For this to occur, one must rise above his own experience of pain, so to speak, and become an observer of it. This is by no means impossible, and indeed, it is not even unusual. Small children cannot usually achieve such detachment from their experiences, but many adults can. A measure of educational or intellectual sophistication is conducive to achieving this type of self-observation, for the "natural" (uneducated) attitude to affects, and in particular to strong affects of a bodily nature, is to accept them at face value. The following type of occurrence is an everyday example of the validation of pain in a one-person situation. While working at a manual task, you feel a sharp pain in your eye. Instantly you conclude that a foreign body has lodged in it. There is a conviction that you *have* a foreign body in it. You proceed to the mirror, locate the speck of dirt, and remove it. The pain in the eye, sometimes quite unchanged from what it felt like before the substance was removed, may nevertheless persist. Yet if you are convinced that no foreign material has been left in the eye, your *conclusion* about the pain will be quite different from what it was a few moments earlier. In other

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words, the affect of pain before the removal of the foreign body and afterward is virtually the same. In the first instance, there is no validation: Body-as-object and physical body are one and the same. Examination of the eye and removal of the offending substance constitutes the validation. The pain after the removal points to the body-as-object, but is contrasted with one's knowledge that the material has been removed from the body (eye) as a physical structure. Someone may object to this analysis and claim that the afterpain is simply due to scratching of the cornea. I have deliberately neglected to mention this factor, not because I think it is irrelevant, but rather because it distracts from the phantom quality of this type of experience. In other words, the slightest injury to the eye immediately becomes heavily cathected, and this largely accounts, I think, for the type of experience which I sketched above.

THE TWO-PERSON SITUATION

In a two-person situation we can distinguish between two different meanings of pain. The first pertains to what may be called the "basic model of pain." This refers to what is usually called "pain sensation" and denotes the phenomenon of the ego registering that something is wrong with the integrity of the body. The second meaning of pain is a product of childhood development in which the infant's expression of pain—for example, by crying—leads other persons to minister to him in ways designed to relieve the painful state. This pattern of communication establishes pain as a powerful help-seeking symbol. Accordingly, in a two-person situation the word "pain" may refer simultaneously to one or both of these meanings. This accounts for most of the ambiguities encountered in terminology and clinical practice. When a person reports a painful experience, he speaks in terms of *his* notion of his body (his own body-image), and the listener receives and interprets the message in terms of *his* own notions (of the patient's body). The distinction between physical and mental pain expresses, among other things, this difference between experiencing ego and judging observer. Physical pain denotes agreement, and mental pain denotes disagreement between sufferer and observer.

On the basis of these considerations we may also distinguish three categories, or levels of symbolization, of pain. These can be described best in terms of the object to which pain points as a referent. In the first category it points to the body; in the second *ambiguously* to both body and other people; and in the third category to a particular person.

THE MANY-PERSON OR SOCIAL SITUATION

The principal new dimension that enters into the role of pain here lies in the social (cultural) attitudes toward this phenomenon. In other words, in certain cultures and social situations, experiencing pain and communicating about it may tend to be strongly rewarded and thus encouraged, while in others it is censured and hence inhibited. The Judaeo-Christian ethic, in general, tends to favor the aggrandizement of suffering and pain, as opposed to certain other types of distress. An obvious example of this is the "social fact" that a post-traumatic neurosis with painful bodily symptoms (incurred in an industrial accident) will usually be compensated financially. Yet if the patient responds to the "same event" with a depression, he is less apt to be awarded compensation, and in all likelihood his complaint will be regarded as a "psychiatric disorder *due* to his personality." I cite this hypothetical example (which in practice corresponds to numerous similar cases) to illustrate a prevalent social orientation to pain in our culture, and not as a plea for compensation in the latter type of disorder.

¶ Psychotherapeutic Applications

The Localization of Pain

It is of paramount importance in medicine (in the sense of physics) that pain be localized. By using the word "localization," the physician actually has reference to two things—first, to "Where does the patient feel the pain?" and second, to "Where is the lesion?" Both questions refer to loci in physical space, and both

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must be answered as prerequisites for an accurate diagnosis. Often the two loci coincide, as, for example, in the case of a foreign body in the eye, or a fractured leg. Less often, though again quite commonly, the two loci differ; that is, the patient feels pain in one spot, whereas the lesion is in an area removed from it. This phenomenon goes by the name "referred pain," a rather misleading, though serviceable, label. This expression is misleading because it does not take account of the fact that all pains are "referred," the difference being that some are referred but a short distance from the lesion, while others are felt much farther away. For example, the precordial pain of a coronary occlusion is not considered to be "referred," because it is felt over the heart, only a short distance from the anatomical location of the disorder. Only the pain in the left arm and hand, accompanying this disorder, is labeled "referred pain."

These remarks about localization are somewhat trivial, but they are a necessary introduction to a more penetrating analysis of the problem. First it should be noted that the word "pain" is used in the foregoing paragraph in the language of medicine (and physics) and not in that of psychology.

Woodger[11,12] addressed himself to this problem in some detail, and it seems to me worth while to quote his argument. The following passages are relevant, moreover, not only to our present concern with the localization of pain, but also to what has been said earlier about the dangers of mixed languages. In a section entitled "Some Linguistic Difficulties in Neurology," Woodger[11] stated:

> Our next task is to examine some specimens of the mixed statements which occur in neurological writings and which I mentioned at the beginning of the last lecture. Among the commonest mistakes, as it seems to me, are: (i) treating sensible objects as though they were physical objects, for example, by identifying stimulus or neural impulse with sensible objects; (ii) identifying person with brain, i.e., putting a person into his own head and (iii) being too easily satisfied with metaphors, as when neurologists speak of "pictures" being "projected" on the cortex as though the brain were a kind of private cinema.

An example which illustrates most of these points is provided by the following passage from a well-known work on pathology:

> "Paradoxical as it seems, pain cannot exist in the tissues; a pain in the foot is a disturbance of those nerve cells in the brain whose function it is to receive stimuli conveyed to them by the afferent nerves from that region . . . we must recognize two orders of tissues, irritation of which may set up the sensation of pain, but in the one this process is accurately localized, while in the other the sensation is localized by the brain as originating in some other area or areas."

Thus pains are treated as though they were physical objects and identified with nerve cells in certain states. But the process of localization is not a process of saying where the pain is. A pain, being a sensible object, can only be atopically related to other objects. Localization is a process of saying where the pain appears in. And this is performed by the person, not by the brain, because it is a characteristic of persons that their parts are not persons; although certain of their parts are capable of becoming persons, otherwise surgery and reproduction would be impossible. The same point is curiously illustrated in the following passage where the writer speaks in one place of "the female cerebral cortex" and in another of "a woman." It is from a letter in *The Lancet* in reply to a previous letter:

> "First, he (the author of the previous letter) asks why in women renal pain is not referred to the ovaries whereas in men it is referred to the testes. The answer is that the female cerebral cortex (where localization of pain actually takes place) has never really had the chance to determine the position of the gonads; ovaries do not normally suffer specific traumata, whereas testes often do by reason of their somatic isolation. Mr. Brown need only ask a woman where her ovaries are, and the comparative indefiniteness of her answer will soon convince him that in this respect, even without pain, women cannot be compared to men."

This seems to me to be an extraordinary argument. Because testes protrude, in a sense, outside the body, male cerebral cortices know where they are and refer renal pain to them. Why they should do so is not stated. Ovaries, on the other hand, do not stick out, so female cerebral cortices

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are not so learned in anatomy and do not refer renal pain to them. But in order to examine them in this subject you must ask, not the female cerebral cortex, but the woman who possesses it (pp. 286–288).

These statements are so lucid that they require no explanatory comments. Another way of putting the matter might run like this. In so far as we speak of the localization of pain, we must distinguish what the patient does from what the physician does. The patient reports on his affective experiences. His feelings function as pointers to his body-as-psychological-object; the latter, as has been emphasized, has a variable relationship to the body-as-physical-object. The physician, on the other hand, does not really try to localize the pain at all. What he is after is the lesion, to which the pain points in much the same way as the evidence in a crime may point toward the criminal. The physician's role is that of a detective: he is interested in apprehending the criminal, that is, in making a diagnosis.

Using the analogy between the work of the medical diagnostician and the detective, we must now ask, "What happens if the clues to the crime are misleading and confusing?" Will the detective-physician conclude that the most likely suspect is indeed the criminal, and let it go at that? Or will he assume, as is often done in totalitarian states, that some habitual criminal or some other unwanted member of society has committed the offense in question? The reasoning behind this is that he has done so before, so why not this time also? Both of these "criminal solutions" are frequently resorted to in medical practice if the problem is that of obscure pain. Illustrative of the first solution, namely that based on circumstantial evidence, is the frequent diagnosis of acute appendicitis in cases of abdominal pain. This example may apply also to the second solution, namely to that based on the theory of the habitual criminal. The appendix has been regarded in just such a way by some members of the medical profession; it is a chronically suspect, unwanted, and expendable member of the "body" (politic). Medical fashion, however, has an important role in determining what parts of the body are regarded in this suspicious light, so that the blame for undiagnosed painful ailments shifts from time to time among any of the following: the retroverted or otherwise "misplaced" uterus, the appendix, peritoneal adhesions, the tonsils, the gallbladder, the teeth (as foci of infection), and others.

Clearly, a more honest conclusion than either of the above is openly to acknowledge that the crime—the problem—remains unsolved. Perhaps it is not even a "crime," that is, there may be no "criminal" (lesion) that can be located in space (anatomy). In other words, what looked like a "crime," may have been an "accident" or a "suicide." It is, therefore, necessary for us to consider the problem of pain localization in an altogether different light. The neurological (physical) concept of pain must be abandoned and the psychological one adopted in its place. If we regard pain as an affect indicative of a particular ego-object relationship, the problem of localization—in the anatomical sense—does not arise. Pain is still felt, or experienced, in one or another body part, but this simply means "body part as psychological object." Lest it be thought that there is something unreal or mystical about a "psychological object," I would like to point out that it is no more or less mystical than are other words and concepts which designate nonphysical entities, such as, say, "patriotism" or "justice." As was noted before, the body-as-object may or may not correspond to the body-as-physical-thing (as seen by various observers). This view makes it possible to account, without doing violence to the facts of observation, for such phenomena as phantom pain and chronic pains of all sorts which are not accompanied by serious physical damage to the body. Without going into the psychological details of these phenomena, suffice it to note that the general meaning of persistent pains seems to be that of a *reassurance* that the body part in question *still hurts*, and is, therefore, still present. The pain, while apparently undesirable for the ego and for the physician, is on a more unconscious level, a denial of, and reassurance against, the danger of body loss. This antithetical meaning of pain is not as unusual as it may seem at first glance, for a similar duality of meaning also applies to most other affects. Thus, if we

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are anxious, this affect not only means that we are afraid of something, but also it tells us that we are prepared and vigilant and, therefore, unafraid. Indeed, in Shakespeare's *Hamlet* Laertes says: "Be wary then; best safety lies in fear." Similarly, feelings of guilt tell us both that we have done something wrong and are "bad" and that we are conscientious and therefore "good" (Szasz,[10] pp. 147–169).

The Psychiatrist as Translator

The problem of pain can also be fruitfully approached by viewing it much as one would view the task of translating a foreign language. This is true for the work of both the medical and the psychotherapeutic physician, but more so for the latter. The diagnostician's task, in these terms, is to translate from pain to diagnosis. Pain, in this context, is a foreign language for the patient, since his pains make no sense to him. It is simply a signal or message which disturbs him and to which *he must respond,* but he does not really know how. It is for this reason that he seeks a physician who is regarded as an expert in the language of pain. The physician will translate this strange and disturbingly compelling language, and will tell the sufferer (messenger) what to do about these coded commands. And, indeed, if the patient suffers from a clearly defined and recognizable disorder of the bodily machinery, the physician will be able to effect the proper translation from pain to diagnosis, and hence to medical action. Both the diagnosis and the medical action inherent in it will then be recognizable and understandable to the patient. In other words, they can usually be rendered also into ordinary English (or any other language).

If no bodily disorder is found, the problem which the language of pain presents is, as we have already seen, compounded. This is due to the fact that the language of pain, and of bodily feelings in general, is commonly used as a pattern of communication in situations other than those pertaining to disorders of the bodily machinery. I refer to the need to translate and to express certain experiences — particularly those relating to intimate personal relationships and feelings—into other than ordinary verbal language. This need arises, of course, largely as a result of cultural and social influences. And, however variable these influences may be in Western cultures, they all necessitate the avoidance of the open expression of various personal feelings. Freud was naturally struck by the avoidance of sexual and money matters in his social milieu. Viewed in terms of language and social roles, what happens in many medical situations may be briefly described as follows. The patient knows—that is, he has learned—that he is not supposed to complain about, say, sexual and marital problems. These things, and many others, are not supposed to be mentioned. Even in intimate friendly relationships, the discussion of such matters is not usually condoned. If there is trouble in these sectors of one's life, something, of course, has to give. The psychosocial pressures then become "translated," so to speak, into other idioms, and find expression in derivative forms. Some literary creations are one such idiom. Excessive drinking is another. And bodily symptoms constitute still another, very common, outlet. Thus, while the patient may feel unable to complain about personal unhappiness, he can complain about dizziness, weakness, palpitation, and pain or itching in this or that part of his body. The physician may feel similarly disinclined, and unprepared, to function as an aid to the patient in his personal troubles, but he does feel that it is his proper function to communicate with him in the language of his bodily feelings, that is, in terms of possible bodily disease.

Viewed in this light, the psychiatrist's role is like that of a translator and interpreter of a foreign language. He must translate the patient's body-language (for example, "I have pains in my chest") into the language of everyday speech ("I am unhappy with my wife, husband, job, children, religion, etc."). It is important to note, in this connection, that when patients go to physicians, they do not expect—and, as a rule, do not welcome—such efforts at translation. They wish to speak in the idiom in which they have addressed the physician, namely, in the language of bodily disorder. Moreover, it is clear that the problem is not

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simply one of translation. The task at hand, as I see it, is rather to explore, in the relationship between patient and doctor, whether the patient can address himself to his problem in some other, possibly more effective, manner. Merely to tell the patient that translation is necessary (that is, "Your troubles are probably 'emotional,' therefore, you should go to a psychiatrist . . .") is of no service to him, unless two basic conditions can be fulfilled. First, both patient and physician must be able to converse in the new idiom (ordinary language, in this case) about the problem at hand; and second, there must be a likelihood that the original problem, rendered anew in translated form, will be more readily soluble than it had been before. Unless both of these conditions are met, persistent communication between patient and physician in the idiom of bodily feelings may be the best (least harmful) solution for everyone concerned.

It is always possible, however, that the patient is interested in, and capable of learning, another language. Or, better still, he may be already in possession of another language, but is afraid to reveal his knowledge lest he offend his apparently less polyglot physician. For these reasons it would seem to be good medical practice if the physician could learn to relinquish, when necessary, the language of bodily disease and would introduce, on all appropriate occasions, the topic of "translation." By this I mean, quite concretely, informing the patient that, in his physician's opinion, further inquiries along physical (medical) lines are not indicated at this time. He could then *add* that the patient, accordingly, has one of three basic choices open to him: (1) If he feels strongly that a bodily disorder is the cause of his troubles, he is free to consult another physician. (2) He may choose to do nothing further but wait to see what develops. (3) He may wish to explore the possibility of finding a solution for his troubles along psychological lines, that is, by thinking about his life and human relationships. He (the patient) may do this, moreover, either alone or with someone close to him (wife, husband, friend, or medical physician if the latter is so inclined) or, finally, with the aid of a psychiatrist. Only the patient's response to such medical advice will determine the proper course for him. If the patient does consult a psychiatrist, the possibilities of translation and "working through" in a new idiom will be explored further. Two examples illustrating these considerations, and the type of work discussed will now be cited.

CASE I: "TRANSLATION" AND PSYCHOTHERAPY AS SOURCES OF DANGER

A middle-aged man was referred to me by a colleague in one of the medical specialties for possible help with a problem of chronic pain of the left arm. The patient was an intelligent man and welcomed psychiatric consultation. Excrutiating pain occurred several times during the day and also during the night. It had been present, on and off, for about eighteen months when I first met the patient. So much for the pain.

Let me suggest now that we think of the pain —as I did—as a thread woven into a complex tapestry. We must therefore back away, so to speak, from a close-up view of our object and look at the "ground" on which the pain is the "figure." This is what I saw.

The patient had been suffering from multiple sclerosis for nearly twenty years, and for several years had been almost completely disabled. He was barely able to move around, needing crutches as well as personal support in order to take a few steps. He spent most of his time at home in a wheel chair. He could not do useful work and had few hobbies. His wife was devoted to him, cared for him conscientiously, and was, of course, deeply involved in various pharmacological attempts to relieve his pain.

After several visits during which the symptom subsided somewhat, we began to exhaust the topic of pain as a subject of conversation. Then, as we shifted to a consideration of the patient's life situation, his serious neurological illness, and his personal relationships, a very depressing and disheartening picture came into view. While, in one sense, he knew that he had multiple sclerosis, in another he befuddled and denied what this meant to himself. Moreover, it emerged that the patient had a quite distressing relationship with his father. The crux of this was his complete submission to, and subjugation by, his father from whom

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he felt escape was impossible. Indeed, he harbored a "psychosomatic theory" of his multiple sclerosis, according to which the disease was due to this conflict. The physical incapacity was regarded by him as the only "safe" means of rebellion against or noncompliance with his father. This view of the patient's, I want to make clear, had no connection with his few interviews with me. He had formed it many years before, during the development of his neurological illness.

The treatment of the pain, in a situation of this sort, as may be surmised, became an important matter for the patient, his physicians, and those about him. There developed a pattern of receiving codeine by injection every three to four hours, sometimes more often, sometimes less. He took other analgesics as well. Sometime during his painful complaints he was given an injection of sterile saline solution, and this relieved the pain as well as the codeine did. This resulted in much confusion and conflict about the "reality" of the pain.

The patient came to my office once a week, accompanied by his wife. The trip seemed to be a considerable hardship for both of them. The patient was eager to speak about his personal difficulties and hoped that improvement in his pains —as well as in his multiple sclerosis—would result from this treatment. At the same time, it became clear—both to me and perhaps somewhat less vividly to the patient—that his painful symptom, waiting for it, and treating it, had become the most important things in his life. "Translation" of the pain, and reconstruction of its onset and "meaning" offered no promise of beneficial change. It was not that the patient lacked interest in undertaking this sort of work. Indeed, discussion of the onset of his painful symptom led rapidly to his recollection of certain traumatic events with his father, and other family members, at whose hands he had been humiliated once again immediately prior to the onset of this symptom. Thus, many of the symbolic meanings of the pain were clear, as was its retaliatory implication. Yet, the fact was that the pain functioned as an important object in his life and, in addition, was a vehicle through which he was able to reach other people from whom he had receded irretrievably because of his multiple sclerosis.

The relief of the pain, in the light of these considerations, did not seem to be a desirable therapeutic goal. Whether it would have been possible to bring about relief of this pain at all, of course, is open to doubt. If it was possible, it seemed to me that the price which would have been paid for it would have been too high. Increasing contemplation of, and insight into, his personal situation could have easily led this patient into a serious depression and/or paranoid orientation. He dramatically expressed his awareness of his lifelong inability to ever "stand up" to his father, and other aggressive relatives. He felt he was doing so now by asserting himself in asking for relief of pain and, in a sense, he was. He did not feel that he could do this on a less symbolic (that is, more real-life relationship) level with them—and how could he, now, in his crippled condition?

It was a logical denouement of these explanatory interviews that we came to speak of the difficult situation in which he found himself. I stated frankly that, although some of the psychological meanings of his pain were evident, I did not believe that further inquiries along this line would be of benefit to him. I advised "bearing up," tolerating, and living with the symptom as the best course to follow. I also discussed the problem of the "reality" of the patient's pain—in the light of the effect of the placebo injection—with his wife. She was quick to grasp and to understand the patient's "need" for pain as an object of life interest. The patient expressed no wish to continue once I voiced my doubts about the advisability of doing so.

This tragic clinical example illustrates many of the previously mentioned theoretical considerations concerning pain. It shows clearly that mere "translation" of pain into the language of personal troubles is not enough. Like any method or action that can be helpful, so translation of this sort can also be damaging. This is a truism which applies equally to all forms of medical treatment and social action. Still, it is forgotten often enough to merit re-emphasis. In other words, the translation of bodily feelings (often erroneously called "somatic symptoms") into the language of personal troubles is helpful only if it leads to a successful mastery of the problem in the new idiom or, at least, to more successful mastery

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than had been achieved before. Contrariwise, if it results, or promises to result, in an even greater and more decisive defeat of the patient, then "translation" becomes an iatrogenic trauma, roughly comparable to unnecessary surgery or ill-advised counseling.

This clinical example points to another problem which merits comment. It is the problem of what kinds of medical and surgical action are called for, and are justified, in situations of this sort. The patient's problem cited may be considered as paradigmatic of that presented by many men and women who complain of severe pain and who are often treated with measures of increasing destructiveness. These measures range all the way from increasing dosages of opiates to neurosurgical interventions at various levels of the nervous system (for example, nerve blocks, rhizotomy, lobotomy) and often culminate in combinations of these, finally ending in the commitment of the patient to a mental hospital. It is important, in considering this problem, to define clearly the aim of treatment. Is it to relieve pain? If this is the sole aim, then indeed rather drastic measures may be logically employed. Sometimes the result is a cessation of the complaint. But clearly this approach to pain does violence even to the common-sense medical practice of considering the complications and side effects of treatments, and to the time-honored adage according to which, as physicians, we should, above all, do no harm.

A more sophisticated phrasing of the problem also points to the need for extreme caution not to employ excessive medical and surgical action in such cases. We should ask again, "What is the purpose of our therapy?" It no longer is enough to answer, "To relieve pain." We must ask: "What is the matter with the patient?" "How can we help him (as a person)?" "What will be the effect of our personal therapy (whatever this may be)?" If we ask such questions, it will be evident, however terrible this may seem, that sometimes we are forced to conclude that we (as physicians) *can do nothing*. The physician's inability to comprehend and admit his own helplessness is of great significance in connection with many chronic pain problems. Yet, as is often the case, it may be possible to turn defeat into a kind of victory. For once the physician realizes that he cannot help by medical, surgical, or psychiatric treatments, it follows that he can do the most good by desisting from doing harm. Finally, these considerations may help the physician to see that, in many cases, therapy is really aimed at the relatives. In the example cited, for instance, the patient's pain was most distressing to his wife and to others about him. Silencing the pain would have been most beneficial to them, not to him. Often, the physician must include himself among those who are distressed by the patient's persistent complaint of pain. His insistence on silencing it, at any cost to the patient, can be understood best by comparing this situation with that of the parents' distress with the painful crying of their infant. Parents are driven, as we say, to "distraction" by such crying and will try to do anything to stop it. In human relationships, as in medicine, it is sometimes most humane to understand and to bear suffering. Action, no matter how benevolent (therapeutic) in intent, can add to suffering as easily as it can relieve it.

CASE II: AN EXAMPLE OF SUCCESSFUL PSYCHOTHERAPY

The following case note* is cited to illustrate some aspects of the translation of bodily symptoms into the language of human relationships and the psychotherapeutic work which this renders possible.

A girl in her late teens came for psychiatric treatment after an incapacitating illness of about two years' duration. Her chief symptoms were attacks of severe pain referred to the abdomen, pelvis, and lower back. There were also episodes of anorexia and occasional vomiting. At first she did not accept the possible relevance of psychiatric treatment to her situation. She came only because, over a period of two years, repeated medical examinations resulted in conflicting diagnoses, and because the many treatments which were tried proved to be of no avail. Finally, she went to a large diagnostic center, where the need

* This illustration was first published in my paper, "The Nature of Pain."[9]

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for psychiatric treatment was impressed upon her as well as upon her family physician.

As is true of all excerpts from psychiatric observations, a few paragraphs cannot possibly do justice to all of the clinical material as it emerged in the process of psychotherapy. It must be borne in mind, therefore, that I shall cite only some highlights of the history and focus on those specific factors from the therapeutic interaction which are relevant to the problem of pain.

The patient lived in a distant community and was unable, therefore, to make frequent visits to my office. She averaged two appointments a week for a period of a year and a half. During the first six months, many appointments were broken because of attacks of pain for which she remained at home, confined to bed.

The patient was reared in a well-to-do Catholic family in a small town. She had three older sisters and one younger brother. Approximately three years before the beginning of treatment, her mother underwent an operation. There was some concern about the possibility of a malignant tumor, but at surgery it was established that the symptoms were due only to extensive fibroids. The family was relieved. Then, suddenly, the mother died of a massive postoperative hemorrhage. The patient was stunned, as was the whole family. Indeed, no one in the family seemed to recover fully from this loss. The father became depressed and withdrawn. The older sisters tried to help, but they, too, had been dependent on the mother, even though they were married and had families of their own. In this situation the patient found it impossible to "let go" and mourn the loss of her mother. Not only could she find no support for her own needs in this moment of stress, but, realizing her father's suffering and the older sisters' ineffectiveness, she began to feel increasingly that she should take an active role in managing the household and in comforting her father. Her father, however, remained depressed and about a year later drove his car into the abutment of a bridge and died immediately. Everyone in the family regarded this accident as a suicide. Shortly after the father's death, the patient became ill, with the symptoms described earlier.

When the patient first came for psychiatric treatment, she appeared to be an intelligent and introspective girl who suffered much but bore it stoically. She was neither depressed nor anxious but, on the contrary, appeared well composed. She also "looked sick" in that vague and undefinable manner in which people give the impression of being, as we say, "physically ill." Indeed, had it not been for the repeated physical examinations and the recent tragic events, I would have been strongly tempted to feel with the patient that hers was not a "psychiatric problem."

On the basis of the historical material, much of which was related during the first few hours, it could be surmised that, because of the magnitude of the traumata to which the patient was exposed, she had been unable to integrate them, and that this failure to resolve the losses which she had experienced was related to her present illness. It also became apparent that the patient, in her day-to-day life, was quite isolated from people. Although she lived in the home of an older sister, with the sister's family and with her younger brother, she was quite estranged from them. They did not understand her, and the lack of understanding grew monumentally as her undiagnosed illness dragged on and baffled, worried, and angered them. She was also alienated from her friends and her teachers at school.

About two months after the beginning of psychotherapy, the patient canceled several appointments because of severe pain. Although she had missed appointments during the preceding two months, it was not with the same implication as at this time; namely, that she was stopping the treatment. This had been anticipated and discussed with her. Now she was urged to continue the treatment. The full significance of these events did not become apparent until later. The loss of her parents and repeated disappointments in relation to her sisters and physicians had led her to feel all alone. She felt that no one cared whether she was well or ill and, further, that since no one understood what was wrong with her, no one was capable of helping her. These notions, which have well-known ubiquitous childhood sources in all of us, were reinforced by her recent life experiences. The intense attacks of pain (for which her family physician, responding to the calls of her

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panicked family, gave repeated injections of morphine) in this last episode had, at least among other meanings, the function of protecting her from the dangers of a positive transference which was developing. By urging her to continue the treatment, I gave her the realistic support and reassurance required when one's trust in human helpfulness is shaken. As she became more certain that she could rely on me, she was able to review and to come to grips with the circumstances of her parents' deaths and the reactions of the various members of the family to these events. Her distrust of physicians and the misunderstandings that ensued from her painful illness, for which no demonstrable physical cause could be found, became conscious and understandable. The persistent pathogenic effect of the confusion that resulted from her sisters' and physicians' reaction to her illness—which was added to the trauma of the original losses—was thus replaced by understanding and knowledge which became an important source of comfort to her.

The patient was greatly improved after about one year of treatment. Pain occurred very infrequently. Instead, a much broader spectrum of human emotions was experienced, and she could regard these as reflections of her relationship with the people about her. She was no longer alienated from her family. She concluded that they had little in common with her, and she now had a consciously more distant and more comfortable relationship with them. She also entered a training program for professional work from which she obtained much satisfaction.

I think it is reasonable to assume that this sort of problem is ubiquitous. The patient's story—and human distress—is paradigmatic of the problems which countless patients bring to their physicians. In these cases the possibilities for doing harm with medical and surgical treatments loom very large, and the possibilities for rendering help by providing the needed psychological assistance are equally great.

This case illustrates several communicative meanings of pain. Not only was the pain initially a request for help, addressed first to the older sisters and later to physicians, but subsequently it became an aggressive, frustrated complaint of, "You see, you still have not done anything for me . . ." Still another function of it was that of a warning signal of an impending danger. It was as if the patient, having lost both parents, had no really significant object left to lose other than her body. Then, as if to make sure that she would not be taken by *surprise* again as she was by the death of her mother, she experienced the warning signal in a chronic manner. In this way the warning itself became—as it always does in such instances—a source of security. This accounts, in part, for the patient's composure during her illness.

I may add that the foregoing interpretation of the function of pain is analogous to our ideas concerning anxiety and distrust as defenses against transference in the psychoanalytic situation. By this, we understand the patient's anxious expectation of being deserted or let down in some manner by the analyst. This fear either echoes some actual childhood (or later) event or expresses the dread of aloneness based on some other source. In other words, if we look upon the body as an object of the ego, it may be possible for us to expand the concept of transference from human objects to the body. I think that this phenomenon does occur. In this case the body functioned as a transference object, substituting for both the mother and the father. The experience of pain is the appropriate signal warning of danger in relation to the body. In this case it warned—in the last analysis—against the danger of losing the parents, thus recreating the unsolved traumatic situation in the hope of eventually solving it. The similarities between the structure of this symptom and that of melancholia are evident (Szasz,[16] pp. 150–154).

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