THE NATURE AND TREATMENT OF MENTAL DISORDERS

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FOREWORD

From the reservoir of his rich clinical experience, Dr. Moore has presented in this volume a very useful treatise on clinical psychiatry.

One of the advantages of the book is that it leads back to psychiatric understanding from the description of highly interesting and pertinent case reports. Thus, one gets the feeling that the clinical phenomena and the needs of the mentally sick patient build the framework of formalized psychiatric concepts. This is as it should be. The test of psychiatry, as an art or as a science, is its utilitarianism—its capacity and ability to understand and meet the needs of those who are sick in mind.

Dr. Moore's contribution clearly interprets this sound principle. The individual and the family are studied in their "distress of mind"; the unit and social disorganization that is produced is analyzed; the application of restorative psychiatric formulae is exemplified.

Dr. Moore's book will be helpful to the psychiatric clinician irrespective of his particular psychiatric beliefs; to physicians and to medical students; to psychiatric nurses and to social workers.

EDWARD A. STRECKER

Philadelphia, July, 1943

PREFACE

The present work is an attempt to make a contribution to our understanding of mental disorders and to illustrate a wide variety of techniques in dealing with the many and varied problems with which the psychiatrist is confronted.

Our understanding of the nature of mental disorders demands a sound psychology and psychopathology, much in the same way as insight into somatic disease depends on a knowledge of physiology and pathology. We have therefore attempted to outline, criticize, and supplement classic theories of psychopathology and to make use of these theories in order to throw light on the nature of mental disorders.

We have also attempted to evaluate modern studies of the emotions, not only to give an insight into a whole group of affective mental disorders, but also to find a pharmacological method of treating these "physiological emotional" conditions.

The techniques of therapy illustrated are fairly numerous and divergent. They descend from what is really an application of psychoanalytic techniques to trivialities the only excuse for mention of which is that they may be, on occasion, suggestive and helpful.

The work grows out of personal experience in a long series of attempts to help human beings in mental difficulty. The techniques of therapy are illustrated by cases with a more or less successful issue, not by any means because all or most psychotherapeutic attempts have a successful ending, but in the hope that therapy which as a matter of fact terminated successfully is likely to be more free from blundering than that which ended in failure.

The procedures are, however, given at times in such detail that those with experience will be able to point out the author's

blunders as reefs for the student to beware of in his attempts to treat the disorders of the mind.

Much of the research work which has made possible this study of the nature and treatment of mental disorders was substantially aided by a grant of the Rockefeller Foundation to the Catholic University of America for teaching and investigation in the field of psychiatry.

My thanks are also due to Miss Marie Wolf, statistical assistant in the Department of Psychology and Psychiatry of the university, for help in the proofreading and in checking of the references.

THOMAS VERNER MOORE

Washington, D. C., June, 1943

PART I

PSYCHOPATHOLOGY

CHAPTER I

THE CONCEPT OF MENTAL DISORDER

THE UNDERSTANDING of mental disorders must be derived from a true insight into the structure and functioning of the human personality. For a mental disorder exists only in an individual. It is always a human person who becomes insane.

If this is the case, it is at once clear that a true understanding of mental disorders must be based upon sound psychological theory. It has been the misfortune of psychology that it stands of necessity in the no man's land between physical science and metaphysical speculation, and so it is still looked upon with suspicion both by physical scientists and by philosophers. This would not have been of great moment, had it not led to one-sided and inadequate developments of psychological theory.

Speculative attempts at creating a sound philosophy of the mind, however valuable in themselves, have never been of immediate practical assistance to the psychiatrist in treating the disorders of the mind. On the other hand, the implicit psychology of a man like Griesinger, who saw in mental diseases nothing more than disordered reflexes of the brain, is wholly inadequate to account for the conscious experience of the disordered mind. Such a psychology really offers nothing but a false metaphysics to one who would attempt to treat a mental patient.

It was largely due to Freud and his students that modern psychiatry began to recognize the importance of understanding a patient from a psychological point of view. Unfortunately, Freud and his followers made no attempt to develop a sound

empirical psychology. There are, however, certain psychological facts that must be considered if we are to understand a patient with a mental disorder, which most psychiatrists of the present are willing to face and make use of in the study of the disordered mind.

1. The Existence of Truly Mental Disorders

Within the inner space of the psychological mind there is something more than vascular and respiratory changes and chemical and physical reactions going on without ceasing. The mind, whatever its ultimate nature, is a storehouse of truly *mental* experience of great diversity. There are within it a multiplicity of traces of all kinds of sensory experience capable of being revived with more or less clarity as conscious experiences. Some of these past experiences led to violent emotional reactions, and these reactions may revive when situations occur that have similarity to the original precipitating incident. The human mind is also the home of instinctive cravings and impulses, as well as of ideals and aspirations that transcend all that is sensory and find expression in the intellect and will alone. This inner experience is organized around a system of ideals, and this organization gives the individual a sense of peace and security.

The reactivation of emotional experience which was due originally to some terrifying or unhappy incident, is troublesome and may even become a disabling mechanism. The utter loss of a sense of security or of the hope of attaining one's most cherished ideals, by the crumbling of a plan of life or the loss of those with whom one's own life seemed inextricably intertwined, may precipitate in some individuals one of the major forms of mental disorder. Or the inability of a child to attain security and a normal fixation of his affections may lead to all manner of disorders of conduct.

All this inner organization is something mental or psychic in nature. The concept of the formation of connections between

neurons simply does not apply. Most psychiatrists of the present day would be willing to grant this, but some still cling to the pre-Freudian point of view. Thus Harrington writes: "The so-called 'psychic' factors in mental disease are simply the stimuli which act through our sense organs upon the nervous system to give rise to behavior, and the changes in the structure, the memory impressions, and habit paths laid down in the brain tissue as a result of these stimuli."[1]

A mental disorder is not so much a disturbance of intercellular connections as it is an overaccentuation of emotional experience, or the upsetting of one's mental adjustment to life by the destruction of all possibility of attaining objects of desire upon which one's heart has been set. No mere destruction of neurons by trauma or surgical operation ever produces an emotional mental disorder in an otherwise healthy individual, as many cases of brain injury have now made abundantly evident. Even the supposed necessity for perception of neural pathways connecting the visual center with other regions of the cortex is called in question. Thus Lashley, after his recent extirpation experiments in rats, came to the conclusion "that the functions of the visual cortex in the performance of difficult visual discriminations do not depend upon any direct or specific transcortical connections with other regions of the neopallium."[2]

Some mental disorders at least must be looked upon as truly psychic in nature and do not have a specific organic cerebral pathology.

2. Quantitative Differences in the Disorders of the Mind

Before taking up the problem of the existence of mental disorders that are qualitatively different from one another, let

[1] Milton Harrington, *A Biological Approach to the Problem of Abnormal Behavior*, Lancaster, Penn., 1938, p. 294.

[2] K. S. Lashley, "The Mechanism of Vision: 17. Autonomy of the Visual Cortex," *J. Genet. Psychol.* **60:** 219, 1942.

us consider the quantitative differences in the disturbances of the mind.

If one should attempt to classify mental difficulties according to the degree to which they involve a disorder of the whole mind and the eventual disintegration of the personality, one would find four headings already in use in psychiatry that can be listed in descending order of severity as follows:

PSYCHOSES

The word psychosis is a term used to denote what was formerly designated as a condition of insanity. As a rule a psychotic or insane person has to be taken to a mental hospital, though many persons suffering from mild degrees of psychotic conditions are able, through the help and kindness of their friends, to get along fairly successfully in their own homes. This is not always advisable, however, for some patients seem to settle down and persist in their psychoses at home, whereas they tend to work out of the condition in a mental hospital. However, a psychotic individual is one in whom there is a profound disturbance of the whole personality.

PSYCHONEUROSES

These are borderline mental conditions which may torment a patient for years without seriously interfering with his earning capacity and his ability to adjust in the outside world. They are largely emotional disorders, or unreasonable drives to the repetition of useless compulsive acts, or an abiding sense of weakness and incapacity, etc. In general these symptoms are restricted to a limited field of mental life and do not spread. Thus they do not involve a disorganization of the whole personality.

A classification of the psychoses and psychoneuroses, with brief descriptions, as adopted by the American Psychiatric Association and the National Committee for Mental Hygiene, will be found in the Appendix.

CONSTITUTIONAL PSYCHOPATHIC STATES

There are some individuals whose conduct is abnormal and resembles in various ways the behavior of insane patients. In general, however, they do not go on to the development of a full-blown psychotic condition. Here we have the irritable, quarrelsome, aggressive individuals; the pathological liars who live in a world of phantasy and seem to attempt to make this world of their dreams falsely approach reality by a lie; the pathological swindlers who are endowed with ample mental ability to make an honest living; the kleptomaniacs and the pyromaniacs, and the queer eccentric individuals whose states border on paranoia. In general these individuals live a life outside of a mental hospital, but a life that is scarred and seared with many painful and unfortunate episodes.

Kraepelin[3] pointed out that various constitutional psychopathic states bear a kind of larval resemblance to certain major psychoses. He distinguished the following groups:

(1) The irritable
(2) The unstable
(3) The uninhibited (*Triebmenschen*)
(4) The eccentric
(5) The liars and swindlers
(6) The antisocial
(7) The litigious or quarrelsome

As Huddelson pointed out,[4] Adolf Meyer introduced the term "constitutional psychopathic inferiority" into American psychiatry in 1905.[5] The application of the term is far from any exact limitations and is variously interpreted by those who use it.

[3] Emil Kraepelin, *Psychiatrie*, ed. 8, Leipzig, 1915, vol. 4, pp. 1973 ff.

[4] J. H. Huddleson, "The Part of Conduct Disorders in the Concept of Constitutional Psychopathic Inferiority," *J. Nerv. & Ment. Dis.* **64**: 151, 1926.

[5] Adolph Meyer, *Report of the Pathological Institute*, 17th Ann. Rep., New York State Commission on Lunacy, 1904–1905, p. 79.

BEHAVIOR PROBLEMS

Here we have to do with episodes of abnormal behavior in a personality that is relatively and abidingly sound and normal: stealing, abnormal sex behavior, alcoholism, truancy, wandering, angry outbreaks, etc. The recognition of a group of behavior problems in a normal personality should be accompanied by the *caveat* that abnormal behavior of various kinds may be the sign of a deep underlying disorder of the personality, the first sign even of the onset of a psychosis.

The designations of behavior problems just given must be taken in a general sense. "Alcoholism" or "wandering," for instance, may be a simple behavior problem in some cases; in others, it may be one of many indications of a major psychosis. We have, however, used the terms psychosis, psychoneurosis, constitutional psychopathic state, and behavior problem to indicate *degrees of intensity* in mental disorders. And as a matter of fact the disorders of the mind in relation to their *intensity* may be distributed into the four groups thus designated.

3. The Existence of Specific Psychiatric Entities as a Statistical Fact

Let us now approach the problem of the association of the various symptoms of mental disorders: the concept of the disease entity in the sense of Kraepelin. Are there any disease entities in psychiatry and, if so, what are they?

The answer to this question, and the discussion of the nature of the disease entities of psychiatry, would be vastly helped if there existed a sound experimental psychology for psychiatry to build upon, as there is an extensive empirical physiological basis for medicine. But there is no such empirical psychology in existence. The Wundtian experimental psychology attempted to crowd all mental experience into the molds of sensation, feeling (in the sense of affective mental experience),

and movement. The attempts in certain quarters to take this psychology as it is or was and apply it to psychiatry ended in failure. Ziehen may be taken as a typical example. Enthused by the work of Wundt and his students, he said: "The experimental study of sensations, the cornerstone of our mental life, must precede every other type of examination."[6]

Anyone with a modicum of psychiatric experience will realize that he will derive little help in dealing with mental patients from even the most careful examination of their sense organs. Only one blinded by enthusiasm for a theory could advocate first testing out the sense organs in an attempt to understand the mental problems of a psychotic patient. A psychology that is to be of help in psychiatry must be sound, and adequate to cover the various manifestations of the abnormalities of the mind.

Theoretically it would seem that just as there are organs of the body with physiological functions at the basis of clinical entities of internal medicine, so mental functions should lie at the basis of the clinical entities of psychiatry.

Kraepelin has been criticized for manifesting more interest in the disease entity from which the patient was suffering than in treating his symptoms[7]; and the criticism does express the fact that Kraepelin attacked the problem of the existence of psychotic conditions each of which would be characterized by a syndrome of certain mental symptoms, and he gave so much attention to this problem that he made little contribution to therapeutic technique in psychiatry. However, a man's great work lies often in a single field, and Kraepelin did much to clarify and delineate the true picture of various mental disorders. Whatever may be the faults involved in his vast undertaking, the general analysis of the field of the mental

[6] Theodor Ziehen, *Über die Beziehungen der Psychologie zur Psychiatrie*, Jena, 1900, p. 3.

[7] Gregory Zilboorg and George W. Henry, *A History of Medical Psychology*, New York, 1941, pp. 452 ff.

disorders, as seen in the textbooks of psychiatry before and after his days, has been profoundly influenced for the better by the exhaustive labors of Kraepelin.

It is a matter of profound theoretical import, for both psychology and psychiatry, to know whether or not there is any association between the various symptoms of the mental disorders, or that certain symptoms tend to run together in well defined syndromes. If this is the case, it would seem that we can conceive of the clinical entities of psychiatry as disorders of the functions of the mind. Each disordered function should be manifested by a specific group of symptoms which would be found over and over again in individual patients suffering from the disorder in question.

With this problem in mind, we defined forty psychotic symptoms and determined their presence or absence in a group of over three hundred patients, and then worked out tetrachoric correlations between the various symptoms.[8]

Let us suppose that the various symptoms are all independent and that there is no tendency for two or more to go together to form a syndrome. Then all the intercorrelations will approximate zero. Some of the correlations, however, were high and significant. It is therefore evident that certain symptoms of the mental disorders hang together.

We give below the syndromes found by this technique, with their empirical definitions, and illustrative cases in which one syndrome was present unaccompanied by any other. Those acquainted with modern factor analysis of human cognitive life will be able to see the possibility that the syndromes given below derive from a factor analysis of affective experience. Complementary to the symptoms of the disordered function of the mind, there should be groups of mental traits that flow from a normal affective function of the mind specific to an individual's character type. One familiar with psychiatry will

[8] Thomas V. Moore, *The Essential Psychoses and Their Fundamental Syndromes*, Studies in Psychology and Psychiatry from the Catholic University of America, Washington D. C., vol. 3, no. 3, 1933.

see that the mathematically determined syndromes given below conform fairly well to various clinical entities derived by Kraepelin from the wealth of his experience.[9]

But let us first see what symptoms hang together and then discuss why they are associated.

The case histories set forth below were written to give the external picture of the mental disorder in the given example, and no attempt is made to show from the case history how the mental disorder was rooted in its various etiological factors. In general it is difficult to derive general laws from individual cases; for a discussion of causal factors, therefore, the reader is referred to chapters II, III, and IV.

The fundamental psychiatric syndromes illustrated have been shown mathematically to have a real existence.[10] In

[9] For those not familiar with tetrachoric correlations, we may say that this measurement of the degree of correlation between observable phenomena grew out of Yule's coefficient of association. Let us take for instance the association between anxiety and sadness. We have the following fourfold table:

	sad	not sad
anxious	a	b
not anxious	c	d

a = number of patients both sad and anxious
b = number of patients anxious but not sad
c = number of patients sad but not anxious
d = number of patients neither sad nor anxious

Yule's coefficient of association is:

$$\frac{ad - bc}{ad + bc} = K$$

It will easily be seen that when one trait always goes with another and is always absent when the other is absent, Yule's coefficient is equal to 1. When one trait is always present when another is absent, Yule's coefficient is equal to -1. With no association, Yule's coefficient tends to 0; with *some* association, it may have any value between $+1$ and -1.

[10] T. V. Moore, *op. cit.*

general the concepts of Kraepelin have been confirmed by the modern technique of factor analysis.

4. Some Fundamental Psychiatric Syndromes

a) constitutional hereditary depression

This name was given to a condition manifested by a number of patients and characterized in general by depression (in the sense of prolonged sadness), anxiety, tearfulness, a history of previous attacks, and the existence of insane relatives in the family. Not all these patients manifested this whole pentad of symptoms, but a patient was considered as having the condition if he was markedly depressed and anxious and gave evidence of any one or more of the three remaining symptoms. The disorder was given the following definition[11]:

> A psychosis with an evident tendency to clear and relapse. It is produced by the disturbance of a general factor* underlying a group of symptoms that manifests itself by depression, anxiety, tearfulness, and the tendency to recovery and relapse. These symptoms seem to have their basis in a hereditary constitutional defect, for the presence of a hereditary taint enters into the tetrads on the basis of which this grouping of symptoms was discovered. The hereditary defect manifests itself in an emotional instability rather than an intellectual defect. The average intelligence of the group is much better than that of any of the forms of praecox psychoses.[12]

En Hsi Hsü has reworked the Spearman factor analysis of the symptoms investigated in *The Essential Psychoses* and gives the following group of symptoms characteristic of a psychotic depression, with their weights:

Anxiety	.419
Depression	.396

* A general factor is a cause or group of causes giving rise to a syndrome of symptoms. In the present instance it is a specific emotional function typical of human nature, whose disturbance gives rise to the characteristic manifestations of a definite form of mental disorder or psychosis.

[11] T. V. Moore, *op. cit.*, p. 35.

[12] *Ibid.*

Tearfulness	.118
Retardation	.117
Previous attacks	.053
Suicidal tendency	.048
Insane relatives	.035

This table of symptoms includes both the anxious or active and the retarded type of depression. "Anxiety" and "retardation" are more or less mutually exclusive and are specific symptoms, each giving a characteristic picture to the psychotic condition. But underlying all these symptoms there is one and the same factor. This factor is a specific emotional trait of human nature that may be described by the symptoms above enumerated. The symptoms here named are defined in *The Essential Psychoses*. The weights give the relative importance of the symptoms in the diagnosis of the syndrome. And these weights could be used in obtaining a quantitative measure of the degree in which the syndrome is present in any individual by merely summing the weights of the symptoms present in that individual.

The following case history will exemplify this condition.

Case 1. The patient on admission was a married woman of 48, 5 feet 1 inch in height, and weighed 86 pounds. This weight, however, was abnormal, for later on she attained a weight of 142 pounds. Outside of some unsteadiness in gait and stature when the eyes were closed, the physical examination was negative.

The family history was negative.

She had a normal birth, but was a delicate child until about 5 years of age. She went to school from her sixth to her twelfth year, at which time she was in the fifth grade. She became a dressmaker, but married at 21, having her first child about thirteen years later, this pregnancy having been preceded by one miscarriage.

About fifteen years previous to the present attack, the patient suffered from a similar mental condition.

Some months before her admission she began to "run down physically" and lose weight. But several months before this a "gloom" came over her. She also complained of a pain in her right ear, which was found to be ulcerated. The ulcer healed, but the pain continued. Owing to her

complaints she was sent to a sanatorium where she remained for five weeks. On being brought home she cried a great deal, could not sleep, and kept saying she wanted to die.

She would pay no attention to her daughter, on whom she had previously lavished so much affection that she would never correct her. She disturbed all in her home by her constant moaning about wanting to die and being the worst woman in the world; and so she was taken to an asylum for treatment.

On admission the patient was depressed, thought she was degraded, could never get well, begged to be put to death, wrung her hands, and moaned. Definite delusions were not present. She said she heard no noises and saw no strange things. She was oriented in time and place. Her general information was fair, but calculations were poorly performed. In one test she seemed to have a special memory defect.

For about two months after admission she kept up a constant wailing and crying about having committed the unpardonable sin and lost her soul. She then commenced to show signs of improvement. But she still remained agitated, pacing the floor and wringing her hands. Later she commenced to take interest in occupational therapy, working at the loom and at embroidery. After a while she became a help not only with the ward work, but also in the discipline of the patients.

At a staff conference held about seven years after her admission, her condition was diagnosed as "involutional melancholia" and she commenced paying longer and longer visits to her home. Finally she went to reside at home permanently but she was still on parole and subject to recall to the hospital. Regular visits were made by a social service worker of the hospital. About two years later she became somewhat downcast following the news that her brother, who had taken care of her and brought her up, had been very badly burned and taken to the hospital. Later the patient commenced to phone to the hospital, saying that she would have to return. She again commenced to moan and pace the floor and was returned to the hospital. A few months later she was again allowed to attempt a readjustment at home, where she remained for some six months, and for a time seemed quite normal and cheerful. Then she seemed to develop a condition of tension, though she maintained that she was feeling perfectly well. Nevertheless she could not sleep. She tried to imagine that her brother had not been burned at all, and the whole terrible episode was all imagination. A little later the patient's niece phoned to the hospital, asking someone to come for her at once. She was brought back to the hospital in an acute maniacal excitement. She sang, danced, laughed, and yelled. She was afraid they were going to kill her. Her

temperature rose to 110°. She died suddenly in the course of her maniacal excitement.

An autopsy was held and the anatomical diagnosis was: Acute cardiac dilatation associated with excessive elevation of temperature immediately preceding death. There was also congestion of the lungs, cloudy swelling of the liver, and a normal brain.[13]

b) RETARDED DEPRESSION

This classification was given to a group of patients who were not anxious but were sad and in general not tearful. The condition was given the following descriptive definition:

A psychosis with an evident tendency to clear and relapse. Its characteristic symptoms are depression, retardation, tired, worn-out neurasthenic attitude, and a tendency to suicide. It involves the disturbance of the same general factor as that which underlies constitutional hereditary (or "anxious") depression.

There is a trend by virtue of which the retarded depressions develop toward and take on some of the characters of catatonic praecox conditions, and constitutional hereditary depression in its turn tends to paranoid praecox conditions. It must be remembered, however, that the two forms of depression (retarded and anxious) are more frequently associated with one another than with any other syndrome or psychosis.

In general, neither retarded nor anxious depressions manifest bizarre delusions nor any form of stereotypism. The Hsü weights[14] for this syndrome are as follows:

Retardation	.551
Depression	.368
Neurasthenic attitude	.110
Suicidal tendency	.110

The following case history illustrates this syndrome.

Case 2. The patient presented on admission the picture of an elderly gray-haired withered man of 64 with a stern, grave, depressed appearance, with moderate arteriosclerosis, a systolic blood pressure of 220, and a

[13] T. V. Moore, *op. cit.*, p. 41.

[14] See above, p. 10.

history of diabetes. The eyegrounds were suggestive of nephritis. His family history was largely unknown.

He went through grammar school without difficulty and went to work at 14, learning the trade of a bookbinder, at which he was actively employed up to the time of his entrance into the hospital. He married at the age of 40 and had two children. Though the patient was somewhat domineering, his married life was happy. He neither drank nor smoked.

About a year and eight months before his admission to the hospital he had an infected foot, requiring him to spend about six weeks in the hospital, at which time it was discovered that he had diabetes.

When he returned home he was irritable, shaky, and "nervous." He went back to work but the physician at the plant sent him home and told him to remain there for a while. This led to anxiety about losing his job and the consequent financial difficulties. There was no cause, however, for the financial worries, since the patient had always saved money and was fairly well fixed for the future.

For eighteen months the patient never left the house. He developed a fear that some dire calamity was going to happen to the family. He became irritable, following the other members of the family about the house, but talking only a little and taking no interest in anything. Formerly he was a great talker, a baseball "fan," and always interested in details. But he became entirely apathetic to everything. He would bathe and shave only when forced to do so. He grew progressively worse, so that hospitalization became a necessity.

On admission to the hospital he talked in a subdued voice, low and almost inaudible. Some questions were at first apparently entirely ignored and after a period of silence he would ask that the question be repeated. He said he was depressed but could not give any good reason for his mood. He had no ideas of reference, delusions, or hallucinations. He had no insight but was well oriented in all spheres. He would not cooperate in mental tests. He denied headache, dizziness, or other symptoms which might point to cerebral arteriosclerosis. There was no evidence of confusion or gross memory defect.

The diagnosis of the conference was: Psychosis with somatic disease (arteriosclerosis and diabetes). The patient sat about the ward at first quietly, self-absorbed, dejected, and depressed. After about four months the depression seemed to lift somewhat. The ward notes, however, indicate that the depth of his depression varied, and though he answered questions willingly, it was in a low tone of voice. He remained in about the same condition, becoming well adjusted to his ward life and fairly content.

About a year and eight months after his admission there developed a slight abrasion on the left big toe, which was followed by gangrene. In spite of insulin treatment there was no improvement. An attempt was made to limit the gangrene by an alcoholic injection of the sheath of the femoral artery. After the operation, the patient refused the diet ordered for him. His heart action became poor, the pulse irregular. Three days later the gangrene spread to the foot and leg, the blood sugar rose to 777 mg., and in spite of intravenous insulin treatment the patient died about three days after his operation.[15]

c) MANIC EXCITEMENT

If one examines a heterogeneous group of excited patients, he will find that they fall into two groups: the euphoric and the noneuphoric. If now he selects the euphoric, he will have a group of patients who will in general manifest the following triad of symptoms: *euphoria*, *irritability*, and *excitement*.

One may give to this syndrome the following descriptive definition:

A psychosis characterized by the triad of symptoms, euphoria, irritability, and excitement, that has a marked tendency to clear and relapse. It is similar to constitutional hereditary depression in that it is associated with a hereditary defect. Individuals who belong to this group have a tendency to a strong, robust physique.[16]

The extension of this syndrome and the weights[17] as calculated by Hsü are as follows:

Irritability	.447
Tantrums	.233
Excitement	.158
Destructiveness	.134
Euphoria	.117
Homicidal tendency	.089
Hearing voices	.053

Physique and mental symptoms characteristic of this condition are found in the following case history.

[15] T. V. Moore, *op. cit.*, pp. 50 ff.
[16] *Ibid.*, p. 56.
[17] See above, p. 10.

Case 3. The patient at his physical examination on admission presented the picture of "a large well built man who looks younger than his 62 years. He is slightly overweight. His movements are quick and his muscular system well developed." Except for a rather low blood pressure (112/88) the physical examination was negative.

His family history was imperfectly known, but the only record of anything resembling mental disorder was that his mother during the last three years of her life was irritable, quarrelsome, and tried to commit suicide.

The patient had the ordinary diseases of childhood and graduated from college at 22, receiving his M.A. two years later. He was the captain of the football and baseball teams, the valedictorian of his class, and seems to have had a special ability in memory work.

After receiving his M.A. he engaged in various works of an intellectual character, lecturing, etc. He was successful and happy in his work.

After twenty-one years he had his first breakdown and spent a year in a sanatorium. For about a year before his admission, at the age of 61, he tried to carry on a garage business and later operated a shoe-shining stand, but his mental condition prevented his giving proper attention to his work and so he failed. His depressed days were spent in bed; and on his happy days he gadded about, unable to attend to business.

He married at the age of 26 and from his point of view the marriage was a happy one. But according to his wife, his life was a series of excitements and depressions, increasing in intensity as the years rolled on. He was selfish and inconsiderate at home, extravagant, interested in many subjects but unable to persevere in any. He was a fine "mixer" but not intemperate.

On admission he told a long story of persecution by a man whom he named and also by a gang of Italians, and it was thought to have some basis in truth.

The illness which led to his admission to the asylum seemed to have no definite time of onset, but was merely the accentuation of character traits he had manifested all his life. Just before admission he ran out of the house and told policemen that people were firing pistols and chasing him. He has been in the hospital over five years without any pronounced change in his condition.

His periods of excitement and depression alternate rapidly. On an excited day, for instance, he will keep shouting for water and when it is brought to him he will throw it on the floor.

When I visited him he burst into the examining room with a strap wrapped around his right fist, flourishing his arms, and shouted, "Who wants to see me?"

The attendant pointed to me. He turned suddenly, his apparent anger subsided at once, and he held out his hand in a most friendly manner, and said, "Oh, Father, I am so glad to see you."

He enjoyed his interview and pleaded with me to prolong it so that he would not have to go back to those patients.

When depressed he is always orderly and gentlemanly in his conduct, and talks quite rationally.

Ordinarily he has ground parole, though on one occasion he set fire to a porch. But his ground parole is not removed unless it is found "that he is shouting or cursing too loudly at a dead pigeon or some other such thing that he happens to find."

Hospital diagnosis: Manic-depressive psychosis.[18]

d) PARANOIA IRRITABILIS

If now one takes all the cases that manifest a marked irritability, but are not euphoric, yet at the same time manifest either tantrums or destructiveness or both, the selection comprises a group of patients whom mental hospitals are likely to term schizophrenic or label with the diagnosis of dementia praecox, type undetermined. In the study we are quoting, this condition was given a new name, because it was a syndrome not previously isolated. It was termed *paranoia irritabilis* (*species nova*). Considering the various other symptoms found in these patients, we arrive at the following descriptive definition:

A psychosis with marked tendency to prolonged chronicity, characterized by the disturbance of a general factor underlying irritability, display of tantrums, and destructiveness, but without marked euphoria, and by the presence of delusions that are often associated with hallucinations and usually by definite cognitive defect. Its tendency to combine with other syndromes associates it with the praecox rather than the manic-depressive group of psychoses.[19]

We may consider the following case history.

Case 4. On admission the patient presented the picture of a "well developed, rather poorly nourished woman of early middle age," 5 feet 6 inches tall, and 117 pounds in weight. Outside of low blood pressure

[18] T. V. Moore, *op. cit.*, pp. 57 f.

[19] *Ibid.*, p. 63.

(100/70), weak heart sounds, an impaired percussion note over the lungs, and skin scars suggestive of lues, the physical examination was negative. The blood Wassermann was negative.

The patient was born of highly educated, well-to-do parents, and there was no history of any mental disorder on either side of the family.

She was an only child and entered kindergarten when she was 5, but had to be removed on account of "nervousness." She was educated by her mother at home until she was 9 and then was sent for three years to a high-class private school. She was intellectually precocious. One day she rushed into her mother's room and asked for a pencil and at once wrote down the following poem:

THE WEEPING MOTHER

"By the cradle doth she weep,
Her baby fast asleep.
Asleep forever,
She will awaken never.

"The stars shine bright,
The baby's eyes shut tight,
Asleep forever—
She will awaken, O, never."

She wrote poems until she was 13, when one day her mother happened to interrupt her; she flew into a temper and declared that she would never write another poem; and as far as is known she kept her word.

She was a dreamer all her school life and studied only what happened to interest her.

When in high school she first commenced to show a tendency to untidiness. She became more and more "nervous" and had many temper tantrums with her mother. But all this time her English compositions at school were held up as models to her classmates, and her teachers obtained them to serve as examples for the children of future classes.

Graduating from high school, she took up training for a teacher; however, her mother was told that she was too nervous and too untidy in her person ever to hold a position as a teacher.

She obtained a government position, but was continually shifted to other departments and became increasingly inefficient in her work. She spent all her earnings buying extravagant gifts for her friends and many luxuries for herself.

When she was about 20 she became objectionable to the neighbors by

reason of her noisy tantrums and display of temper by banging on the doors of those who happened to be playing a victrola, etc.

She then went to live by herself, growing more and more untidy and holding positions for shorter and shorter intervals.

She was taken to a city hospital for observation and discharged to her mother as a psychopathic personality. Then followed a history of being requested again and again to leave her boardinghouse because of objectionable temper tantrums, of resigning positions which her mother with marvelous dexterity succeeded in obtaining for her, of going about in soiled clothing and allowing all sorts of old dirty cast-off clothing to accumulate in disorder in her room.

Finally a friend of her mother's appealed to the police and she was sent to the city hospital for observation.

She has now been in an asylum for over six years, with no essential change in her picture. She became rather contented with the hospital, though she has trouble with the patients who sleep near her and often handles them roughly. She remained inaccessible to interviews, and if she ever had any delusions they were not detected. From time to time she will strike an old lady, knocking her down, afterward explaining the matter as lack of self-control—merely her type of insanity. Her history is spotted with records of hair pulling, slapping, knocking down old ladies and fighting—usually being in the wrong.

Her speaking of her own birthday as that of her twin doll may be interpreted as a delusion. More evidence of the existence of delusions is found in the fact that she told her mother that she thought she might forget her birthday because "you were in Egypt when I was born in France." She also once had the idea that her mosquito bites were syphilitic papules.

She continues to live with her doll and celebrate its birthday, her mother bringing a cake for the occasion. She does some work in the occupational therapy department, but is a source of continual difficulty to her mother.

She qualified for our syndrome of paranoia irritabilis, but no other. The diagnosis of the hospital was: Dementia praecox (schizophrenia).[20]

e) PARANOID DEMENTIA PRAECOX

There is a group of mental patients characterized by the prominence of bizarre delusions and an abundance of hallucinations. They lack insight into the pathological nature of their

[20] T. V. Moore, *op. cit.*, pp. 68 ff.

condition, and are so sure of their peculiar mental experiences that they will talk quite freely about their delusions and hallucinations. They are suffering from what Kraepelin termed *paranoid dementia praecox.* The following descriptive definition was formulated, based on the correlation technique and various empirical findings:

A psychosis with marked tendency to chronicity. It is produced by the disturbance of a general factor in mental life that underlies the group of symptoms: auditory hallucinations, bizarre delusions, stereotypism of words, disorientation in space, and "other" hallucinations.* Visual and tactual hallucinations are also frequently present, that is, in 74.3 and 65.7 per cent of the cases respectively. The condition may remain stationary for years but shows a tendency to combine with other syndromes and so contribute to the various forms in which the praecox condition is manifested.[21]

The extension of this syndrome and the weights as calculated by Hsü[22] are as follows:

Auditory hallucinations	.308
Bizarre delusions	.263
Tactual hallucinations	.136
Visual hallucinations	.133
"Other" hallucinations	.129
Stereotypism of speech	.065
Talking to voices	.056
Disorientation in time	.046
Rational delusions	.044
Disorientation in space	.044
Absence of insight	.042

The following case history illustrates this type of mental disorder.

Case 5. The patient, at the time of admission, was about 37 years of age. In the physical examination nothing was found except an active gonorrhea. He was 5 feet 8 inches in height, weighed 160 pounds, and had an excellent muscular development.

* The term "other" refers to olfactory, gustatory, kinesthetic, or organic—any hallucinations, that is, *other* than visual, auditory, or tactual.

[21] T. V. Moore, *op. cit.*, p. 72.

[22] See above, p. 20.

The family history revealed that his maternal grandmother was 85 years of age and for four or five years had suffered from a senile psychosis, with vague persecutory ideas and alternating excitement and depression. His father had been alcoholic for two years of his life.

The patient had had measles and chickenpox as a child, and tonsillitis for several winters when about 19 or 20. When 22 he contracted a specific urethritis, complicated by joint involvement and rheumatic fever a year later.

He was a good student and entered a profession, holding a number of positions with credit and success.

When he was about 29 "slight difficulties arose that caused him an undue amount of worry and made him irritable, and at the same time he suffered from a phlebitis which, however, soon cleared." But a few months later he commenced to notice that people in his neighborhood had a peculiar attitude toward him, and he suspected two boys in the laboratory of stealing alcohol. A little later his first actual break occurred, preceded by restlessness, insomnia, worry, and tension. He thought he was spied upon and had auditory hallucinations of an unpleasant character. The condition seemed to clear after about two weeks in a sanatorium. A week or so after the "clearing," while going in a car to pay a visit, he thought he was under close observation, and that his fellow passengers were ridiculing him. He was bothered by the sounds on the street and the noise made by people he thought were on the roof. He objected to tobacco smoke being blown in his room and to the man on the roof peering at him. He made an attempt at suicide, resulting in a fracture of the skull. After a decompression operation he made an uneventful recovery. On leaving the hospital he went to a sanatorium. He complained while on the train of the unnecessary ringing of bells and that the porter had called him "boy."

On arriving at the sanatorium he was apathetic and retarded but did well on intelligence tests and was well oriented.

In the sanatorium he gradually improved, and even seemed to clear with insight. For a year he held a position in his professional line and did excellent work. His wife remained away on the advice of the psychiatrist, but the following autumn they resumed housekeeping. The family situation again became strained and he became irritated by unexplained noises in the basement and took veronal to be able to sleep. In spite of various ideas of reference and auditory hallucinations, he was promoted with an increase in salary.

Notwithstanding this, he resigned his position to go abroad and study. His delusions of reference and auditory hallucinations continued, and soon he had to be taken to a sanatorium. He was removed to an asylum, where

he had to be tube fed, having refused to eat the food offered him, which he said was poisoned.

He was returned to the hospital in this country, where he continued to present the same picture. Voices were transmitted to him through a distance of 180 miles: a voice said, "The whole attitude is an aggressive attack on your sex life." He was then legally committed to an asylum.

Here he complained of a group of six, one a young lady, who were able to put him in all sorts of states of tension that caused him great discomfort. He has become seclusive and introverted and spends hours every day stretched on the benches with his face turned to the wall, indulging in day-dreams and phantasies. From the letters he writes it seems that he plans to take up his professional work abroad. At times he becomes tense, antagonistic, and bitter, resenting his hospitalization. He continues to be well oriented in all spheres.

The final diagnosis in the hospital was: Paranoid dementia praecox.[23]

f) CATATONIA

There is a tetrad of symptoms found fairly often in a group of patients who would in general be diagnosed as suffering from catatonic or at times hebephrenic dementia praecox. This tetrad is: mutism, negativism, refusal of food (necessitating at times tube feeding), and stereotypism of attitudes (maintaining fixed attitudes for long periods). It has been shown that catatonic patients tend to have a slender, asthenic physical build, in contrast to paranoid dementia praecox patients, who are much more muscular and heavily built.[24]

The following descriptive definition of the condition was derived from our empirical study:

A psychosis characterized by the involvement of a general factor underlying a syndrome whose specific manifestations are: mutism, negativism, refusal of food, and stereotypism of attitudes, that peculiar trait which is most significant of the catatonic muscular rigidity. Patients with this disorder, when their mental content can be opened up, are found to be suffering from delusions and hallucinations. They are, however, markedly "shut in" and manifest in the acute stage of their disorder a rather notice-

[23] T. V. Moore, *op. cit.*, p. 77.

[24] C. J. Connolly, *Physique in Relation to Psychosis*, Stud. Psychol. & Psychiat., vol. 4, no. 5, 1939.

able cognitive defect. It is a disorder of the young rather than the old, and the average age of onset in our group was 25.4 years, ranging from 18 to 42.[25]

The extension of this syndrome and the weights[26] as calculated by Hsü are as follows:

Mutism	.312
Negativism	.273
Refusal of food	.149
Stereotypism of attitudes	.119
Being shut in	.105
Stereotypism of actions	.074
Giggling	.056
Destructiveness	.053
Loss of finer sensibilities	.050
Irritability	.041

The condition is illustrated by the following case history.

Case 6. The patient on admission presented the picture of a fairly well built, rather poorly nourished, anemic young adult male, 5 feet 8 inches tall, weighing 135 pounds. The physical examination revealed nothing abnormal.

One of his father's brothers had mental trouble. The patient had three brothers and two sisters, all living and well. There was no history of alcoholism in the family.

The patient was the youngest in a family of seven children (including one stillbirth). He commenced school at the age of 6 and continued until 14 or 15 years of age, at which time he was in the sixth grade. He then began to sell clothing and while so engaged went to night school and took a business course. He held several small jobs and at 19 he commenced to do clerical work for his brother. He ran away from this work and joined the United States Army. After remaining as a private for about eleven months, he went A.W.O.L., finally obtaining a position as clerk in a hotel, from which he was taken to an asylum.

During the last months of his career as a soldier he was often in the guardhouse for talking back to superior officers and not performing his duties. On leaving the army, he became bashful and seclusive. Periods of depression alternated with periods of wild excitement.

[25] T. V. Moore, *op. cit.*, p. 80.

[26] See above, p. 10.

After his entrance into the ward of a private hospital, it was noticed that he would sit a great deal by himself, often smiling without apparent cause and staring into space for long periods of time. Auditory hallucinations seemed to increase in frequency. He was disagreeable, irritable, and ready to pick quarrels. His interest in occupational classes decreased. He became vile and obscene in his conversation. He talked loudly about the restriction of his liberties and addressed letters to the commissioner of police. He made many attempts to escape and on each occasion, when apprehended, was threatening and homicidal. Sometimes for an hour or more he would stand stiffly in one position, staring fixedly at one object. Again, impulsively and without cause, he would suddenly attack an attendant.

He was then transferred to another hospital. On admission to this hospital his talk was irrational, his memory and intelligence markedly defective. He would answer questions by repeating what was asked and then make some irrelevant remark or say nothing. He was careless in dress, though at first not unclean in his habits. At times he would yell out of the window over and over again, "In one ear and out the other;" again, he would mutter over and over again an obscene phrase referring to a sexual perversion. He had a peculiar mannerism of suppressing a yawn, as it were, while talking.

His stream of talk was incoherent: e.g., "I am mentally insane. The voice of . . . I have no ears. I am the voice to take the clouds out. I am sorry I spoke to you. I drunk the holy conversation, some sort of drugs here. Intelligence don't count. The nerves are green. Drugs hold a conversation with I. I have been in the clouds. I have been dead. The voice of human beings holds conversation with me. They use the voice of I."

He passed from excited stages, in which he would shout aloud, thinking he was broadcasting over the radio to President Coolidge, to seclusive periods in which he would be mute, negativistically drawing his lips tightly together if asked a question, staring, and taking no interest in his surroundings.

Sometimes when asked a question he would reply, "Buz inch of a life that is a life of life for a life, to a life, because a life protects a life," and repeat the phrase again and again with variations, but "life" had for some reason to appear as every third or fourth word. While doing this he would indulge in all sorts of threatening mannerisms and end by grinding his teeth with a loud crunching sound that made one think he was breaking them to pieces.

At times he became very irritable. In some way, however, he managed

to keep himself very well informed on racing events, showing that his mind was not as deteriorated as it seemed. If women came on the ward he would burst out talking in a vulgar fashion or make exhibitionistic attempts.

The patient remained regressed, deteriorated, and out of touch with his environment, but still cleanly in his excretory habits.

He was diagnosed at the first hospital as catatonic dementia praecox; at the second one, where he has remained for eight years, he was diagnosed in conference merely as dementia praecox, although several of the ward physicians said he was a case of hebephrenic dementia praecox.[27]

To appreciate the full import of the above given groupings of symptoms, one must understand the correlation technique and modern factor analysis.[28] The mathematical technique puts the data through a statistical mill and out come a number of syndromes in which one recognizes certain diagnostic entities discovered by Kraepelin. The fact that more Kraepelinian entities did not appear is probably due to the fact that only a limited number of traits or symptoms were investigated. The appearance of the statistical factors (which turn out to be Kraepelinian entities) is no mere chance event. There is a biological foundation in the nature of a human being which accounts for the collocation of the various symptoms in specific syndromes.

5. A Psychological Explanation of the Entities of Psychiatry

From the data and calculations just considered, we must recognize that the clinical entities of psychiatry are realities whose nature and existence must be explained.

[27] T. V. Moore, *op. cit.*, pp. 85 ff.

[28] L. L. Thurstone made use of our table of intercorrelations and obtained essentially the same groupings. We have not mentioned the factor of cognitive defect in this account, though it was pointed out in 1933. We split the excited group into two classes, and also the depressed group, though along with Thurstone we found the same five fundamental group factors or constellations of symptoms. See L. L. Thurstone, "The Vectors of Mind," *Psychol. Rev.* **41**: 1, 1934.

The following possibilities of explanation are to be considered.

(1) "A mental disorder is an abnormality of human behavior whose specific manifestations depend on the mental history of the patient. The character of these manifestations is, therefore, *independent of the original physical constitution or mental temperament of the patient.*"[29]

This concept seems to have hovered before the minds of Freud and his followers in seeking the origin of mental disorders first in the sexual traumata of childhood and then in the early repression of infantile sexuality.

The studies we are about to report show that there is a relationship between the type of psychosis and the prepsychotic personality. Furthermore, the long series of investigations initiated by the work of Kretschmer show that there is even some relationship between body build and psychotic type. Taking these things into consideration, we must conclude that while the previous mental history of the patient may color his psychosis in various ways, it cannot account entirely for the phenomena observed in the study of mental disorders.

(2) "A mental disorder is an abnormality of human behavior whose specific manifestations depend largely on the *original physical constitution* of the patient."

One who might be blind to the presence of truly psychic elements in the human organism might take this attitude; but it could not be based on the work of Kretschmer. The correlation between body build and psychotic type, while due to something more than chance, is not close enough to warrant our seeking the entire explanation of any psychosis merely in the physical constitution of the patient. Furthermore, as we have pointed out above, a psychosis is essentially a profound dis-

[29] T. V. Moore, "The Prepsychotic Personality and the Concept of Mental Disorder," *Character & Personality* **9**: 170, 1941. The outlines presented here of various possible theories of the nature of mental disorders are taken from this study.

turbance of the inner organization of the mental life of the patient, and it is reasonable therefore to look for an explanation of the entities of psychiatry that involves at least some psychic factor.

(3) "A mental disorder is an abnormality of human behavior whose specific manifestations depend largely on the *original mental temperament* of the patient."

This explanation of mental disorders approaches the truth, but is one-sided, like the second view just mentioned. In the explanation of human behavior we must not confine ourselves entirely to either the physical or the mental, but give due consideration to both sides of human nature. In the light of what we now know about the physiology of emotions, it is not likely that the essential mental disorders, which always manifest some kind of emotional disturbance, can be explained without taking into consideration various physical conditions.

(4) "A mental disorder is an abnormality of human behavior whose specific manifestations depend neither on the physical constitution nor the mental temperament of the patient, but on the accidental *localizations of vascular, toxic, or other types of cerebral lesions.*"

This concept of mental disorder has hovered before the minds of brain pathologists in a host of scientific investigations to be found in the literature. It has been applied with some success in the field of hallucinations, but it is far from being adequate to account for the specific forms of various manic-depressive and schizophrenic psychoses in terms of cerebral lesions. Furthermore, if the localization alone of cerebral lesions adequately accounted for the phenomena of the psychoses, the form taken by the psychoses should bear no more relation to the prepsychotic character than disabilities due to gunshot wounds bear to the temperaments existing in those wounded prior to being shot.

The theory calls for an investigation of the relationship between the prepsychotic personality and the symptoms of the

mental disorder. If there is such a relationship, its explanation should be formulated somewhat as follows:

(5) A mental disorder is an abnormality of human behavior dependent to a very great extent on the *original psychobiological constitution* of the patient. This original psychobiological constitution is manifested by anthropological, biological, and mental traits which tend toward one type of grouping in some individuals and toward quite a different type in others.

An investigation of the relationship between the prepsychotic character and the type of the patient's psychosis did show a very definite trend to an association between the two.[30]

Let us take for instance the manic patients, and compare them with those suffering from anxiety depression. It has been claimed by Kraepelin that these conditions are two species in the genus of manic-depressive mental disorders, and as a matter of fact we do find that the prepsychotic character in each has a definite trend to certain generic traits found also in the other, while on the other hand certain specific traits are found in one disorder but not in the other.

These patients are *alike* in having been (1) not timid nor retiring in their social contacts, but (2) rather forward and bold, and in (3) having a tendency to overdo in their various activities. Strange to say, the manics as well as those suffering from anxiety depression (4) have a tendency to worry, (5) to be scrupulous, and (6) to suffer from peculiar abnormal fears. They are alike also in (7) not preferring indoor recreations to outdoor sports, (8) not liking to be alone, (9) not tending to sulk and pout when scolded or meeting with some difficulty, (10) not tending to "give up and quit" and to say "What's the use?" when meeting with serious obstacles, and (11) being not slow in speech.

On the other hand, each type has a group of symptoms that the other *tends to lack*. These are as follows: (1) fickleness of

[30] For the details and technique of this investigation see the above mentioned study in *Character & Personality* **9**: 169, 1941.

mood; (2) spells of the blues; (3) deep sadness when in mental difficulty; (4) peculiar outlook on life; (5) visionary tendency; (6) suspiciousness.

The first three of these traits tend to appear in the prepsychotic personalities of those who suffer from anxiety depression. The second three are utterly foreign to the prepsychotic character of manics, but may or may not be found in the prepsychotic traits of those who have anxiety depression. For some reason those with anxiety depression tend to leave school earlier than manics, perhaps because some of them worry so much about examinations that they are glad to quit school and go to work.

This example will suffice to show what is meant by a relationship between the prepsychotic character and the type of the psychosis. For further details, the study just mentioned may be consulted. Each type of schizophrenic and manic-depressive psychosis has its specific form of prepsychotic personality. The explanation of this relationship will throw a great deal of light on the nature of a mental disorder. One must seek the explanation in the recent investigation of the physiology of the emotions.[31]

6. Physiological and Psychological Emotions

From a number of investigations, it is evident that the various forms of emotional expression are reflexes with centers in the hypothalamic region. Little has as yet been done to find a point center for any individual type of emotional expression. Gibbs and Gibbs,[32] for instance, were able to elicit purring in the cat by electric stimulation of the infundibular region. And then there is the classic work of Foerster and Gagel,[33] who

[31] A preliminary review of the literature on this problem was made by the author in "Psychoses and Prepsychotic Personality," *Am. J. Orthpsychiat.* **9**: 140, 1939.

[32] E. L. Gibbs and F. A. Gibbs, "A Purring Center in the Cat's Brain," *J. Comp. Neurol.* **64**: 209, 1936.

[33] O. Foerster and O. Gagel, "Ein Fall von Ependymcyste . . . ," *Ztschr. f. d. ges. Neurol. u. Psychiat.* **149**: 312, 1934.

produced in man a condition of manic excitement by stimulation of the hypothalamic region, and a kind of catatonic lethargy by pressure in the region of the aqueduct of Sylvius and the medulla.

Though it is possible to find patients in whom emotional expression is devoid of emotional experience,[34] sometimes the two go hand in hand. Marañon[35] found that in some individuals the injection of 1 cc. of adrenalin called forth such physical accompaniments of emotion as palpitation of the heart, etc., while the subjects nevertheless remained cold and without emotional experience. Others along with the physical reactions experienced an attack of genuine anxiety. This would look as if emotional experience as well as emotional expression could appear as a cerebral reflex due to the activity of certain centers that we have good reason to believe lie in the hypothalamic region.

This does not mean that any mere nucleus of cells is a center of emotional experience. The question as to what is involved in experience is a problem that is not solved by finding out that experience of some kind can be elicited by stimulating a cerebral center. Stimulation anywhere in the optic tract would lead to visual experience, but that does not show that the place stimulated is a center in which the visual experience takes place.

Granted, therefore, that emotional expression and emotional experience may be produced by stimulation in the hypothalamic region, it is reasonable to suppose that the lability of this center varies from individual to individual and from time to time in one and the same individual. The intensity and duration of an emotional reaction depend in some manner on the lability of the emotional centers.

If emotional experience as well as emotional expression can

[34] Cf. T. V. Moore, *Dynamic Psychology*, Philadelphia, 1923, pp. 118 f.

[35] G. Marañon, "Contribution a l'étude de l'action émotive de l'adrénaline," *Rev. franç. d'endocrinol.* **2**: 301, 1924. For a fuller discussion, see below, pp. 248 ff.

be called forth by irritation of centers in the hypothalamic region, we have a class of emotions that may be termed physiological. Some of the anxieties of later life may belong to this class of physiological emotions. They are not produced, as emotions usually are, by an insight into the intricacies of a situation of great moment to the individual. But the anxiety experience arises without psychological *raison d'être*. It then attaches itself without warrant to this or that item of past experience. Something of a kindred nature is often true of the phases of manic-depressive insanity. Though a depression, for instance, is sometimes precipitated by an event that would naturally lead to more or less sadness, there is often no due proportion between the loss experienced and the intense, prolonged sadness which it precipitates.

The recognition of the existence of a class of "physiological emotions" should not blind us to the fact that normally an emotion has its roots deep down in the history of theperson who experiences the emotion. It results from the appraisement of the meaning and consequences of something that has transpired and usually comes about as a sudden violent reaction to an insight whose depth and wide extent overwhelm the mind with the realization of all manner of actualities now existing and possibilities that may transpire. In man this insight involves intellectual function of the highest order. But even animals may be capable of a power of estimation that transcends the reflex limits of the simple sensory feelings.

The emotional reactions of man are complex phenomena. They consist of (*a*) what is termed the bodily resonance, and (*b*) truly psychic experiences that precede[36] the resonance and arise from the psyche itself, the latter being the center of the psychic reflexes that portray but do not constitute the formal essence of the emotional experience.

These psychic experiences are the mental states that we term anger, sorrow, anxiety, joy, elation, etc. For some reason,

[36] T. V. Moore, *op. cit.*, pp. 116 ff.

human beings differ in their tendencies to react to trying situations, more or less habitually, not only with certain forms of bodily resonance, but also with a specific type of emotional experience. If the state of the hypothalamic centers has something to do with the intensity and duration of emotional reactions, both physical and psychic, this difference in individuals is easily understood. The original psychobiological constitution of the individual will have something to do with the habitual type of his emotional reactions. This constitution will be modified by the psychic traumata of life's experiences. Both organic conditions (hereditary and toxic factors, for instance) and the mental history of the individual will provide a psychosomatic basis for emotional trends. Those individuals will be more likely to develop psychoses in whom the hypothalamic centers, by virtue of their original organic constitution and their subjection to repeated emotional shocks, are in a condition of abnormal lability. And so the psychosis will bear a relation to the prepsychotic character and will often be essentially an overaccentuation of character defects. The natural collocation of character traits will have a great deal to do with the collocation of psychotic symptoms in certain syndromes that give rise to the clinical entities of psychiatry.

Chapter II

TYPE CONCEPTS OF PSYCHOPATHOLOGY

Pathology is a science ordinarily conceived of as dealing with the organic conditions that give rise to the various disorders of the human organism. The term psychopathology indicates that there are various *mental* conditions and experiences which produce certain types of disorder, physical or mental.

These mental conditions may be divided into (*a*) those that affect permanently temperament and character, or what is at present occasionally referred to as the structure of the personality, and (*b*) those that act as individual experiences and by their intensity precipitate a mental disorder or even produce an organic change in the physical structure of the organism.

Let us first consider the Freudian concept of the pathology of temperament and character.

1. Sigmund Freud

Temperament is to some extent dependent on hereditary constitution and to some extent on the chance mental experiences of early life.

Coming now to the chance experiences of early mental life as determinants of temperament, we are confronted with the interesting speculations and observations of Freud and his followers as the most important school of psychopathology at the present day. Before the days of Freud little attention was paid either to chance experiences of early life as determinants of temperament or to the possibility that in these early experiences one might seek for the real origin of certain mental disorders. The following statements give in brief the Freudian point of view in psychopathology.

(1) Freud minimizes the influence of heredity and leaves to

this factor in mental abnormality what cannot be explained by the individual person's experience.

(2) He feels that the major factors in any mental disorder are to be found (*a*) in the accidental sexual experiences of childhood; (*b*) in the reactions of parents to these early sexual manifestations; (*c*) in the possibility of normal sexual satisfaction in adult life.

(3) Freud holds that the individual's character traits, plan of life, and adult interests are determined by the accidents of infantile sexual experience.

To understand Freud's psychopathology, it will be necessary for us to outline his concept of the structure of the personality and of the origin of mental disorders.

In our presentation of Freud, we have aimed at setting forth various typical concepts of psychopathology. We have not tried the very difficult task of giving the latest expression of his views, much less have we attempted to surmise what Freud might have thought in the light of more recent developments. Whenever we have described any Freudian concept, we have drawn from the works of Freud himself and tried to illustrate his point of view by citations drawn from his own writings.

THE STRUCTURE OF THE PERSONALITY

When we speak of personality and its structure, we mean in general an individual intelligent being. What is this being, originally, according to Freud? The answer is that it is an undifferentiated something to which he gives a name: the *id*. The id is the bearer of heredity and evidently must be regarded as the fertilized ovum when we trace it back to the first stages of its development. But according to Freud the id contains not only a mass of bodily physical traits due to organic inheritance, but also the mental experiences of former ages which "have been repeated often enough and with sufficient intensity in the successive individuals of many generations."[1]

[1] Sigmund Freud, *The Ego and the Id*, trans. by Joan Riviere, London, 1927, p. 52.

It is evident that at first all this mass of racial experience is unconscious and therefore, according to Freud, the unconscious must be the primary element of mental life.

But in due season conscious experience pours into the id by way of the senses.[2] These experiences do not remain indefinitely in the field of consciousness, but sink below its level to a region that Freud terms the preconscious or foreconscious. And so we have ontogenetically in their order of development in the mind three strata of mental life: (*a*) the unconscious, (*b*) the conscious, (*c*) the foreconscious.

The "coherent organization of mental processes" is termed by Freud the *ego*. In the course of life the ego meets with certain experiences to which it bears an intense dislike and which it hates to recall. It endeavors to repress them and drive them even from the region of the foreconscious into the unconscious so that they may never be able to trouble consciousness again. So the unconscious in the course of experience comes to contain two types of material: (*a*) its original racial experience, and (*b*) the repressed elements that were formerly conscious.

Verbal association is the royal road from consciousness to the unconscious or the preconscious. And so by free association one is able to delve into the depths of the unconscious.[3]

One might ask a question concerning the unconscious mental states and activities. Do they exist as potentialities or as actualities? Freud makes a distinction here between ideas and emotions:

> A comparison of the unconscious affect with the unconscious idea reveals the significant difference that the unconscious idea continues, after repression, as an actual formation in the system *Ucs*, whilst to the unconscious affect there corresponds in the same system only a potential disposition which is prevented from developing further. . . . There are no unconscious affects in the sense in which there are unconscious ideas.[4]

[2] *Ibid.*, p. 20.

[3] *Ibid.*, pp. 20 ff.

[4] S. Freud, "The Unconscious," *Collected Papers*, London, 1925, vol. 4, p. 111.

The reason back of this is that Freud conceives of ideas as charged entities (cathexes), but an emotion is the process of discharge, "the final expression of which is perceived as feeling."[4a]

How do ideas exist in the unconscious? Freud is very strong in his insistence that they exist there as mental and not as physical entities. They are no mere traces in the nervous system, but psychic entities capable of powerful emotional discharges.

The ego, according to Freud, is not a simple and homogeneous entity, but is differentiated into the ego proper and the superego. How does this come about?

Psychoanalysts refer to our tendency to imitate one whom we love and admire, as identifying ourselves with that person. By identification they cannot reasonably mean that one actually thinks that he is another person, but rather that he would like to be.

The boy very early learns to love and admire his father and so in the psychoanalytic sense identifies himself with his father. Freud goes beyond this and points out that the boy also loves his mother and identifies himself with her, and so there arises an ambivalence in his emotions, for now he loves his mother and hates his father. This is spoken of as the Oedipus complex. Again he loves his father and hates his mother. When a girl does this it is sometimes spoken of as the Electra complex. Freud prefers to term this the feminine Oedipus complex and does not advocate the term Electra complex.[5] As a result of this there is formed in the child's mind a parental representation that constitutes an ego ideal. Inasmuch as the ego does not always want to conform to the parental ideal, there arises a conflict similar to that between the ego reality principle and the pleasure-pain principle of the id. By the pleasure-pain principle is meant the drive to have and enjoy whatever we

[4a] *Loc. cit.*

[5] *Op. cit.*, vol. 2, p. 211.

want to have and enjoy without regard to consequences. Very early, however, the child learns that it cannot have everything it wants. It is face to face with reality and must sooner or later make up its mind to get along without what cannot be had. Soon it learns that certain present pleasures entail much suffering later on, and so it has to adapt itself to this element in reality. In the process of adaptation the ego reality principle is in conflict with the pleasure-pain principle of the id.

A similar conflict arises between personal desire and the voice of conscience. Freud attributes the voice of conscience to the superego, and the conflict of the individual with conscience is termed the conflict between the ego and the superego.

> By setting up this ego-ideal the ego masters its Oedipus complex and at the same time places itself in subjection to the id. Whereas the ego is essentially the representative of the external world, of reality, the superego stands in contrast to it as the representative of the internal world, of the id.[6]

From this point of view the superego is a part of the id rather than of the ego, for it has to do with the internal forces of the mind, whereas the ego deals with the external forces of reality.

Thus we see in outline the Freudian concept of the human personality. It contains no element of a novel nature, though its author has given its various strata rather interesting names.

By way of criticism one might say that, since there is no clear evidence of the transmission of experience by heredity, there may well be considerable doubt about the phylogenetic acquisitions of the id. The transmission of human nature, with its fundamental and essential capabilities of acquiring experience and reacting to it, and the continuity of society with its languages, its living milieu, and its nonliving monuments, seem capable of accounting for present-day experience and its resemblance to what we know about the mental life of early man.

We all recognize that everything in a human being is not conscious, though we may not be familiar with the term id as

[6] S. Freud, *The Ego and the Id*, p. 48.

the designation of the nonconscious aspect of the organism. We are all familiar with the conscious mind, which keeps us in contact with external reality, and see no reason why we should not speak of it as the ego. And each of us has lived with his own moral conscience and known its approval and felt its disapproval. But we have not termed it a superego. Nor have we all regarded conscience merely as a portion of our own minds with which it behooves us to be at peace. Some of us at least conceive of the possibility of a "true light that enlighteneth everyone who cometh into the world," and know that God has ways of speaking to the mind of man through the channel of natural reason as well as by supernatural grace.

It might be well to point out that Freud has merely given names to various spheres of mental life. He has not proved that conscience is no more than one part of the mind scolding another part.

However, aside from his ultimate philosophy, he has classified the data of human individual experience, and his terms refer to actual elements of the empirical personality, though the philosophy by which he interprets man without God has been put forward without any foundation.

THE ETIOLOGY OF PSYCHONEUROTIC CONDITIONS ACCORDING TO FREUD

In a study written in June, 1905,[7] Freud points out how in his earlier writings he had attempted to explain the appearance of neurotic symptoms as due to the accidents of sexual experience in early childhood, and that, too, so as to differentiate the later forms of psychoneurotic manifestations on the basis of passive or active behavior in these early scenes, the former leading to hysteria and the latter to compulsion neuroses.[8] He

[7] "Meine Ansichten über die Rolle der Sexualität in der Aetiologie der Neurosen," *Coll. Pap.*, vol. 1, pp. 272 ff.

[8] *Ibid.*, p. 128.

then tells us that a later investigation of the early sexual life of normal individuals indicated that they had suffered infantile sexual traumata as well as the psychoneurotics and had developed no abnormal symptoms in consequence. This led him to lay aside the concept that sexual traumata in early childhood were a necessary and sufficient cause for the appearance of neurotic symptoms in adult life. He then made the assumption that it is not the sexual experience of infancy which gives rise to the appearance of abnormal mental symptoms, but the fact that the individual who has them often reacts to spontaneous manifestations of infantile sexuality by breaking them off, that is to say, by an act of repression.[9]

One who has had only a little training in the technique of testing conjectures by statistical procedures will be surprised again and again by the utter lack of any attempt on Freud's part to work out any kind of a coefficient of association, much less to look for irrelevant factors, should any such association be found. We have no guarantee that Freud's second surmise would prove to be of any more value than his first, if a large number of normals and psychoneurotics were studied and divided into subclasses—(*a*) those who attempted to put an end to infantile sexuality and (*b*) those who made no such attempt.

Freud attributes the appearance of hysteria in adults to the conflict between libido and sexual repression; but no evidence is introduced to show that this conflict must of necessity be related to infantile sexuality, nor even that hysteria must arise from a specifically sexual conflict, to the exclusion of all other types of stress and strain to which the human personality is subject. That it must be due to a sexual conflict seems clear to Freud on the basis of his own psychology of impulsive and affective life.

Freud suggests that common to all impulses there is a generic

[9] *Ibid.*, p. 130.

drive to action which in itself has no quality or specific coloring.[10] The source of the impulse is some one of the organs of the body. The end toward which it drives is the getting rid of the stimulation. Two excitements of different nature arise from the stimulation of any organ: one is anatomically specific to the organ, the other is a sexual component that is never lacking. This sexual component, according to Freud, is present from the earliest days of infancy.

Does this term sexual applied to infancy have the same meaning as it does in adult life? According to Ernest Jones, it does: "When he [Freud] calls certain infantile processes 'sexual,' he does so because he believes that they are intrinsically of the same nature as the processes that everyone calls sexual in the adult."[11]

What Freud looks upon as the unrestrained sexuality of early infancy is repressed, according to him, in about the third or fourth year of the infant's life by parental training, giving rise to feelings of disgust and shame and to esthetic and moral ideals. According to Freud, parental efforts at repression of infantile sexuality, in the case of boys at any rate, is associated with threats of cutting off the sex organ, and so is laid the root of the castration complex which psychoanalysts are said to find with remarkable unanimity as the basis of psychoneurotic conditions.[12]

The origin of psychoneurotic conditions in girls seemed very obscure to psychoanalytic writers till Karl Abraham developed the analogy that their origin was to be traced to an infantile

[10] "Die einfachste and nächstliegende Annahme über die Natur der Triebe wäre, dass sie an sich keine Qualität besitzen, sondern nur als Masse von Arbeitsanforderung für das Seelenleben in Betracht kommen": "Drei Abhandlungen zur Sexualtheorie," *Gesammelte Schriften*, Leipzig, 1924, vol. 5, p. 41.

[11] Ernest Jones, *Papers on Psychoanalysis*, London, 1923, chap. iii, p. 28; first published in *Psychol. Bull.*, vol. 7, April, 1910. For a confirmation see Freud, *Gesam. Schrift.*, vol. 5, p. 56.

[12] Cf. Ives Hendrick, *Facts and Theories of Psychoanalysis*, ed. 2, New York, 1941, pp. 62c, 62g ff.

anxiety relating to the idea that they were once like boys, but had been punished by the removal of their sexual organs for indulging in some kind of sexuality.[13]

Florence Teagarden is perhaps not the only woman who has some doubts about the psychoanalytic theory of the origin of all psychoneurotic conditions in women:

> Because some feebleminded or neurotic children, wrongly trained, display a great interest in fecal matter, play with it, or put it into their mouths, it does not follow that all children do likewise. Because some girl children, by reason of circumstances peculiar to their upbringing and locale, wish they were boys and express a regret that their external genitalia are not like those of boys, it does not follow that all girls or women go through a phase of development dominated by a "penis envy" or a "castration complex."[14]

Jacob H. Conn[15] attempted to get evidence on the reactions of children to first seeing the genitals of the opposite sex. He tried to obtain his information by means of the play interview. "It appears," he says, "[that] the large majority of boys and girls responded to the first sight of genital differences with tranquil, unperturbed acceptance."[16] It seems that those who did not were not excessively perturbed, though they might occasionally think in a puerile fashion that the male organ did not grow in girls or even that it had been cut off.

David M. Levy[17] made a control study with a somewhat different result. His most important criticism of Conn's results was that since Conn obtained his data by the play interview method, he must have procured his information long after the

[13] Karl Abraham, "Manifestations of the Female Castration Complex" (read at the Sixth International Psychoanalytical Congress, The Hague, Sept. 8, 1920), *Selected Papers*, London, 1927, no. 22, pp. 338 ff.

[14] Florence M. Teagarden, *Child Psychology for Professional Workers*, New York, 1940, pp. 357 ff.

[15] "Children's Reactions to the Discovery of Genital Differences," *Am. J. Orthopsychiat.* **10:** 747, 1940.

[16] *Ibid.*, p. 754.

[17] " 'Control-Situation' Studies of Children's Responses to the Difference in Genitalia," *Am. J. Orthopsychiat.* **10:** 755, 1940.

child had first been confronted with the genitalia of the opposite sex. Furthermore, increasing the number of interviews would have decreased the number of cases that responded to the situation "with tranquil unperturbed acceptance." In concluding his study, Levy says: "The real problem is not, therefore, are such responses common, but under what conditions do they create neurotic symptoms?"

Neither author presents evidence of a really violent emotional reaction comparable to those we mention below in discussing the origin of phobias.

It is doubtful whether the first sight of the genitalia of the opposite sex was ever in and of itself alone the source and origin of any neurosis. It is doubtful that any single castration threat was ever in and of itself alone the cause of a neurosis.

But what if the castration threat is an element in an unhappy home situation in which the child feels himself rejected by his parents? There we have a different situation. Previous evidences of rejection prepare the child's mind to believe that the threat will really be carried out by a parent who hates him. And this might be all too much for the child to endure.

Mothers who have several children have more than once reported to me that a child seeing for the first time another child of the opposite sex being bathed will notice the difference but manifest no particular emotional disturbance. Freud seems to have laid too much stress on the analysis of a phobia in a 5-year-old boy. The child's mother once threatened to cut off his organ when she saw him handling it. Of this Freud says: "This was the occasion of his acquiring the 'castration complex,' the presence of which we are so often obliged to infer in analyzing neurotics, though one and all struggle violently against recognizing it."[18]

Again he says that the mere observation of the absence of a male organ in a girl forces the male child to attribute the lack to castration and to think of himself as being likely to suffer a

[18] "Analysis of a Phobia in a Five-Year-old Boy," *Coll. Pap.*, vol. 3, p. 152.

like penalty.[19] In various places he and his followers point out this complex as the source of every psychoneurosis, and maintain that it is necessary to lead the analysis back to these events in childhood. That is to say, the hysterical phobia is an attempt to avoid thinking about some kind of sexual desire forbidden in childhood, lest the patient should have to pay the penalty threatened in childhood and be castrated

Conn's work (and even Levy's), and the older observations of Bridges and of Charlotte Bühler and her school (see below, pp. 45 ff.), give little ground to expect that further studies of infantile life will confirm the Freudian theory.

Here as so often in psychoanalytic theory a surmise was put forward with dogmatic assurance of universal validity before the basis for a legitimate induction had been established by a long series of exact and constant findings. In order to make facts fit the theory, the early concepts have been gradually broadened. As pointed out by Dicks, "psychoanalysts have stretched the meaning of terms until castration fear has come to mean almost *any* fear of punishment or loss of love, which has no sexual significance whatever."[20]

Such a broadening of the concept, however, is not strictly Freudian, for Freud once said that there were two concepts he had never denied or forsaken in all the changes through which his theory had wandered, and these were, first, the relation of the psychoneuroses to sexuality, and second, their origin in infancy. And he says, if a convincing proof of this is wanted: "I name the psychoanalytic investigation of neurotic individuals as the source."[21]

Freud's earlier view of the origin of unreasonable and persistent fears in adults is expressed in the following passage:

> The same thing occurs in them [the phobias of adults] as in the fear of children; unemployed libido is constantly being converted into real fear

[19] "The Infantile Genital Organization of the Libido," *ibid.*, vol. 2, p. 247.
[20] Henry V. Dicks, *Clinical Studies in Psychopathology*, London, 1939, p. 28.
[21] *Gesam. Schrift.*, vol. 5, p. 131.

and so a tiny external danger takes the place of the demands of the libido. This coincidence is not strange, for infantile phobias are not only the prototypes but the direct prerequisite and prelude to later phobias, which are grouped with the anxiety hysterias. Every hysteria phobia can be traced to childish fear of which it is a continuation, even if it has another content and must therefore receive a different name.[22]

Those who followed Freud years ago, as well as those who follow him today, still look upon the Freudian concept of the psychopathology of psychoneurotic conditions as satisfactorily established. Thus the analytic procedure is directed toward discovering the sexual incident in early childhood which gave rise to the psychoneurotic condition.

Some years ago Ernest Jones wrote that, according to Freud, "unconscious mental life is indestructible and the intensity of its wishes does not fade."[23] The unfulfilled desire of infancy lives on with all its potency undiminished. The fear that was engendered by parental threats of punishment makes the man afraid to think of the forbidden object from which he was frightened away in infancy. And much later Hendrick pointed out that psychoneurotic anxiety arises from the fear of an internal danger. The patient dares not think of that which caused his anxiety in infancy and gave rise to all manner of ideas of imagined punishments if he should yield to an attempt to satisfy the forbidden desire.[24]

INFANTILE SEXUALITY

If the Freudian concept of the origin of psychoneuroses is correct, it is a doctrine of supreme importance to one dealing with these patients. We can hope for their permanent cure only by tracing present symptoms back to their origin in fears engendered by repression of infantile sexual behavior, helping

[22] *A General Introduction to Psychoanalysis*, authorized trans., with Preface by G. Stanley Hall, New York, 1920, p. 353.

[23] "Freud's Psychology," in E. Jones, *Papers on Psychoanalysis*, ed. 3, London, 1923, p. 25.

[24] Cf. I. Hendrick, *op. cit.*, pp. 179 ff.

the patient to see the real cause of his psychoneurotic symptoms, and so dissipating them by a knowledge of their true character and first beginnings. This, as a matter of fact, is the opinion of those who practice psychoanalysis. One finds again and again the statement that in order to bring about the cure of a patient one must discover or lead the patient to recall and reveal the original sexual incident in childhood that was unreasonably repressed and so gave rise to the pathological symptoms.[25]

One would think that psychoanalysts would have confirmed their theories of infantile emotionality by a careful observation and study of large numbers of children in private homes and in institutions of various kinds. But I have been unable to find any such study by a member of the psychoanalytic school. Landauer, for instance, writes of the emotions and their development,[26] but it is a theoretical analysis of the problem in which a case is mentioned as it were by way of illustration. No attempt was made to collect observations on a number of cases and determine when and how often emotional phenomena of various kinds appear in the development of the child.

That we must beware of reading into a child's emotional expressions some interpretation which occurs to our minds is suggested by the work of Mandel Sherman, who found that when observers (students of medicine and psychology, nurses, undergraduates) did not see the stimuli producing an emotional reaction in infants less than 12 days old, they had very little success in giving the correct name for the child's emotional experience.[27]

The experience of Bridges, from whom we have an excellent study of emotional development, suggests a reason for this dis-

[25] *Ibid.*, p. 221.

[26] Karl Landauer, "Die Affekte und Ihre Entwicklung," *Imago*, **22**: 275, 1936. Otto Rank, "The Development of the Emotional Life," *Internat. Cong.* [1] *Ment. Hyg.*, **2**: 118, 1932 (a theoretical discussion of will in emotional training).

[27] Mandel Sherman, "The Differentiation of Emotional Responses in Infants," *J. Comp. Psychol.* **7**: 265, 335, 1927.

ability. She suggests that there is one primary emotion that might be termed, in agreement with Stratton,[28] *basic excitement*: "There is not in the baby of 3 weeks any evident reaction that one can term 'love' even in the widest sense of the word."[29] In line with this conclusion is the somewhat earlier conclusion of Pratt and his co-workers: "It seems certain that such well coordinated reactions as those implied by the terms love, rage, and fear, do not exist at this early age."[30]

Bridges thinks that very soon there develops out of this basic excitement, as a response to sudden strong stimuli, an emotion which might be termed *distress*, and as a result of being picked up and fondled, or of the appearance of food, a contrary emotion that might be termed *delight*. She thinks that her term distress is what Watson termed anger; and her term delight, what he termed love. But she regards naming this early emotion "love" as an abuse of the word. It is a generic something out of which that which is known to adults as love may later develop. Affection this author looks upon as one of the derivatives of delight—affection for parents and other children, manifested by mutual caresses and the protective care that the older child shows for the younger. But it seems to be, or can be looked upon as, presexual in character: "Among children of preschool age, one sees no sexual preferences."[31] The child's interest in caressing other children appears at about the age of 15 months.[32]

The observations of Bridges can be interpreted only as apply-

[28] G. M. Stratton, "Excitement as an Undifferentiated Emotion," in *Feelings and Emotions*, Clark Univ. Press, 1928, pp. 215 ff.

[29] Katherine Banham Bridges, "Le développement des émotions chez le jeune enfant," *J. de psychol. norm. et path.*, **33**: 45, 1936. See also *The Social and Emotional Development of the Preschool Child*, London, 1931; *Child Development* **3**: 324, 1932.

[30] Karl Chapman Pratt, Amalie Kraushaar Nelson, and Kuo Hua Sun, *The Behavior of the Newborn Infant*, Ohio State Univ. Stud. Contrib. Psychol., no. 10, 1930.

[31] K. B. Bridges, *op. cit.*, p. 59.

[32] *Ibid.*, p. 80.

ing to emotional expression. The inner emotional life of the child was not observed. It may well be that the infant is capable of a variety of emotional experiences at birth, but only in the course of development does the child attach to each specific affective experience a definite type of emotional expression.

As to infantile sexuality, one must distinguish between acts more or less similar to various sexual acts of adults and the specific sexual experience that accompanies these acts in the adolescent and postadolescent periods. Charlotte Bühler and her students made infantile sexuality an object of special observation in their studies of the behavior of children. From these observations we gather that children may handle their sex organs in early infancy, and perform other acts similar to masturbation in what Charlotte Bühler terms the second period of infancy, that is, from the second to the fourth year of life. But is is not clear that these acts resembling masturbation constitute a stage of development common to all children. Nor is it clear that there is any fundamental difference between touching the genitals in early infancy and in the second-to fourth-year period.[33] When it comes to seeking a partner in manipulating the genital organs, this may be observed from the fifth year on, but the frequency with which this occurs in children of that age has not been determined.[34] Evidently much will here depend upon circumstances.

If now we ask ourselves whether or not these acts are accompanied by specific sexual pleasure, Charlotte Bühler maintains that there is no evidence that this is the case, even though there are signs that the child in some manner enjoys them. She points to a very important difference between the sexual play of 5-year-old children and that of adults: it does not involve a tender personal attachment to the play partner. Any companion of about the same age will do, and no strong per-

[33] Charlotte Bühler, *Kindheit und Jugend*, Leipzig, 1931, p. 196.
[34] *Ibid.*, p. 198 ff.

sonal tender attachment develops between the two. But the child is capable of this strong personal tender attachment. This tender attachment is manifested by kissing and embracing and loving words to an adult who has the general care of feeding and tending the child.

In other words, Charlotte Bühler's work[35] seems to indicate the existence of a tender personal love of a nonsexual character that develops in the child in the period from the second to the fourth year of life, and that has normally nothing to do with the apparent beginnings of sexuality in the child. The child stands in great need of this personal attachment, and it is a matter of great importance to distinguish it from sexual love. Psychoanalysis has done much harm by its coprolagnic accentuation of the sexual, and has obscured one of the most important elements in the mental life of the child and we may say in that of the adult. Personal attachment should not disappear from the life of man in the adolescent period. Marital affection that is mere sexual lust is not likely to form the basis of a permanent wedlock. True friendship is possible without a sexual component. In marriage the two components—personal attachment and sexual desire—exist side by side, but the true basis of marital life is a warm, tender personal attachment that can endure on into old age even after the sexual interest has disappeared.

As to the presence of specific sexual experience in infancy and early childhood, we shall never be able to solve the problem by appealing to the introspection of the infant and the child. Neither does the memory of the adult reach back to those early years so that he can tell us whether or not it is really true that in infancy and early childhood he experienced specific sexual excitement, and that this was repressed and became latent, as Freud maintained.

[35] William Stern agrees with Charlotte Bühler on this point. He points out that mother love, and particularly the love of the child for the parents, has nothing to do with erotic or sexual love: "Das Kind innerhalb der Familie," *Ztschr. f. Kinderpsychiat.* **7**: 8, 1940.

But our present knowledge of endocrine activity and sexual experience and behavior does throw light upon the subject. Certain eunuchoid individuals who have never experienced sexual excitement or indulged in sexual behavior will begin to feel sexual emotions and manifest sexual behavior when the gonads are stimulated by an anterior pituitary extract or when a specific gonadal extract is administered.

Adults in whom the pituitary has been injured by a tumor or a gunshot wound may lose the power of sexual experience and drop all forms of sexual behavior. Women in whom the sex drive is abnormally acute may lose sexual desire after the injection of male testicular extract.

Facts such as these indicate that specific sexual experience is possible only when the gonads give forth their proper endocrine secretions. The gonads do not normally pour their specific secretions into the blood stream in infancy and early childhood. Exceptions due to precocious development associated with tumors of the pineal gland, or other cases of precocious sexuality, do not affect the general conclusion that normally the gonads are not sufficiently active in infancy and early childhood to cause specific sexual emotions and to lead to genuine sexual behavior. This being the case, it would seem that genuine sexual cravings could not be a major factor in emotional conflicts prior to puberty.

FREUD'S TOXIC MENTAL DISORDERS

We come now to a group of mental conditions for which Freud could find no direct and immediate psychogenic mechanism. They are rooted, according to him, not in the frustrated sexuality of infancy, but in the blocking of sexuality in the present, or in excessive indulgence of this impulse through inadequate channels of satisfaction.

In one of his earliest studies[36] Freud pointed out a group of

[36] "The Justification for Detaching from Neurasthenia a Particular Syndrome: the Anxiety Neurosis," *Coll. Pap.*, vol. 1, pp. 76 ff.; first published in *Neurol. Zentralbl.* **14**: 50, 1895.

cases in which the essential factor producing the condition was not psychic but organic. To the mental disorder from which these patients suffer, he gave the name of *anxiety neurosis*. Its symptoms were a free-floating unmotivated anxiety, a fear of something going to happen, frequently accompanied by attacks of vertigo, palpitation, night sweats, nocturnal fears, etc.

The predisposing cause he looked upon as heredity; the specific cause, as "a sexual factor in the sense of a deflection of sexual tension from the psychical field"; and contributing causes are said to be "all 'ordinary' injurious factors: emotion, fright, as well as physical exhaustion through illness or overexertion."[37] By the specific cause Freud meant one without which the condition does not arise, as tuberculosis never occurs without an infection by Koch's bacillus. What does he mean by "deflection of sexual tension from the psychical field"? The lack of any, or a very inadequate, sex satisfaction. By this he means inadequate sex life due to various attempts at contraception and voluntary or enforced total abstinence from all forms of sex indulgence. He looked upon the action of the specific cause as a noxa that produces its effect by summation.[38] He suggests that the noxa is a visceral tension continually produced and never relieved:

> Once it has reached the required level, the somatic sexual excitation is continuously transmuted into psychical excitation; the activity which will free the nerve endings from burdensome pressure and so abolish the whole of the somatic excitement present, thus allowing the subcortical tracts to re-establish their resistance, must absolutely be carried into operation.[39]

Anxiety neurosis is something quite different from neurasthenia, the ill-defined group of conditions from which Freud separated the unmotivated anxieties:

[37] "A Reply to Criticisms on the Anxiety Neurosis," *Coll. Pap.*, vol. 1, p. 124.

[38] *Coll. Pap.*, vol. 1, p. 95.

[39] *Ibid.*, p. 98.

Pure neurasthenia, which after it has been differentiated from anxiety neurosis presents a monotonous clinical picture (exhaustion, sense of pressure on the head, flatulent dyspepsia, constipation, special paraesthesias, sexual weakness, etc.) admits of only two specific etiological factors, excessive onanism and spontaneous emissions."[40]

Freud is so confident that he has discovered the specific cause of neurasthenic conditions that when he finds a condition simulating the syndrome and can exclude its etiological factors, he always suspects some other condition. In this way, for instance, he several times arrived at a diagnosis of general paralysis and once suspected "a latent suppuration in one of the nasal sinuses," which was confirmed by a specialist.

And so we have mental conditions whose origin is not always to be traced back to childhood as are the psychoneuroses, for their specific cause is something that is taking place while the patient is developing his symptoms.[41] One might conclude from this that the cure of these patients would be a very simple matter: throw aside the moral law and seek unrestrained sex satisfaction. As a matter of fact, this is precisely what a number of physicians prescribe, though they may also suggest that certain patients need to supplement this simple treatment by a psychoanalysis.

Hendrick, for instance, even at the present day follows this line of treatment:

Neurasthenia and *anxiety neurosis* without conspicuous phobias were in 1896 carefully distinguished by Freud from the psychoneuroses. The clinical picture of neurasthenia is dominated by general irritability and lassitude, and a variety of chronic organic complaints. The primary indication is for persuasion of the patient to substitute normal erotic practices for coitus interruptus, protracted sexual abstinence, or excessive masturbation.[42]

[40] "Heredity and the Etiology of the Neuroses," *ibid.*, p. 146; first published in *Rev. neurol.*, 4: 161, 1896. "Sexuality in the Etiology of the Neuroses," *Coll. Pap.*, vol. 1, p. 229; first published in *Wien. klin. Rundschau*, 1898.

[41] Cf. *Coll. Pap.*, vol. 1, p. 226.

[42] I. Hendrick, *op. cit.*, p. 231.

In an interesting study entitled "Observations on 'Wild' Psychoanalysis,"[43] Freud tells how a woman "in the second half of the forties" was referred to him by a physician. She had divorced her last husband and then entered into an anxiety state. The physician told her that Freud had shown that her mental condition was due to unsatisfied sexuality and that she must choose between three methods of cure: (1) return to her husband, (2) find another lover, or (3) practice self-abuse. She felt that she could not return to her husband and "the other two alternatives were repugnant to her moral and religious feelings." The physician sent her to Freud for confirmation of his theory of treatment.

In discussing this case, Freud seems to have modified his original concepts. He points out that the sexual in psychoanalytic literature goes "higher and also lower than the popular sense of the word." It embraces all "expressions of tender feeling" and often finds very inadequate outlet in sexual acts. If Freud means that there is a suprasexual affection which is devoid of any sexual component, he has generalized the term so as to deprive his theory of the actual neuroses of any definite meaning. Such an idea might mean that these conditions could arise from general discontent. As a matter of fact, he does not mean this,[44] but he seems to be willing to escape from a difficulty by means of a smoke screen which makes it for the moment impossible to see his real meaning.

This clouding of the concept is found at various times in psychoanalytic writers. Thus, according to Friedjung, Freud conceives of the sexual as "all pleasure-toned instinctive satisfactions which do not serve the ends of self-preservation."[45] This, however, is not true. Freud finds the sexual even in the

[43] *Coll. Pap.*, vol. 2, pp. 297 ff.; first published in *Zentralbl. f. Psychoanal.* **1**: 91, 1910.

[44] See above, pp. 40 ff.

[45] Josef K. Friedjung, "Die kindliche Sexualität und ihre Bedeutung für Erziehung und ärztliche Praxis," *Ergebn. d. inn. Med. u. Kinderh.* **24**: 129, 1923.

child feeding at its mother's breast. When he seems to admit nonsexual satisfactions, it is merely by a statement that the nonsexual is on the surface, but the specifically sexual is a latent component. Furthermore, he points out that all anxiety is not the same anxiety, and suggests that in spite of the fact that the patient above was acted on by the specific cause of anxiety neurosis, she was suffering from anxiety hysteria. This latter condition refers not to a general fear but to a specific phobia, and its origin is sought by Freud in a forgotten incident of infantile sexuality.

If hysterical anxieties are to be traced back to infantile repressions and the anxiety neuroses of adults to inadequate sexual satisfaction, what are we to think of the earliest anxieties of childhood? In later life Freud attempted to account for these anxieties in the following manner: "As the prototypic experience of such a sort, we think in the case of the human being of birth, and on this account we are inclined to see in the anxiety a reproduction of the trauma of birth."[46] Thus the earliest anxieties of childhood arise, according to Freud, from situations analogous to birth, in which the child is separated from the mother or what she can give him.[47] Later on the castration anxiety is essentially the same thing, that is, an anxiety arising from threatened loss of something that is highly prized. Freud even goes so far as to say "that the possession of this organ contains a guaranty of reunion with the mother (or mother substitute) in the act of coitus."[48]

What now are we to think of the Freudian concepts by which he would explain the conditions he speaks of as anxiety neurosis, that is to say, a free-floating anxiety referring to nothing definite, or ascribed to something that is evidently a wholly inadequate cause?

In the first place, we may again call attention to the fact that

[46] *The Problem of Anxiety*, New York, 1936, p. 93.
[47] Cf. *op. cit.*, p. 100.
[48] *Ibid.*, p. 103.

Freud formulates his argument on the basis of findings in a large number of cases. We would expect a carefully controlled statistical procedure, but we never find it. Again and again in Freud one meets with statements such as the following: "I have collected and analysed a great number of observations which have provided the material for these conclusions."[49] Freud never tells us what he means by "a great number"; he does not tell us how he avoided suggesting to the patient the concepts he expected to find, and we never find in his works a statistical comparison between "experimental" and "control" conditions, or any kind of check upon the validity of the surmise which seems to have been suggested to him at times by a single case.

If one were to decide to lay aside every theory which is propounded and not supported by adequate scientific evidence, then the Freudian theory of the etiology of "anxiety neurosis" and "neurasthenia" must be discarded as lacking scientific evidence.

Moreover, in recent days the evidence has been accumulating that there exist in the hypothalamic region centers of emotional expression and affective experience.[50] These centers can be affected by a variety of causes of a psychological and a non-psychological nature. There is no evidence to show that lack of adequate sexual satisfaction is in any way an essential requirement, in the same manner as the Koch bacillus must be present in order to have tuberculosis. Furthermore, under appropriate pharmacological treatment[51] these anxieties are often relieved without anything being done about the sexual adjustment of the patient.

And then those who have for years been sexually abstinent have a lower rate of insanity than the general population.[52] In

[49] "The Anxiety Neurosis," *Coll. Pap.*, vol. 1, p. 88.

[50] See below, pp. 252 ff.

[51] T. V. Moore, "Pharmacological Factors in the Treatment of Mental Disorders," *Psychiat. Quart.*, October, 1942.

[52] *Idem*, "Insanity in Priests and Religious," *Ecclesiast. Rev.*, November, 1936.

these individuals one would expect, according to Freud's concept of etiology, to find a very large number suffering from psychoneurotic conditions. The percentage of psychoneurotic conditions in first admissions to hospitals for mental disease in the United States in 1933 was 2.1 for men, and 4.1 for women; whereas the percentage of psychoneurotic conditions for all priests in the mental hospitals in the United States in 1935 was 1.90, and for nuns 2.58.[53] And so it would seem that there is no evidence that a celibate life as such is a causal factor in either psychotic or psychoneurotic conditions.

Freudian psychopathology, in spite of its appeal to experiences based on the study of a large number of cases, has its roots not in empirical findings but in the lively imagination of its author. Freud was an interesting writer with a happy gift of inventing a captivating terminology.

Sears has attempted a survey of empirical studies of Freudian theory. He says: "Several sources of evidence indicate, however, that Freud seriously overestimated the frequency of the castration complex and the importance of childhood sex aggression."[54]

Freud has profoundly influenced the treatment of mental disorders by psychological procedures. His fundamental technique of mental analysis was an important contribution to psychotherapy. But his theoretical interpretations never grow out of a sound statistical procedure and amount to nothing more than suggestions for future scientific investigations.

2. C. G. Jung

Much light is thrown on Jung's psychopathology by an understanding of his concept of the structure of the personality.

Jung distinguishes in man four basic functions: thought and feeling, at the two ends of one pole, and sensation and intuition, at two ends of another pole, in a bidimensional spatial system.

[53] *Ibid.*, pp. 493 ff.

[54] Robert R. Sears, *Survey of Objective Studies of Psychoanalytic Concepts*, Bull. 51, Social Science Research Council, 1943, p. 35.

They may be represented schematically by a diagram in which the two poles lie at right angles to each other in a circle which represents the total personality.

Accentuation of one of these types of mental function leads, according to Jung, to the development of a particular character type. The character type is seldom pure but most commonly mixed. Hume is cited as an example of a pure thinking type and William James as an example of an intuitive thinking type.[55] The intuitive type is contrasted with the "sensation" type. The sensation type sees, for instance, the details of a sensory presentation; but the intuitive type will see the whole in relation to its psychological context. The thinking type is concerned with conceptual relations and logical deductions, and evaluates the world in terms of true and false. The feeling type accepts or rejects the world according as it is pleasant or unpleasant, agreeable or disagreeable.

Besides these function types Jung distinguishes the general attitude types: introversion and extroversion. In the introvert the libido is turned inward; in the extrovert, it is turned outward. This means that the introvert has his main interest centered within himself and his own mental life, whereas the extrovert thinks, feels, and acts dominantly in relation to the objective outside world.[56]

The dominant function becomes more and more developed and differentiated and is termed the superior function. The activity of the superior function is conscious, that of the inferior function is unconscious.[57]

One familiar with modern studies of character and factor analysis is likely to ask: On what ground are these character types differentiated? Jung answers, "Immediate experience

[55] Jolan Jacobi, *The Psychology of C. G. Jung*, London, 1943, p. 16. Jung himself wrote a foreword to this study, in which he says that Dr. Jacobi has succeeded in giving a systematic account of his psychology "free from the ballast of technical particulars."

[56] Cf. C. G. Jung, *Psychological Types*, London, 1923, pp. 412 ff., and also chap. xi., pp. 518 ff.

[57] J. Jacobi, *op. cit.*, p. 14.

with human beings."[58] Subjective analysis of wide personal experience should be capable of leading to roughly the same results as factor analysis. Jung's differentiation of introverts and extroverts, as a matter of fact, is ever reappearing or finding its confirmation in statistical analyses of character.

One accustomed to the objectivity of scientific thought, however, looks with suspicion on the idea expressed by Jacobi that Jung's fourfold division of mental functions does not have its basis in real relations but in the personal peculiarities of Jung's own character. It is due, according to the fundamental psychology of Jung, to a predominating "archetype"[59] in his "collective" unconscious. Thus Freud's psychology, according to Jacobi, is due to the dominance of the "sexuality" archetype in his collective psyche; Adler's, to the dominance of the "will to power" archetype. "Jung's system also is based on an archetype that finds its special expression as 'tetrasomy' fourfoldness."[60] The scientific mind is willing to admit that unconscious or subconscious drives may give to the expression of a person's thought a dominant character or trend; but the scientific mind also demands objective evidence for the truth of the system of thought evolved by any thinker. There is such a thing as an objective analysis of mental functions and any scientific psychology must conform to objective reality. Freud, or Adler, or Jung, or various others may give expression to their personal impressions, which may be very interesting as manifestations of individual psychology, but such impressions alone can never give rise to an objectively valid psychology.

From the point of view of degrees of consciousness and unconsciousness, Jung distinguishes (*a*) the ego at the focus point, (*b*) the sphere of consciousness, (*c*) the sphere of the personal unconscious, consisting of memories easily recalled and repressed material, and (*d*) the collective unconscious.

[58] *Ibid.*, Foreword, p. viii.
[59] See below, p. 58.
[60] J. Jacobi, *op. cit.*, p. 47, footnote.

Jung thus distinguishes between the personal and the collective unconscious:

We can distinguish a *personal* unconscious, which embraces all the acquisitions of the personal existence—hence the forgotten, the repressed, the subliminally perceived, thought, and felt. But, in addition to these personal unconscious contents, there exist other contents which do not originate in personal acquisitions but in the inherited possibility of psychic functioning in general, viz., in the inherited brain structure. These are the mythological associations—those motives and images which can spring anew in every age and clime, without historical tradition or migration. I term these contents the *collective unconscious.*[61]

The contents of the collective unconscious are the *archetypes.* The archetypes, according to Jung, are symbolic phantasies which represent the fundamental instinctive drives and cravings of human nature. In various passages Jung wavers between two different concepts of their essential character.

a) They are the acquisitions of experience accumulated in the race from the dawn of history:

The collective unconscious is the sediment of all the experience of the universe of all time, and is also an image of the universe that has been in process of formation for untold ages. . . .[62]

People have simply not *known* that the psyche contains all the images that have ever given rise to myths, and that our unconscious is an acting and suffering subject with an inner drama that primitive man rediscovers, by way of analogy, in the processes of nature both great and small. . . .[63]

These archetypes, whose innermost nature is inaccessible to experience, represent the precipitate of psychic functioning of the whole ancestral line, i.e., the heaped-up or pooled experiences of organic existence in general, a million times repeated, and condensed into types. Hence, in these archetypes all experiences are represented which since primeval time have happened on this planet.[64]

[61] C. G. Jung, *Psychological Types*, pp. 615 ff.

[62] *Idem*, *Collected Papers on Analytical Psychology*, trans. by Constance E. Long, London, 1917, p. 432.

[63] *Idem*, *The Integration of the Personality*, New York, 1939, pp. 55 ff.

[64] *Idem*, *Psychological Types*, pp. 507 ff.

The concept is more fully explained in the following citation:

> The collective unconscious is a part of the psyche, which can be distinguished from a personal unconscious by the fact that it does not owe its existence to personal experience and consequently is not a personal acquisition. While the personal unconscious is made up essentially of contents which have at one time been conscious, but which have disappeared from consciousness either by having been forgotten or repressed, the contents of the collective unconscious have never been in consciousness, and therefore have never been individually acquired, but owe their existence exclusively to heredity. The personal unconscious consists for the most part of complexes; the essence of the collective unconscious consists in archetypes.[65]

b) The archetypes are not experiences acquired by the race and transmitted by heredity, but merely drives to react in a definite manner:

> The archetypes do not consist of inherited ideas but of inherited predispositions to reaction.[66]

In a passage in his *Psychological Types*, Jung seems to indicate that by virtue of all cosmic and psychic influences from the beginning of time, the man of today receives a brain which reproduces spontaneously in given situations the archetypes of antiquity.[67]

Jung likens his archetypes to the categories of Kant, which the latter thought of as given with the very structure of the mind. But on the other hand he compares them with the eternal ideas of Plato, which, as we know, Plato conceived of as acquired by experience in an existence in a spiritual world prior to the union of body and soul.[68] Jung seems to attempt a combination of these two concepts. The archetypes are ac-

[65] *Idem*, "The Concept of the Collective Unconscious," mimeographed notes of a lecture delivered before the Analytical Psychology Club of New York City, Oct. 2, 1936, p. 49.

[66] *Two Essays on Analytical Psychology*, p. 139; quoted by J. Jacobi, *op. cit.*, p. 41.

[67] Cf. *Psychological Types*, pp. 554 ff.

[68] *Ibid.*, p. 548.

quired by racial experience, but in such a manner that they arise in their full perfection like Minerva from the brain of Jove. A poetic concept indeed, but is it objectively true? However, this poetic concept is made the basis of the psychopathology of insanity.

In an address before the Royal Society of Medicine,[69] Jung gave a brief and clear exposition of his concept of schizophrenia and its etiology.

He suggests that the main guiding and controlling force of mental life may be termed *will power*. From time to time there occurs what Janet terms an *abaissement du niveau mental*, in which an individual is unable to carry a train of thought through to its logical end. Neurotic individuals are subject to various eruptions of the unconscious which temporarily produce an *abaissement du niveau mental*, consisting in a disturbance of normal volitional domination and the logical sequence of the thought processes. But even in conditions of multiple personality, there remains a *spiritus rector* or central manager that organizes mental life.

In schizophrenia the eruption is of such violence that every shred of central control is destroyed. An eruption of this character may be due either to the weakness of the will or to the power of the unconscious. Dream conditions are analogous to schizophrenic states, for in each there is a loss of central conscious control of the flow of thought. There are two types of dreams: one in which everything can be explained by a study of the remnants of conscious impressions, another in which one must go back to the archaic symbols of primitive races.

Jung leaves undetermined the problem of how these eruptions of the unconscious take place. He says:

> I admit that I cannot imagine how "merely" psychical events can cause an *abaissement* which destroys the unity of personality, only too often beyond repair. But I know from long experience not only that the overwhelming majority of symptoms are due to psychological determination,

[69] "On the Psychogenesis of Schizophrenia," *J. Ment. Sc.* **85**: 999, 1939.

but also that the beginning of an unlimited number of cases is influenced by, or at least coupled with, psychical facts which one would not hesitate to declare as causal in a case of neurosis.[70]

We have already seen what Jung terms the unconscious. It is the unconscious which by its volcanic eruptions precipitates acute schizophrenic conditions. Here we notice a marked difference between Jung and Freud. Freud in his psychotherapy attempts to trace back the patient's difficulties to personal experiences of childhood which have become unconscious by repression. He admits, however, that there are elements in the unconscious which we should look upon as derived from the experience of the race. Such experiences are termed by Jung the collective unconscious and in his psychopathology are the sources of delusions and hallucinations.

Jung defines the collective unconscious as "a part of the psyche which can be distinguished from a personal subconscious by the fact that it does not owe its existence to personal experience, and consequently is not a personal acquisition."[71] The characteristic content of the personal unconscious, therefore, embraces the complexes of past experience, while that of the collective unconscious consists of archetypes. Archetypes are categories of the imagination found in endless repetitions in the dream life of normal as well as psychotic individuals, and capable of being recognized in the lore of races and mythological literature. They seem to be in fact unconscious images of human instincts. Mythological research terms them "motifs." Jung gives as an example the idea of double parenthood, which we find at times in a child who thinks its real mother is only a foster mother. This motif is repeated in various forms in anthropological and mythological literature.

There are as many archetypes as there are typical situations in life. . . . When something occurs in life which corresponds to an archetype, then the

[70] *Ibid.*, p. 1011.

[71] "The Concept of the Collective Unconscious," *St. Barth. Hosp. J.*, **44**: 46, 64, 1937.

latter becomes activated and a compulsoriness appears, which, like an instinctual reaction, gains its way against reason and will, or produces a conflict increasing to the point of pathology—that is to say, a neurosis.[72]

Thus, as in the example given above, when a child develops the idea that his mother cannot really be his mother and that his real mother must be someone quite different, something has arisen in life that corresponds to an archetype, and if this suffices to account for the etiology of the neuroses, then an instinctual reaction should gain its way against reason and will, produce a conflict, and develop a neurosis. Anyone, however, who has had concrete experience with children who have this difficulty, knows that the development of a neurotic or psychotic condition will depend upon many factors besides the resemblance of the situation to an item of archaic symbolism.

The proof which Jung attempts for the existence of archetypes is to examine the symbolism in hundreds of dreams and then take symbol after symbol and trace it back through the mythological literature of the centuries. The argument might be stated somewhat as follows: If one and the same symbol is found in the dreams of numbers of patients and throughout the mythological writings of centuries, it must be the product of one and the same collective psyche, and not that of the individual minds. It is so found; therefore, these symbols are the products of a collective psyche.

One might raise as an objection against the major premise, the fact that various human minds in similar circumstances might think of similar things and so form similar images or symbols, by the activities of the individual minds themselves—on the general principle that, given like conditions and like causes, similar effects will be obtained. Only in exceptional conditions, when a whole series of details is identical, would one suspect that the symbols of one race are borrowed from

[72] C. G. Jung, "The Concept of the Collective Unconscious," mimeographed notes of a lecture delivered before the Analytical Psychology Club of New York City, Oct. 2, 1936, p. 49.

another, or that a patient has in some way read or heard about the archaic symbolism. In general, the variations of the symbolism described by Jung are so marked that one need not postulate either a collective psyche or some kind of process of derivation by contact in order to account for the facts.

One is likely to ask: What after all does Jung conceive an individual to be? One may say that, according to his concept, the individual is a bit of protoplasm separated from the great cosmic mass, which mass is essentially an unconscious psyche in which personality lies dormant. This "unconscious is anything but a capsulated, personal system; it is the wide world, and objectivity as open as the world."[73] But the individual is capable of experience and in due season attains to consciousness; the traces of experience develop as the personal unconscious: "the conscious mind is based upon, and results from, an unconscious psyche which is prior to consciousness and continues to function together with, or despite, consciousness."[74]

The concept of psychotherapy[75] which results from this psychopathology differs profoundly from the purely analytic technique of Freud:

> The psychological treatment must not only destroy an old, morbid attitude, it must also build up a new, sound attitude. But for this a reversal of vision is needed. Not only shall the patient see from what beginnings his neurosis arose, he shall also be able to see towards what justifiable aims his psychological tendencies are striving. One cannot, as though it were a foreign body, simply extract the morbid element, lest one removes with it an essential piece, which, after all, is destined to be lived with. This piece must not be weeded out, but must be transformed till it attains that form which can be included in a way that is meaningful to the whole of the human psyche.[76]

[73] C. G. Jung, *The Integration of a Personality*, New York, 1939, p. 70.

[74] *Ibid.*, p. 13. In the original the passage is italicized.

[75] For a fuller outline of Jung's psychotherapy, see T. V. Moore, *Dynamic Psychology*, pp. 270 ff.

[76] C. G. Jung, "The Question of the Therapeutic Value of 'Abreaction,'" *Brit. J. Psychol.* (Med. Sec.) **2**: 22, 1921.

In concluding our study of Jung, we may point out an important point in his relation to Freud. Jung admits the existence of neurotic conditions due to the traumatic experiences of childhood. Such traumatic neuroses may be treated by the Freudian technique. But he denies the universal application of Freudian psychopathology to all neurotic conditions.[77] A neurosis, according to Jung, may at times be a cry from the unconscious calling for a broadening of the personality, a constructive activity rather than a disease. It is treated by leading the patient to see that his trial is not merely a personal sorrow but the sorrow of the world.[78] It is to be treated by assimilating the unconscious drive of the collective archetype to the conscious striving of the living personality, in which "the conscious and the unconscious are joined together and stand in living relation to one another."[79]

The general effect produced upon the mind by reading Jung's writings is a lively impression of the imaginative genius of the author and the breadth of his reading. His interpretation of what he has read appears to be deeply colored by his own philosophy. Here and there we find fragments of patristic literature interpreted in the light of Jung's own conceptions rather than in that of the context and in the light of the whole system of thought of the author quoted. This superficiality in particular strengthens the impression of one who looks for sound evidence, and does not find it, that Jung's system of thought has various appeals of a poetic character but is very weak in its logical and scientific foundations.

3. Alfred Adler

Alfred Adler was practicing neurology in Vienna when he published his classic work, *Studie über Minderwertigkeit von Organen.*[80] This was followed in 1912 by his book, *The Neurotic*

[77] Cf. J. Jacobi, *op. cit.*, p. 97.

[78] *Ibid.*, p. 96.

[79] *Ibid.*, p. 99.

[80] Trans. as *A Study of Organ-Inferiority in its Physical Compensations*, Nerv. & Ment. Dis. Monog. 24, 1917.

Constitution.[81] In the meantime Adler had come in contact with Sigmund Freud, whose importance he recognized from the beginning, in spite of the cloud of ill repute that hung over the tiny psychoanalytic school in those days of scientific neurology.[82] Adler, however, went to Freud not only to learn but also to criticize, and the appearance in 1912 of *The Neurotic Constitution* marked the parting of the ways between himself and Freud.

The fundamental concepts of his study of the inferiority of organs may be outlined as follows:

Many diseases of the organism are due to the presence in the individual of inferior organs. It is not a matter of pure chance that an infection should find lodgment in any given organ—for example, the lungs. The lodgment of the infection is in part due to the fact that the organ itself has a lowered vitality, and this inferiority is transmitted by heredity. The principle was put forward as an ingenious conception and illustrated but not established by scientific demonstration, a procedure characteristic of various writers of the psychoanalytic school and its several branches.

The possibility of scientific checking was complicated by a very broad concept of an organ. The original inferior organ, for example, might be the nasal mucous membrane, and the inferiority could manifest itself by heredity anywhere in the whole respiratory tract, as, for example, in the lungs. Seeing that an organ inferiority is inherited, and this heredity is possible only through the sex apparatus, Adler concluded that every inferior organ points to an inferiority in the sex apparatus.

The next important principle is that, given an inferior organ, either the inferior organ itself or its paired companion must compensate for the inferiority by increased activity. This does not stop with a bare minimum but leads to overcompensation and overgrowth. The classic example of this is the enlargement of the heart in valvular disease.

[81] English trans. by Bernard Glueck and John E. Lind, New York, 1917.

[82] Cf. F. G. Crookshank, Preface to Alfred Adler, *Problems of Neurosis: A Book of Case Histories*, London, 1929.

But the individual is a mental and not merely a physical being. The mind therefore enters into the process of overcompensation. And so the individual at first protects the inferior organ and later drives it to increased activity, in order to say to others, "You thought I was weak, but, behold, now you can see how strong I am. I excel in the very sphere in which I was accused of weakness."

In this drive of an inferior being to manifest superiority, Adler finds the roots of the neurotic constitution. Out of this drive to superiority comes the guiding fiction, the plan evolved by an individual to attain the goal of superiority:

> The child seeks to gain a standpoint which will enable him to get a perspective in the problems of life. From this point of departure, which is taken as a fixed pole in the flux of phenomena, the child psyche projects its thoughts towards the goal which it longs to reach.[83]

We can never understand an individual's behavior till we know the goal toward which he is tending. And so psychoanalysis, with its search into the past history of the individual, must be supplemented by a gaze into the specific future toward which the individual is tending:

> The conclusion thus to be drawn from the unbiased study of any personality viewed from the standpoint of individual psychology leads us to the following important proposition: *every psychic phenomenon, if it is to give us any understanding of a person, can only be grasped and understood if regarded as a preparation for some goal.*[84]

What then is the essential psychopathology of a neurosis? Perhaps we may prepare the answer to this question by first stating what theories of the neurosis Adler specifically excludes: (1) It is not a conflict between the conscious and the unconscious.[85] (2) It is not due to any kind of chemical reaction in

[83] *The Neurotic Constitution*, p. 35.

[84] A. Adler, *The Practice and Theory of Individual Psychology*, London, 1924, p. 4.

[85] *Idem*, *Social Interest: A Challenge to Mankind*, London, 1938, p. 158.

the nervous system.[86] (3) It cannot be conceived of as a condition willed by the patient.

> We must therefore reject at once all explanations which imply that a person produces his own suffering, or that he wants to be ill. Without doubt the person concerned *does* suffer, but he always prefers his present sufferings to those greater sufferings he would experience were he to appear defeated in regard to the solution of his problem.[87]

In this way it would seem, however, that the neurosis is the choice of the lesser of two ills. What then is the neurosis?

One of the chief characteristics of a neurosis, according to Adler, is a marked emotional lability: "all authors agree that the nervous state is connected with a life of intensified affects."[88] The neurotic is extremely sensitive and this sensitivity arises from his feeling of inferiority. He does not want his worthlessness laid bare so that he who runs may read and see what manner of man he is. "We see now what a nervous state actually is. It is an attempt to avoid a greater evil, an attempt at all costs to keep up the appearance of being of some value."[89]

The neurotic has therefore a sense of superior worth. This is his "superiority complex."[90] Rather than fail and demonstrate inferiority, he withdraws from reality behind the screen of his neurosis.

Thus the neurotic is one who craves to be first in everything, finds out however that he cannot, and elects to withdraw from every contest on the basis of some excuse rather than be surpassed by anyone. Adler cites the case of a boy who when he started to school worked very hard and did well, but when he commenced to find out that others could do better, complained of illness, and so contrived to be kept at home by his overindulgent parents. This gave him the opportunity to say that he

[86] *Ibid.*
[87] *Op. cit.* p. 164.
[88] *Ibid.*, p. 158.
[89] *Ibid.*, p. 165.
[90] *Ibid.*, p. 173.

could not do well in school because he was sick and had to be away so often. His later life was a whole series of these withdrawals, because he desired to dominate and feared the confusion of defeat.[91]

Adler seeks the origin of neurotic conditions in the degree to which an individual has been well or ill prepared to meet and solve the problems of life. This lack of preparation may be traced back to the earliest years of childhood. It is a matter not so much of the conscious or of the unconscious, as of lack of understanding. Treatment, according to Adler, must be undertaken along intellectual lines by which the patient is made gradually to understand the origin of his difficulties and so led to face them and deal with them adequately and reasonably.[92]

One with only a little experience in clinical psychology will realize that a lack of preparation to meet the difficulties of life has frequently been a factor in the development of neurotic conditions. It is easy to recall a number of children and adolescents who attempted to shrink from school difficulties by the exaggeration of minor ills.[93] But it is also possible to recall a number of cases in which this theory of the origin of neurotic conditions has no obvious application. We cannot trace all neurotic conditions back to a faulty education of the child for meeting the difficulties of life.

Adler's concept of the nature of a neurotic condition, and his suggestion that we try to find out the end toward which the neurotic is striving, will often be found most helpful. To use his theories exclusively, however, and with all patients on all occasions, would prevent a true insight into many mental disorders and hamper treatment.

In his work entitled *The Practice and Theory of Individual Psychology*, Adler has given us an ingenious attempt to apply

[91] A. Adler, "Was ist wirklich eine Neurose?" *Internat. Ztschr. f. Individualpsychol.* **11**: 183, 1933. For a group of such cases, see *Idem, Guiding the Child on the Principles of Individual Psychology*, New York, 1930.

[92] *Ibid.*, p. 179.

[93] See case of hysterical paralysis, below, pp. 233 ff.

his concepts through the whole gamut of the major and minor mental disorders. The work abounds in statements regarding etiology, but the evidence for the statements is not given. Thus he says: "Melancholia develops among individuals whose method of living has from early childhood been dependent upon the acts and the aid of others."[94] It is this same lack of critical scientific evaluation of statements and theories that mars the work of Freud and of many other writers who have been influenced by the founder of the psychoanalytic school.

4. Franz Alexander

An interesting concept of the psychopathology of the psychoses and psychoneuroses has been formulated by Alexander.[95] One can gather from this author's statements that he traces the beginnings of mental experience back to an early infantile stage in which the child does not differentiate between himself and the outside world or, to use Alexander's terminology, between the ego and the nonego.

This assumption of an early confusion between ego and nonego is frequently met with in psychoanalytic authors. It may well be that this is the first stage of conscious life. But as a matter of fact we do not know. Perhaps the mental life of the infant is such that the terms ego consciousness and non-ego consciousness simply do not apply. It is very likely that they have no application to the mental life of animals in the same sense in which they apply to the mental life of the normal human adult. And perhaps when the terms eventually do apply to the mental life of the child, at least implicitly, it is not until the child refers all experience to something outside himself without any explicit ego consciousness ever arising.

However this may be, Alexander makes the assumption that the infant must learn to differentiate between the ego and the nonego and that this differentiation may be more or less clearly

[94] *The Practice and Theory of Individual Psychology*, p. 247.

[95] Franz Alexander, *The Medical Value of Psychoanalysis*, New York, 1932.

established during the first two years after birth. He then goes on to assume that, in spite of years of subsequent sensory and motor experience, there are individuals in whom the distinction between the self and objective reality is never firmly established.[96] As a result of a very thin mental veil between the ego and the nonego, it becomes possible for certain individuals to accord objective validity to imaginal experience and so become subject to hallucinations. Their mental disorder is, therefore, to be traced back to childhood in a very different sense from that of a pure Freudian psychology. From this concept of the origin of psychotic conditions, Alexander deduces the conclusion that they must owe much to inherited constitution. This he says is less true of the psychoneuroses.[97]

This leads to the conclusion that in treating psychotic patients we should abandon psychoanalytic technique with its classic methods of dream analysis and free association.[98] As a matter of fact, Alexander says, the modern mental hospital has done this and lays increased emphasis on an attempt to make the environment more acceptable to the patient, by choice of attendants, by occupational therapy, and by stimulating transfer to the physician.

Psychoneurotic conditions, on the other hand, owe their origin, according to Alexander, to emotional conflicts with parents and siblings during the period of the development of the superego.[99] It was for conditions such as these that psychoanalytic methods were devised and in such conditions they still find their field of application.

Alexander applies psychoanalytic methods also to various organic conditions. The reasonableness of this procedure is apparent from the fact that the various organs of the body are subject to the control of the autonomic nervous system.[100]

[96] *Op. cit.*, pp. 145 f.
[97] *Ibid.*, p. 147.
[98] *Ibid.*, p. 151.
[99] *Ibid.*, p. 147.
[100] *Ibid.*, p. 175.

Another possibility is that certain conditions, such as high blood pressure, may be aggravated by emotional disturbances. Anything, therefore, that can be done to tone down and soften emotional reactions will have a favorable influence on hypertensive conditions. Thus in one patient Alexander found an average blood pressure of 160/111 at times of very disturbed emotional states; 150/105 in somewhat disturbed emotional states; and 141/99 in periods of emotional calm. Psychoanalysis led to "a slow downward tendency of the average blood pressure level."[101]

By way of criticism, one might say that it is high time for psychoanalytic writers to test their theories of the origin of mental disorder by empirical study and statistical procedures. Symonds accuses Freud of having developed his concept of the castration complex on the basis of the analysis of a single case.[102] Alexander attributes the origin of psychotic conditions to the fact that psychotic individuals have never firmly established the differentiation between the ego and the non-ego. Probably the only basis for this is that it was suggested by the fact that psychotic patients often have hallucinations and often ascribe objective validity to their hallucinatory experiences. Such an idea might at most be the starting point for some kind of empirical investigation, but it should never be put forward seriously as an explanation of the origin of psychotic conditions, without a marshaling of the evidence.

[101] F. Alexander, "Psychoanalytic Study of a Case of Essential Hypertension," *Psychosom. Med.*, **1**: 139, 1939.

[102] Percival M. Symonds, "Symposium: Psychoanalysis as Seen by Analyzed Psychologists," *J. Abnorm. & Social Psychol.* **35**: 139, 1940.

Chapter III

SOME FUNDAMENTAL PRINCIPLES OF PSYCHOPATHOLOGY

Psychopathology may be defined as the scientific study of those mental conditions which give rise to physical or mental disorders.

1. The Emotional Origin of Organic Conditions

Let us first take up the problem of mental conditions that give rise to pathological organic changes. Here the literature points apparently to two ways in which mental conditions affect the physical organism. The first is *indirect*. Emotional states affect the appetite or raise the blood pressure and so affect more or less seriously the well-being of the patient.

Thus Cabot reported[1] the case of a patient whose fractured leg failed to knit. During the time he was in the splint he was tormented by fears that his family would suffer because he was in the hospital and could not support them. The anxiety was so intense that he lost his appetite and could not eat. This resulted in impaired nutrition, which in turn prevented the necessary process of repair, and so the broken fragments failed to unite. Psychological methods were then applied. Measures were taken to see that the family was properly cared for and the patient was assured that they were being looked after and were well and happy. This led to a transformation in the patient's attitude, his anxiety disappeared, his appetite returned, he gained weight, and the broken fragments in due course of time knitted together.

Many such cases could be cited. Our empirical knowledge of the influence of emotions on the digestive apparatus commenced

[1] Cabot, *Harvard Alumni Bull.* **28**: 384, 1925, quoted by W. B. Cannon, "The Mechanism of Emotional Disturbance of Bodily Functions," *New England J. Med.* **198**: 881, 1928.

with the classic work of Beaumont, first published in 1826 in the twenty-ninth number of the Philadelphia *Medical Records.*[2] Beaumont was surgeon to Alexis St. Martin, a young French-Canadian, who was wounded accidentally by a shotgun and on recovery had an open fistula of the stomach large enough to permit observation of the interior and the introduction of instruments and experimental feedings. Beaumont noted incidentally the effects of violent anger on digestion, in that it slows the process and causes reverse peristalsis, thus bringing bile into the stomach.[3]

Disordered heart action is a common sequence of emotional crises. Cannon in the following account traces back a condition of disordered heart action to its emotional source.

A woman happened to see her husband walking in the street arm in arm with an unknown woman and acting in a manner to arouse her jealousy and suspicion. She was deeply agitated by the incident and went back home and remained in the house for several days. When she later thought of going out, she experienced an acute anxiety lest she should meet her husband with her rival, and so she kept to the house. After some days of this unhappy condition, she decided on the advice of a friend to go out anyhow. She started out but experienced such terror that she ran back to her home. She then noticed that her heart was beating so violently that she felt a pressure in her chest and a sensation of smothering. Renewed efforts at going out produced the same alarming symptoms. Then came the idea that she might die on the street if she went out. She had no organic cardiac disorder of any kind, nevertheless the slight effort she made in leaving the house brought on a condition of acute cardiac distress.[4]

In these gastro-intestinal and cardiac disorders due to emotional disturbances we seem to see the mechanism of

[2] William Beaumont, *Experiments and Observations on the Gastric Juice and the Physiology of Digestion,* Plattsburg, N. Y., 1833, p. 18.

[3] *Ibid.,* pp. 153 ff. For a more recent study, see A. Cade and A. Latarjet, "Réalisation pathologique du petit estomac de Pavlov," *J. de. physiol. et de path. gén.* **7**: 221, 1905. See also Walter C. Alvarez, "Ways in which Emotion Can Affect the Digestive Tract," *J.A.M.A.* **92**: 1231, 1929 (extensive bibliographical references).

[4] W. B. Cannon, "Troubles émotifs des fonctions de l'organisme," *Montpellier méd.* **52**: 395 1930.

mediation in well known pathways of the autonomic nervous system. But there are a number of physical conditions which follow promptly on violent emotional episodes and seem to be causally connected, though we do not know how. These give a second group of mental conditions in which emotional excitement *apparently* causes a bodily change directly. We may, however, lay down the heuristic principle that *a mental state cannot cause a physical change in the organism except through some psychophysical mechanism of the organism.* The fact that we often do not know what psychophysical mechanism is involved does not allow us to say that none is active.

Let us take for example the phenomenon of the graying of the hair (canities). It is hard to see how the pigment could be suddenly taken from the relatively long hairs, even though their roots are imbedded in a network of blood vessels. And yet there are a few cases on record in which this has occurred. The following case may be cited.

A correspondent of the *London Medical Times*, having asked for authentic instances of the hair becoming gray within one night, Mr. D. P. Parry, staff surgeon at Aldershot, writes the following very remarkable account of a case of which he made a memorandum shortly after the occurrence: "On Friday, February 19, 1859, the column under General Franks, in the south of Oude, was engaged with a rebel force at the village of Chamba, and several prisoners were taken; one of them, a sepoy of the Bengal army, was brought before the authorities for examination, and I, being present, had an opportunity of watching from the commencement the fact that I am about to record. Divested of his uniform, and stripped completely naked, he was surrounded by the soldiers, and then first apparently became alive to the danger of his position; he trembled violently, intense horror and despair were depicted on his countenance, and although he answered the questions put to him, he seemed almost stupefied with fear. While actually under observation, within the space of half an hour, his hair became gray on every portion of his head, it having been, when first seen by us, the glossy black of the Bengalee, aged about 54. The attention of the bystanders was first attracted by the sergeant, whose prisoner he was, exclaiming, 'He is turning gray,' and I, with several other prisoners, watched its progress. Gradually but decidedly the change went on and a uniform grayish color was completed within the time named.[5]

[5] *Dublin Med. Press*, 1861, p. 332.

In another case the hair became gray as a result of intense emotional strain, but after the crisis was over gradually returned to its normal color.[6]

There are on record many cases of cutaneous lesions of one kind or another resulting from acute or prolonged emotional strain. A rather remarkable case was reported by Leloir. A man brought suit against a neighbor who was disturbing his peace and quiet by continuous noise. On hearing that he had lost his case, he broke out into a violent rage, would not eat, and had to take to his bed. Neuralgic pains developed, followed by a skin eruption and the appearance of the bullae of pemphigus. In a little while the whole body was covered by these bullae, which soon attacked the mucous membranes, and the patient died.[7]

The following case, reported by Goeckerman, may serve as an illustration of a skin eruption which seemed to have its source in a condition of chronic anxiety.

A farmer aged 60 developed a skin eruption known as lichen planus. He was quiet, reserved, and seemingly stolid. Treatment for some time led to no improvement. He denied all emotional difficulties. It was later learned from a son, who came to visit him from a great distance, that the older man had been worrying for some years lest he should lose his farm by foreclosure of the mortgage. He was conscious of an increasing inefficiency with his advancing years and had no hope for the future. The son was able to clear up the financial situation and the "itching subsided promptly and the lichen planus involuted rapidly without further medication."[8]

[6] Paul Sollier, "Un cas de canitie par commotion et émotion," *Lyon méd.* **125**: 329, 1916. For an interesting study of the problem, with citations of cases, see Hyman S. Barahal, "The Psychology of Sudden and Premature Graying of Hair," *Psychiat. Quart.*, **14**: 786, 1940.

[7] Henri Leloir, "Leçons nouvelles sur les affections cutanées d'origine nerveuse. Des dermatoses par choc moral (émotion morale vive)," *Ann. de dermat. et syph.* **8**: 367, 1887. The author mentions also 2 other cases of pemphigus of emotional origin and various efflorescences of the skin following upon emotional conditions. For a more recent investigation, see Gonsalez Medina, "Dermatosis de causa psiquica," *Actas dermo-sif.* **33**: 229, 1941.

[8] William H. Goeckerman, "The Relationship of the Emotions and Cutaneous Lesions," *M. Clin. North America* **14**: 646, 1930.

Such cases indicate that a good deal of very effective psychotherapy could be done by some kind of rehabilitation. But very often it is not within our power to eliminate the factors in a patient's life that produce intense emotional strain, and all that we can do is to try to enable the patient to accept the situation peacefully.* It would have been unreasonable and ineffective had someone attempted to treat Goeckerman's farmer by an analytic type of therapy which attempted to find an analogy between his skin eruption and some buried complex of childhood.

It is not within the scope of this study to give a complete picture[9] of the various types of physical disorder which may arise from mental causes and therefore be said to represent, in the main, psychopathologic changes rather than organic pathological conditions. We merely wish to make it clear that genuine physical conditions may be due to mental causes. This is an important principle to bear in mind in considering the treatment of organic conditions in many cases.

Let us now pass on to the psychopathology of mental disorders.

2. The Emotional Origin of Mental Disorders

When we think of the psychopathology of mental disorders, we turn naturally to emotion rather than intellect for our introduction to this field. And when we consider emotions as the source of mental disorder, we distinguish at once between acute emotional episodes and prolonged emotional strain. Let us first consider acute emotional episodes as the origin of mental disorders.

a) acute emotional experiences

When one asks whether a single acute emotional episode can give rise to a psychoneurosis or a psychosis, one is likely to seek further specification of the problem. Do we mean in (*a*)

* The case described on pp. 164 ff. may be studied from this angle.

[9] Cf. the extensive and valuable work of Flanders Dunbar.

a stable, normal personality, or in (*b*) an unstable, psychoneurotic individual?

When one takes into consideration also the intensity of the emotional experience, one is likely to draw the conclusion that it would take a very strong single emotional experience to upset the balance of a stable, normal personality. But as a matter of fact this is only an apparent conclusion. In reality it evades the issue. The problem is one that approaches insolubility, for if we find a psychoneurotic or a psychotic episode arising out of a single violent emotional experience, it might be very difficult to prove conclusively that the patient was or was not a stable, normal personality prior to the episode in question. The most we can do is to ask whether or not there is evidence that a psychoneurosis or a psychosis is ever precipitated by a single emotional episode, leaving in abeyance the problem of the stability of the personality.

When so formulated, the answer to the question is yes—and that, moreover, as to both psychoneurotic and psychotic conditions.

There is abundant evidence that phobias may often be traced to a single emotional episode. Such episodes sometimes occur in adult years, as in the case of the phobia accompanied by disordered heart action that has been described above.* They often occur in childhood. A number of such cases are reported below in the chapter on the origin and course of some common phobias.†

When we turn now to acute emotional episodes and the onset of psychotic conditions, investigators of wide experience find a number of cases that belong in this category.

Krafft-Ebing sums up his experience on the problem in the following words:

> Emotions can without doubt give the impulse which gives rise to a psychotic condition, just as they are occasionally the causes of hysteria, epilepsy, chorea, paralyses, aphasias, and can even result in death through

* P. 73.

† Pp. 89 ff.

a kind of shock paralysis of the heart and respiration. Again, on the other hand, they can bring about a cure of a mental condition, [such as] a paralysis of volitional activity, aphasic conditions, etc. The intense action which emotions exert on the vasomotor and motor centers is a fact which at least shows clearly the power of such mental activities.

But from here to insanity there is a long stretch. The view of the laity, particularly dramatists and novelists, who without any more ado allow insanity to come out of intense passion and emotions, is at least one-sided. To be sure, there are cases in which a very strong emotion, mostly fright, produced almost at once a psychotic condition (stupor, acute dementia, maniacal excitement). But as in analogous cases of epilepsy, there always exists in these circumstances a significant predisposition (psychopathy, mostly hereditary) or a temporarily increased cerebral irritability (menses, puerperium). The psychic factor, acting after the manner of shock, disturbs the vasomotor innervation (spasm, paralysis) and so the circulation and nourishment of the brain. . . .

A somatic or psychic predisposition existing prior to the emotional crisis favors the outbreak [of a psychotic condition], but the undermining of the constitution by the psychic factor can produce insanity without any such [predisposition].[10]

Krafft-Ebing points out that as a rule the insanity does not follow at once upon the emotional crisis, but after a more or less considerable interval, during which the patient seems to recover his normal balance. The same is true of insanities that follow upon infectious diseases such as typhoid fever[11] and influenza. This suggests that the emotional condition has produced an organic change.

Kraepelin wrote thus of acute emotional conditions and insanity:

Concerning the clinical types of mental disorder which are placed in causal relation to emotional conditions, one should mention first those cases which arise immediately after sudden emotional shocks and that are termed emotional psychoses. Unfortunately I am not in a position to describe them in any further detail on the basis of personal experience, because, on account of their rapid course, they seldom come into the hands of the psychiatrist. However, we often hear that in some great misfortune this

[10] R. von Krafft-Ebing, *Lehrbuch der Psychiatrie*, ed. 7, Stuttgart, 1903, pp. 162 f.

[11] E. Kraepelin, *Psychiatrie*, vol. 1, p. 66.

or that person commenced, all of a sudden, to talk in an insane manner, to run about as if crazy, to attack those about him. As a rule in these cases death is imminent.[12]

The following account of a schizophrenic reaction may be taken as an example of how a psychotic condition in a child had its origin in a violent emotional shock.

The patient was a girl of almost 13 years of age when she was brought to the clinic because of auditory and visual hallucinations and the delusion that her touch was poisonous and had killed her mother's cousin, who in reality had died of cancer.

Prior to the manifestation of these symptoms she was said to have been a perfectly normal child. The physical examination was negative. She weighed 109½ pounds and was 62½ inches in height.

Some two or three months prior to the appearance of the girl's symptoms, her little 7-year-old brother was digging a tunnel in a sand pile and a big boy ran up, jumped on the mound, and caved in the tunnel. When the little boy was dug out he was dead. This was a profound shock to the patient and she kept brooding over her little brother's death, during a period in which the family noticed nothing abnormal about her conduct.

Some weeks after her little brother's death, while reading in the newspapers the story of two murderers, she became obsessed with the idea that she might kill someone. Then she heard that her mother's cousin had died of cancer and the thought came to her mind that she had touched the flowers that her mother had brought to her cousin when she was ill. Then came the idea that her touch had contaminated the flowers with poison and that the poison from her fingers had been the real cause of her cousin's death. When she came to the clinic she had the idea that she had poison all over her dress, so that if anyone touched her, he might die of the poison. She tormented her father by insisting that he wash and rewash his hands.

Along with these abnormal anxieties there developed crying spells, lasting for an hour or so at a time and coming on about once a week. But several spells would usually occur on the day on which one appeared. The patient complained of pain in the epigastrium at these times and tormented her mother with questions.

Besides her delusional concepts, the child seems to have experienced something akin to visual and auditory hallucinations. She would at times see or rather, as she expressed it, "not exactly see" electric chairs and chains, as if someone were going to try "to get me and tie me up with

[12] *Ibid.*, pp. 126 ff.

chains." Then again she would seem to hear a voice that said, "Francis [her little brother who was killed in the sand pile] is in heaven."

At times she was negativistic to her mother's requests. Her expression was dreamy and somewhat expressionless. She was said to have muttered and mumbled to herself at times and was once found talking to herself. Several times a day she was a source of anxiety to her mother because of what were termed "spells of crossness" lasting half an hour or more. There was no euphoria and no retardation. Her general mood was one of anxiety conditioned by delusions. Sadness, strictly speaking, was not markedly in evidence at any of her visits to the clinic. Besides her anxiety about poison, the patient had a chronic fear of dogs.

While there was no record of any major form of psychotic condition in the family history, it is worth while noting that the patient's father was alcoholic, as also his father and the patient's mother's father had been. The father's sister's children were dull in school, but all learned to read and write. The patient's mother had been having nightmares for the preceding twenty-five years, in which she would rave about someone being about to kill her, plead for help, beg to go to confession, and so forth. The child had often seen her mother in this condition, but it was said that she never manifested any disturbance in witnessing her mother's anxiety.

The main elements in the treatment of the patient were (1) talking things out, (2) dream analysis, (3) reports by the child of her difficulties between interviews, (4) reasoning with and persuading the child to take a more satisfactory attitude toward her mother, and (5) teaching the mother to understand the child.

The dream analysis revealed that the child harbored a good deal of antagonism toward her mother, because she was so unkind. "Maybe," the girl said, "I killed my real mother when I was born."

There were also ideas in her mind from reading fairy tales about the princess who poisoned the little girl by having her eat the pretty red side of an apple that was flushed with poison. Then there were all sorts of tales she had read about mean

stepmothers. The patient was also given to daydreaming about such things as the pretty clothes she might wear if she had fifty dollars. There was also an element of jealousy in the patient's life. Once during the treatment the patient had a rather violent emotional outburst because her mother danced with her brother.

A full analysis, and explanation of all the phenomena in the patient's schizophrenic reaction, were not attained. Perhaps the patient commenced to understand herself better than the analyst understood the patient. But at all events there soon developed a better parent-child relationship. In the interviews the author spoke now with the child and now with the mother. This seemed to cause no blocking of rapport between the analyst and the child.

The child's fears waned rather rapidly and after the surprisingly short period of only a month she was no longer troubled about her fundamental delusional fear of poisoning people by her touch. Fifteen years later she was looked up. She was then a healthy, happy woman and had never had a return of her mental trouble.

Such a rapid fading of so marked a psychotic tendency shows how the psychoses of children may be very shallow, and leads one to surmise that psychotherapy in the mental disorders of childhood is likely to be more fruitful and satisfactory than in the deep-grained psychotic conditions of later years.

We have introduced this case history as an example of how a psychotic reaction may have its origin in a profound emotional shock. We then went on to discuss the treatment, for therapy is one of the major objectives of these studies.

Returning now to the psychotic reaction and the emotional shock, we see that our case illustrates the point made by Krafft-Ebing, that as a rule there is an interim between the emotional shock and the appearance of psychotic symptoms. In our case this was true, though the interval was not empty, but filled with brooding. One suspects the existence of a

factor not demonstrated in our brief story of the patient: an element of self-reproach, the patient feeling that she might in some way have prevented her little brother's death and that therefore she herself had caused him to die. This fundamental fear was transformed into a fear that she might cause the death of others; for to think that she had let her little brother die was something all too horrible to face. The point in the history of her schizophrenic reaction where the substitute fear came to consciousness finds its locus in reading the newspaper story of two murderers. Then the idea comes, "I might kill someone even as they did." Subsequent events wove themselves into the warp of fairy tale notions and so her phobia became a delusional system.

What does the emotional shock do when it starts a train of mental events that develop into a psychotic picture?

We must remember that an emotion is a psychophysical event which involves reflex cerebral centers controlling various physical reactions of emotional expression and at the same time a flow of affective mental experience and the activation of conscious memories, hopes, ideals, insights, meanings, and principles of conduct. Judging from many cases published in the literature (for example, the above cited case of disordered heart action), a single intense emotional experience can in some way permanently increase the lability of the reflex emotional centers, so that situations that bear a resemblance to the precipitating incident reproduce the original type of emotional experience. Furthermore, a violent emotional experience carries with it at times a sudden insight into the fact that one's cherished haven of rest and one's adjustment in life have vanished into nothing and the moorings of one's affections have been broken in the storm. This or a similar psychological reaction does not at once fade out, but persists, and produces a profound disturbance of the patient's whole mental life. If now emotional experiences produce also pathological changes in the physical organism, one can readily see how a psychotic reaction could follow upon a profoundly unhappy emotional experience.

It is well known that major and even minor emotional shocks may precipitate a manic-depressive attack.

Bleuler is probably correct in looking upon both schizophrenic and manic-depressive mental disorders as having a physical factor in their etiology. He says of schizophrenia: "Certainly most forms of schizophrenia, if not all, are due to toxic or anatomical changes in the brain, of whose primary symptoms we as yet know very little, but upon whose mental mechanisms most of the manifest symptoms mature."[13] He says also that "manic-depressive insanity, even though in certain attacks it may now and again be due to a mental cause, is nevertheless a physically conditioned disease."[14]

How a trivial emotional strain may precipitate a depression in individuals thus predisposed, is illustrated by one of his patients, who was very unhappy with her husband. On coming to a mental hospital she would rise out of her depression, but she could always be forced into a relapse by serious talk of sending her back to her husband.[15]

b) CHRONIC EMOTIONAL STRAIN AND THE ESSENTIAL PSYCHOSES

Let us now pass from a consideration of the acute emotional episode to chronic emotional strain. Is there any evidence that the stress and strain of life are a factor in the production of psychotic conditions?

Anyone who has studied the life histories of psychotic patients will have noticed how often they reveal an unfortunate parent-child relationship or various factors that contribute to the development of unhappy homes. It is not necessary that antagonistic relations between parent and child should be the difficulty which gives rise to mental disease. Anything that makes for chronic unhappiness may be a factor in producing mental disorder. At the International Congress of Psychology

[13] Eugen Bleuler, "Physisch und Psychisch in der Pathologie," *Ztschr. f. d. ges. Neurol. u. Psychiat.*, Orig. **30**: 473, 1915.

[14] *Ibid.*, p. 473.

[15] *Ibid.*, pp. 451 f.

held in Paris in 1937, Herbert Barry read a paper entitled, "Childhood Bereavement, a Neglected Factor in Mental Disease."[16] In his investigation, based upon a study of 1,500 patients, he found:

> Over 25 per cent of the younger psychotics had lost one or both parents by the age of 12. Comparable rates for control groups were materially less. Further analysis of the figures suggests that maternal orphans are more frequently psychotic than paternal orphans, and that bereavement is especially critical if it occurs before the patient has reached the age of 9.

In line with these results are the statistics published every year in Massachusetts, in the annual report of the commissioner of mental diseases. Thus, for 1934 the figures for the incidence of insanity per 100,000 of the population by marital classifications were: single, 261.1; married, 158.83; widowed, 330.73; divorced, 745.1. The high rate among the divorced may be due to the fact that they were divorced because they were insane, rather than to the fact that they became insane because they were divorced. But widowhood strikes indiscriminately, and the fact that the insanity rate for the widowed is about double that of the married, suggests that the stress and strain of life are a factor in the production of mental disorder.

An investigation by Malzberg suggests that economic stress and strain also constitute a factor in the production of mental disorder. He made a special investigation in the New York State hospitals, in which an attempt was made to pick out for the years 1920 to 1937 all those cases in which loss of employment or financial loss was considered a possible causative factor in the development of a psychosis. The accompanying curves are based on data published by this investigator.[17] A study of these curves reveals an increase from about 1930 in the percentage of first admissions of all cases in which economic stress

[16] *Cong. internat.* [11] *de psychol.*, Paris, July 25–31, 1937, p. 335.

[17] Benjamin Malzberg, "The Influence of Economic Factors on Mental Health," *Mental Health*, ed. by Forest Ray Moulton and Paul O. Komora, Am. A. Advancement Sc. Pub., no. 9, 1939, pp. 185 ff.

seemed to be a causative factor, a maximum being reached in 1934. For the manic-depressive and dementia praecox cases, the increase is already evident in 1929, the year of the great stock market panic that initiated the financial depression.

Let us now raise the question: Do those causes that Freud termed precipitating conditions, alone suffice for the production of a mental disorder, or must there always be present what he terms the specific cause, the sexual maladjustment or the

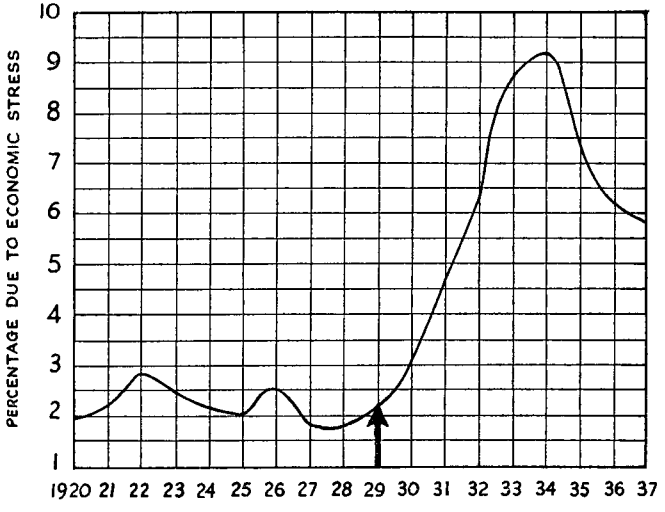

FIG. 1. Percentage of all first admissions to New York State hospitals, 1920–1937, in which loss of employment or financial loss was considered a causative factor

sexual trauma in infancy, which must be uncovered if the patient is to emerge from his mental disorder?

Several years ago, stimulated by the interesting data mentioned above on the incidence of insanity in the single, the married, the widowed, and the divorced, I attempted to find the incidence for priests and religious. Information was obtained from 100 per cent of the Catholic mental hospitals, 96.53 per cent of the state institutions, 100 per cent of the city hospitals, 91.04 per cent of the county sanatoria, and 76.96 per cent of the

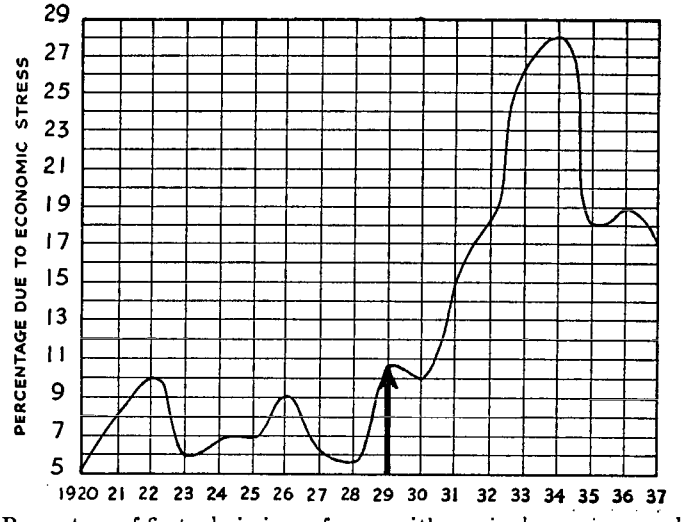

FIG. 2. Percentage of first admissions of cases with manic-depressive psychoses to New York State hospitals, 1920–1937, in which loss of employment or financial loss was considered a causative factor

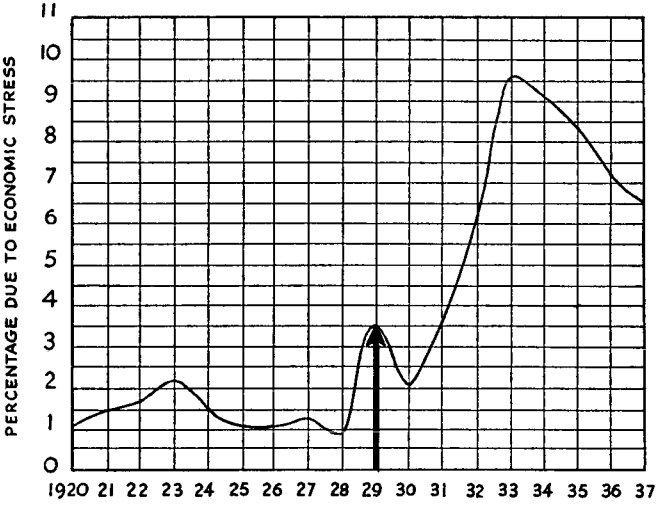

FIG. 3. First admissions of cases of dementia praecox to New York State hospitals, 1920–1937, in which loss of employment or financial loss was considered a causative factor

private institutions. Corrections were applied for those not answering. The insanity admission rates per 100,000 in 1935 were: for all priests, 121.65; for all nuns, 124.40.[18] It will thus be seen that the insanity rates for priests and nuns are lower than those for any of the above instanced classes in the general population. A celibate life does not contribute to insanity, as strict Freudian theory would demand.

Furthermore, among persons leading a celibate life, one would expect, according to Freud's concept of etiology, that a very large number would suffer from psychoneurotic conditions. The percentage of psychoneurotic conditions in first admissions to hospitals for mental disease in the United States in 1933 was 2.1 for men and 4.1 for women[19]; whereas the percentage of psychoneurotic conditions for all priests in the mental hospitals in the United States in 1935 was 1.90[20] and for nuns 2.58.[21] Thus it would seem that there is no evidence that a celibate life as such is a causal factor in either psychotic or psychoneurotic conditions.

It would seem that psychotic reactions have a tendency to develop wherever there is a condition of profound discontent, whatever the cause. If sexual disorders are a factor in the development of psychotic conditions, this does not come about through any necessary essential relationship between sexual maladjustment and psychotic conditions, but by way of the paths of general discontent. Mental disorder is associated with maladjustment in general rather than with any specific type of maladjustment.

This is suggested also by a study of Malamud and Palmer on masturbation.[22] These investigators studied 500 consecutive

[18] The total number of nuns in the United States in 1935 was 122,220, and of priests 30,250. See T. V. Moore, "Insanity in Priests and Religious," (Am.) *Ecclesiast. Rev.* **95:** 490, 1936.

[19] *Statist. Abstr. U. S.*, 1935, p. 72.

[20] T. V. Moore, *op. cit.*, p. 493.

[21] *Ibid.*, p. 494.

[22] William Malamud and G. Palmer, "The Role Played by Masturbation in the Causation of Mental Disturbances," *J. Nerv. & Ment. Dis.* **76:** 220, 366, 1932.

admissions to the Iowa State Psychopathic Hospital. They found that in 50 of these cases masturbation played an important role in the development of the mental condition, but not through any direct disturbance of the nervous system or of the physical well-being of the organism. "In all of the cases," they say, "the disturbances seemed to be directly based upon the fear of consequences and feelings of guilt. In most of the cases these elements could be traced directly to misinformation as to possible effects."[23]

Some patients had gone through a period of acute fear developed by parents and others, who had led them to believe that the practice had brought on a serious degeneration of the nervous system. These cases promptly cleared with a little rational psychotherapy, in the form of explanation removing such misunderstanding and of assurance that no real physical harm had been done. In these cases fear of the consequences of masturbation (not masturbation itself) was evidently the essential cause of the condition. When such rational psychotherapy did not suffice, other factors were probably involved.

If a single acute emotional experience of any kind can lead to a prolonged mental disorder, it would be most surprising if chronic intense emotional strain could be neglected in considering the etiology of the psychoses.

[23] *Op. cit.*, p. 376.

Chapter IV

THE ORIGIN AND COURSE OF SOME COMMON PHOBIAS

Human emotions are conscious processes in which body and mind are simultaneously involved. It has long been recognized that this simultaneous involvement has to do with the emotional experience proper and its bodily resonance. Various findings in recent years have made it likely that, while most emotional states are due to insight into a situation, some seem to have no definite psychological cause and apparently have their origin in physiological conditions of the organism. When the patient becomes conscious of a strange, unaccounted-for emotional state (the physiological emotion), he attributes it to this or that event in his early or recent history. We might say that general states of anxiety, especially those of later life, that are more or less constant conditions, are likely to have physiological rather than psychological causes as their bases; whereas acute conditions of anxiety, phobias which arise only in the presence of a certain definite type of condition—for example, being in a crowd, in a shut-in place, etc.—are likely to have a definite psychological cause. It may well be that human beings are more or less disposed to react with intense emotional experience by reason of an original lability of the psychological centers that give rise reflexly to various types of emotional expression and also to the corresponding emotional experience.

1. Incidence of Phobias

It is with the specific phobia rather than general anxiety that this chapter is concerned.

The members of the graduating class of a girl's college were asked to write out a history of their emotional experiences and what they did to overcome them. Similar studies have been

attempted by the author at various times. The gleanings from these studies are interesting and valuable under several headings, as set forth below.

In one group sixteen out of seventy seniors, or 22.9 per cent, had suffered or were still suffering from some kind of phobia. These fears were more or less uncomfortable or disabling. It would seem therefore that annoyance by unreasonable fears is a rather common disability among college girls. Another group of 121 seniors and juniors was asked to check a list of phobias, indicating whether they had ever experienced such a fear, and to describe any phobia they had known that was not mentioned in the list. The phobias experienced and their frequencies are given in the following list. The figures represent in each case the percentage of subjects who checked the phobia named, indicating thereby that they had experienced that particular type of fear.

Reckless driving	54.54	Meeting someone in the dark	28.09
Snakes	52.06	Spending the rest of life alone	27.27
Dying when not in state of grace	47.10	Malicious persons	26.44
Speaking in public	46.28	Being without friends	24.79
Examinations	45.45	Robbers	23.14
High places	42.14	Hell	21.48
Being laughed at	41.32	Being thrown off a horse	21.48
Mice	41.32	Bugs	15.70
Lightning	40.49	Being conspicuous	15.70
Being home alone at night	38.84	Death	14.87
Someone in the family would die	37.19	Anything coming close to the eyes	14.87
Spiders	36.36	Doctors	13.22
Making mistakes	35.53	Rough ocean	12.39
Bats	35.53	Crossing a street	11.57
Cancer	35.05	Having no one in whom to be interested	10.74
Dark	33.05	Being smothered	10.74
People don't like me	32.23	The devil	09.09
Fire	31.40	Going around a curve	09.09
Not being a success after graduation	30.57	Elevators	05.78
Diving	29.75		

2. Origin of Phobias

Several of our histories pick out a special event in childhood as the origin of the phobia. In each of these, the subsequent acute emotional condition arises in a situation that has a specific resemblance to the original precipitating incident. This is true of many other cases in the literature. The phobia is renewed only by incidents which repeat or closely resemble the original terrifying experience. Let us consider some sample cases, as recorded by the subjects themselves.

Case 1. When I was about 6 years old my mother, my aunt, and I were driving in the rain, and the brakes did not work while we were going down a steep hill. To this day I can still hear the screech of brakes, see ourselves rushing towards the truck at the bottom of the hill, and feel the panic and fear as I realized what was about to happen. Even though this happened fifteen years ago, I still am afraid to drive a car in the rain. I have tried to tell myself that it is silly to feel this way as long as I drive carefully, but every once in a while that old feeling comes back. Lately, I have said a prayer to Our Lady, which I find is the best help of all.

Case 2. I have for many years maintained a violent and hopeless fear of thunderstorms. I remember once when, as a mere child, I had been left entirely alone in the house when a raging storm struck, and my fear was so great that I sat frozen to my chair, too frightened to move while the lightning and thunder crashed. For many years since that significant day, I have had an unconquerable fear of thunderstorms. Terror rises high in my heart at the sight of lightning and at the echoing crash of thunder, and I find it necessary to strain every fiber of my nerves in order to control my feelings. However, I am determined to attempt to overcome this fear and, with the help of God, I know I shall. God, who is the God of nature as well as of man, ordains that nature employ the thunderstorm as an outlet for her activities. I should regard it as a beautiful manifestation of God's power and salute it as a demonstration of His glory. If I trust implicitly in God and place my life in His omnipotent hands, I will no longer fear this insignificant force, but will regard it as a perfectly natural, harmless exhibition of the physical condition of nature. Thus calmly and quietly, with the help of sound reasoning and trust in God, I can overcome this fear.

Case 3. I was once possessed of a violent and awful fear of the ocean. As a tiny child, I remember well the agonizing fear that enveloped me when

one day the pounding surf carried me far beyond all hope of human help. The Providential God, however, protected me and I floated toward shore, a shaking, helpless child. For many years since that memorable day, my heart has always contracted in terror at the sight of the roaring waves. However, two years ago, I vowed to overcome this almost hopeless dread. I reasoned with myself that if God, the Creator of all things good, had snatched me from the jaws of death and shielded me by His divine power, then I should trust Him, and this confidence, allied with my normal faculties of sense and courage, enabled me by slowly marked degrees to overcome my appalling fear. Now that I have conquered this morbid panic which so often assailed me and oppressed my spirit, I find that my life has thus been made fuller and happier in many ways.

Case 4. Another fear that I have is fear of lightning. At one time I was so afraid of it that I used to hide in closets. I have outgrown that habit, but I am still afraid of lightning. I think that what caused me to be afraid of lightning is the fact that one day during an electric storm I was in the kitchen and was holding an iron in my hand. Just then a streak of lightning shot across the floor of the kitchen. It was really like a ball of fire. Ever since then I have been afraid of lightning storms. I have never done anything to overcome this fear.

Let us pause for a moment and consider these cases. The simple facts are as follows:

(1) A child suffers an experience producing intense fear. In the automobile accident case, the child was only 6 years old.

(2) From that time on, whenever the person comes into a situation resembling the precipitating incident, the fear reappears. This "burnt child dreads the fire" reaction is different from many cases reported in the literature, in which there is a long latent period between the precipitating incident or complex and the appearance of the phobia.

(3) One girl by her own devices freed herself from her phobia and then found that life had become "fuller and happier in many ways." It was shown by Jones[1] that when a child had overcome one fear, a whole genus of fears disappeared. This experience of a fuller and happier life may have been due to a

[1] Mary Cover Jones, "A Laboratory Study of Fear: the Case of Peter," *Pedagog. Sem.* **31**: 308, 1924.

similar release from a host of more or less vague and unreasonable anxieties. But there is One who hears prayer and in His answer sometimes gives what prayer does not presume to ask.

Is it possible that the essential psychopathology of these conditions is the "burnt child dreads the fire" reaction, which has its biological value in teaching children to avoid things that are harmful? But the child at first makes no distinction between things like fire, which always burns, and rainy days, which do not always lead to automobile accidents. But the child persists in his unreasonable reaction until there is formed a more or less ineradicable habit. If that is so, can a pathological association be formed between a situation and an emotion of fear, so that when any individual situation pertaining to a certain species is experienced, the fear reaction follows?

Watson's experiments[2] on the genesis of fear in children lend support to an affirmative answer to these questions. On the other hand, a much more involved explanation has been developed by the Freudian school. Let us formulate it in the words of Frink:

> What the patient fears is his own unconscious sexual impulses. But in the place of ideas corresponding to these impulses, there appear in his consciousness some substitute ideas, bearing, to be sure, a certain relation to the repressed ones, but generally referring to some possible external danger.[3]

Must one come in the last analysis to a sexual interpretation of the phobias described above? That the precipitating incidents were nonsexual is evident. And it can scarcely be doubted that the incident mentioned was in each case the true precipitating cause, for it gave rise to a series of acute fears right down to the present or to the recent past in which a cure was effected. Is it not more likely that, for example, the fear of drowning in the sea was itself the primary emotional experience,

[2] John B. Watson and Rosalie Rayner, "Conditioned Emotional Reactions," *J. Exper. Psychol.* 3: 1, 1920.

[3] H. W. Frink, *Morbid Fears and Compulsions*, New York, 1918, p. 433.

rather than that it cloaked an infantile sexual desire that the child was afraid to indulge and had repressed into the unconscious?

In the experiments of Watson mentioned above, a child was just reaching out its hand to play with a white rat when it was frightened by the bang of a hammer on a steel bar behind its head, and so developed a fear of white rats and various other white things as well. Did the sight of a white rat really cloak an infantile sex drive? A child is bathing in the surf and is carried out to sea and almost drowned: did bathing in the surf cloak an infantile sex drive, or was the child simply "conditioned" to a fear of the sea by the experience of peril in it?

Wallin has given an abundance of material to indicate that a phobia may develop on the basis of any intense emotional experience. The following biographical note shows the origin of the fear of dogs:

> My first conscious fear was of dogs. At the age of 5, I saw my dearest playmate bitten and lacerated by a huge mad dog. She died several weeks later. The memory of this event has never left me, and, even worse, a miserable fear of the most harmless pup has persisted.[4]

Wallin's study is based largely upon biographical notes given by college students when asked to write a clear, accurate picture of their personal maladjustments. He obtained about six hundred case histories from about three hundred correspondents, and published 293 of the histories in his *Minor Mental Maladjustments*.

One critic who read the manuscript of this book suspected that our cases were selected with the idea of showing the nonsexual origin of phobias. Should anyone have the same suspicion, let him consider Wallin's monograph and he will come to the conclusion that the phobias of apparently normal people seldom have their origin in a castration complex. Sexuality plays a very small role in the case histories cited by Wallin.

[4] John Edward Wallace Wallin, *Minor Mental Maladjustments in Normal People*, Durham, N. C., 1939, p. 40.

"The reports show," he writes, "that fears may be aroused by almost anything: animals of all kinds, inanimate objects (high places, narrow places, inclosed places, dark places, darkness, thunder, lightning, storms), examinations, tests, people, audiences, thoughts, remarks, superstitions."[5]

Some are so sure of the Freudian psychopathology that they feel that all successful treatment must aim at uncovering the sexual mechanism of a phobia. But one of our cases reasoned herself out of her phobia on religious principles and so attained to a life that was "fuller and happier in many ways."

Among the precipitating causes of phobia, one often hears of parental example. Our material offers a case in which a child's phobias were derived from maternal example. The mother sent the child into the cellar to get something for her, because the mother was herself afraid of a mouse that lived in the darkness. The child then developed a fear of mice and with that, as often happens, other fears besides.

Case 5. Up until my fourth year I was afraid of absolutely nothing. I can remember going down into the dark cellar to get something for my mother; she was afraid of a mouse down there. Yet a year later I was afraid to go up into the attic alone. Maybe I was afraid of the dark or maybe of the mouse up there. Mice were dangerous to me, because my mother had been so afraid of them.

From the time I was 7 until I was 10 I was afraid to go to bed by myself. It was not the dark that frightened me, but the fact that robbers might be looking in at the window. I would sit in the hall until I fell asleep, rather than pass the dark window. But those occasions were rare because almost every night my loving parents would "tuck me in 'n kiss me good-night." This fear I attribute to some story I had heard of a robber coming in through a bedroom window. I never mentioned my fears to my parents. In fact, I have hardly ever brought my troubles to them—not that they would not comfort me, but I have never wanted to trouble them.

But all phobias are not copied from neurotic parents. Case 2 above is an example of a fear of thunderstorms having its origin in the circumstances that a "mere child" was left utterly alone

[5] *Ibid.*, p. 36.

in a house, and during this period was terribly frightened by a violent thunderstorm. It would seem that, according to their origin, phobias may be divided into two classes: (*a*) those due to primary violent emotional experiences; (*b*) those derived from the example of the fear reactions of parents, nurses, and others to harmless objects, or from tales told to children in order to frighten them.

The following example illustrates the origin of abnormal fears from a nursemaid's tales.

Case 6. When I was a child of about 4 or 5 years of age, a nursemaid told my twin and me that if we didn't stay upstairs and in bed and go right to sleep, a man would jump out of the panels of the wall and carry us away where we would never see anyone again. As a result of this threat, neither of us would go upstairs first or alone, and even if the whole house were lighted we would not pass the paneled walls alone. It was not until after years of being led up the stairs and being assured that no one was there that we would go up alone at night. I was not frightened after I got upstairs, only on the trip up. That same nursemaid told us, when we were riding down a lonely country road, that in a ramshackle house on the road lived the ragman. Even to this day I am very anxious to get over that road in a hurry.

Not all the phobias of college girls are related to specific incidents in the past. The origin of some is clouded in obscurity, and the individual merely mentions the phobia without attributing it to any cause. The following instance may be taken as an example.

Case 7. My main difficulty has been a growing fear of the dark, which has rendered me sleepless for many minutes after going to bed at night. As a child I always saw shadows and interpreted them as figures. Later, in the solitude of the darkness, I interpreted rustling leaves as footsteps of persons on the gravel of our driveway, or any other noises as doors or windows opening, with some one trying to force an entrance into our house. I always set myself to the task of night watchman for the family, so that no intruder might take them unawares in their sleep. Since we moved into our present house, I have feared the return of the man from whom we purchased it and an attempt by him to harm us, mainly because he was reluctant to sell the house in which his wife had died. I have

often attempted to remedy the difficulty by praying until I could fall asleep, but each new noise interrupted the thought and I slipped back again. This condition is largely due to nerves. I do not suffer under the same strain if, when I go to sleep, other persons are still awake.

In more than half of one of our groups of cases, the phobias could not be attributed either to primary violent emotional experiences or to secondary causes such as adult example or attempts to frighten children into correct conduct by bugaboo tales. This leaves room for a possible Freudian type of psychopathology and various other etiological factors at the root of phobias that have their origin in childhood. No monistic theory is likely to account for all the phobias of childhood.

3. Persistence or Cure of the Phobias of Childhood

All children experience fears, but all fears do not develop into phobias. What brings about this difference in children?

There may be physiological differences which make one individual react more violently than another to emotional experiences. Important as this may be, however, it cannot constitute the whole story. There are psychological reasons, and among these is the general home background. This general factor is illustrated in the following case of a girl, one of a large family, who, in speaking of her emotional problems, could remember no phobias, tantrums, or wild and unruly conduct. She attributes her emotional equanimity to a well organized family life.

Case 8. Perhaps my relatively smooth childhood was due to our family life. We always had a very happy home, with no sorrow and no serious illness. There was ample provision for everything we needed, and our reasonable requests could all be granted. Perhaps it was due to the size of our family. Although it was very large, each seemed to have his place, though mine was not the commanding position of oldest or youngest. Having many children seemed to do away with rivalry and jealousy, because when you thought of complaining about what you had received, you could look around and find others like yourself who hadn't been as fortunate. Perhaps it was because, as has often been charged, I thought of the pranks and the other children carried them out.

Another girl, who also looked upon herself as emotionally well balanced, spoke of the opportunity she always had of talking over all her difficulties with her parents.

Case 9. As I have often said, I am "disgustingly normal"; it always seemed rather appealing to have certain emotional problems confronting one. So I have never considered whether or not I had any emotional difficulties. I know I have certain likes, dislikes, fears, prejudices, and personal problems, but they have never bothered me to any extent; and as for emotional difficulties, I considered them as practically nonexistent in the average person's life.

I have been extremely fortunate in both instances. I am the oldest of six children; I consider my father and mother the epitomes of parental perfection; and my home life is normal and exceedingly happy. From my childhood I have been trained to discuss all my problems and difficulties with my family. Mother would advise me what to do and then tell me to pray to the Blessed Mother for further advice.

The possibility of being able to talk matters over with an intelligent parent is a most important element in the mental hygiene of the home. This is brought out beautifully in the following case, which, though it concerns an inferiority complex rather than a phobia, is worth while reporting here as a good example of homemade psychotherapy.

Case 10. When I was 6 years old, I suffered a very serious illness that left me very delicate and ugly-looking. As a result of the illness I had to wear glasses, and in addition my face was thin and pale and I had straight, dark, unattractive hair. I was rather quiet and shy and did not make friends easily. My constant companion was my cousin, a girl of the same age as I, and a very beautiful and interesting little girl. She was unusual-looking, having silvery white hair that was very curly, lovely blue eyes, and rosy cheeks, and she was very robust and healthy. She was very talkative and made friends with everyone. At first, I guess I was too young to notice the difference between us, but soon people admired and petted her and said how pretty she was and ignored me, until I began to feel most sensitive about it. I think the very first emotional crisis came one summer when she was staying at our house. Mother had taken us both to a toy shop to buy a doll and we each had our money for it. While we were standing together selecting the dolls, an old gentleman came up. He admired Betty, remarking how pretty she was, and said

he would like to buy her doll, which he did. He never even spoke to me and I can still feel the hot tears that came to my eyes and the blind feelings of resentment that came to my heart. From that time on I noticed how different my cousin and I were and that I was uglier than the other little girls I knew. I was blessed with a wise and understanding mother and she met this first crisis for me—or rather taught me how to meet it. I remember that she told me that it wasn't how we *looked* that counted, but what we *did*. I remember that she taught me the saying:

"Beautiful hands are those that do
Work that is earnest, brave, and true,
Moment by moment, the whole day through."

She said that if I could never be pretty, I could be nice and make people like me. I was just starting to school then too, and she said that if I couldn't be the prettiest girl, I still might be the smartest if I tried. There were about fifty children in the room and I thought that this would be rather hard to do, but I studied hard and mother used to help me at night to get the lessons, and at the end of the year I received the prize for the highest average. I think this stopped the serious feelings of inferiority, and although they have come back at times since I have been older, these early experiences have helped me to meet them. I grew up to be unattractive, but I learned to feel that if I were nice to people it wouldn't matter, and I have been compensated by my dear, good friends.

This mother's handling of her child's inferiority feeling saved her from being a sour, disappointed girl, and made her a contented, happy woman, free from anxiety about her personal appearance.

So far we have spoken of the prophylaxis of emotional difficulties. But what becomes of a phobia after it develops?

Some fade out in course of time without any special type of psychotherapy whatsoever. Yet the spontaneous vanishing of a phobia may not be entirely the autonomous process that it seems. Various experiences of life, though not directed primarily at the curing of the phobia, may nevertheless act as very efficient therapeutic procedures. Normal, wholesome contacts in life constitute an unrecognized but valuable type of psychotherapy. The action of this social form of psychotherapy is illustrated in the following cases.

Case 11. My childhood was a perfectly normal and healthy one, the result of a happy home, good health, and any number of congenial playmates. However, I do remember that as a very little girl I was exceedingly frightened by storms, nervous when riding in an automobile, and pretty excitable generally. The fear of storms vanished as I grew older, but, even though I have never been in an accident, I still am unable to conquer my nervousness when riding in a car.

Case 12. One great difficulty I have had since childhood is a tendency to avoid contact with persons in authoritative positions. I am rather in awe of them, and when faced with an actual meeting I become nervous, lose poise, and am exceedingly frightened. This fear has lessened since I have been in college, but is still present to a degree. This may have arisen from the fact that as a child I was of rather delicate health, and I did not have any friends in the city where I lived, since I could not play as the other children did. We moved to a farm while I was still young and it seemed to me out there that everyone was too old or too busy to bother with me.

Case 13. When I was 14 years old, my grandmother died of cancer. She had lived with us and been very close to me from the time I was a small child. Until that time I knew nothing of this malignant disease, but it was not long until I had heard many fantastic tales from various sources of the prevalence and danger of cancer. Somehow, I could not get the idea out of my mind. At that time I was so run down that I had little amibiton or energy. From many unauthoritative sources I acquired information that led me to believe that I had probably acquired this disease from my grandmother. Some years before, I had been running and suffered a hard fall on my stomach, and when I heard people saying that cancer developed at times from a slight injury due to a fall, I became quite convinced that I was subject to this terrible disease.

Even though the doctor told my mother that there was nothing wrong with me that rest and care would not cure, I could not rid myself of the idea. Thinking of it would make me wake up at night in a cold perspiration, and I was very sure that I would not live longer than four years. (This idea was probably due to the fact that I had heard my family discussing the fact that my grandmother's illness had started about four years before her death.) At times, when my spirits were raised, the idea would leave me for a while until, owing to overwork and too little activity and recreation, I would again become very much depressed and dejected. The more I thought of it the worse I felt, and because of the emotional strain my stomach became very much disordered. I dreaded the thought of

dying, and the more I thought of it, the worse I felt. So I was constantly worried with the fear of getting sick when I went out or to school, and life was not very pleasant for me. However, at the end of my high-school years I gradually came to believe that there was nothing wrong with me. The periods during which I had felt badly occurred when I had been overworking and studying too much.

When I began my college career in a Catholic college, I received excellent instruction in the idea of trusting myself entirely to God, who had but loaned me my life as a trust to do my best for Him during the years of trusteeship; when He wished to take me home again, He would. And thus I ceased to worry about dying and the idea of cancer which had been dominant in my mind disappeared. I began to forget myself and put myself to the tasks of my studies, duties, recreation, and social interests.

A number of our cases seem to have been *personally active* in the treatment of their own conditions—some without success, whereas some attribute their final freedom from phobia to their own efforts to overcome it. Thus, as we have mentioned above, the girl of case 3, by strong personal effort and by reasoning based on religious considerations, overcame a fear of the sea and attained to a life that was fuller and happier in many ways.

Another patient had a fear of high places. She was confronted with the dilemma of taking an aeroplane to go back to her sick sister or forsake her in her illness. She took the aeroplane and in that way conquered the phobia. Other items are interesting in her account, and it is given in full.

Case 14. Ever since I was a little girl, until the time came to go away to college, I had certain definite emotional difficulties. Some of these have been solved within the past four years.

Despite the fact that I am the oldest of five, I was extremely shy as a child, and always felt inferior outside my home, that is, while I was at school or in the company of strangers. The very thought of being called upon during class made me dread the time when I must go to class. It is silly now, but it was of much import to me ten or more years ago. In fact, it was as if my whole life depended on that class. I am sure that all this worry brought on fears, of which I had more than a few.

My most predominant fear, and one which, strange to say, I have just about overcome, was that of entering a completely dark room alone. If someone was with me, whether it was my youngest brother or my mother, the fear so inherent in my mind would vanish as quickly as it came.

Another fear that I have recently conquered was about going up into high places. Some time ago, the thought of climbing to any great height or going over a high bridge in a train almost sickened me. Three years ago, it so happened that I was able to overcome my fear of heights. My sister was quite sick and the only way that I could possibly get home in a short time was to take a plane. For some time before the actual flight, I was a nervous wreck, but I was determined to do it. It was at this time that prayer was my best encouragement.

The idea of meeting strangers made me nervous, which brought on worry and anxiety and for the most part made me irritable, and unhappy at times. I always wanted very much to enter into social life, but when the time came to go to a party, I wanted to be miles away, because I felt so inferior. Now, in order to conquer this fear, and to overcome the dread of meeting people for the first time, I take part in the social life of the school, etc., as much as possible, and have found it comparatively easy to make friends.

I attribute the credit for my realization that I am "as good as the next one" to a girl whom I met and became friendly with while I was a freshman in junior college. She would talk to me and help me to solve some of my emotional problems by encouraging me to feel "at home" with new people, and to get my mind off myself by getting interested in others.

Another patient who suffered from a similar fear of high places protested against making any effort to get rid of her phobia, maintaining that she saw no reason why she should change her mind about staying on the ground.

Case 15. One difficulty which I have still not solved, and which grows constantly worse, is a fear of high places. Although I was almost always willing to take a dare or to try anything once, I refused to do anything that would bring me more than 3 feet above the ground. My companions used to tease me because I would not climb trees, fences, or ladders, or any of the other things children delight in climbing. However, this never weakened my determination to stay on the ground. No one could understand why, when I did any number of trick dives on the low board, I would never jump from the high one. Today this fear makes its appearance in amusement parks, in my refusal to take high jumps, though I love to ride, and in my refusal to fly. I have been told that this is a natural instinct and that if I do not conquer it now I shall never be able to do so. I believe that to be true but have no idea what to do about it. I am perfectly happy on the ground and don't see why I should have to change my ideas on the subject.

4. Therapeutic Suggestions

This brings us to a consideration of the importance of the will to get well. Some of our patients demonstrated that they had a will to get well by taking themselves in hand and overcoming their phobias. Some tried to overcome them but failed. One patient frankly confessed that she saw no reason why she should get well. It certainly seems that this patient is less likely eventually to get well than are those who made their freedom a matter of supreme effort.

If now our cases show that personal effort sometimes is successful when the patient is unaided by a physician, is this not a factor to be taken into consideration in scientific psychotherapy? Otto Rank would answer the question emphatically in the affirmative. Few, however, would agree with Stekel in his extreme statement: "The further I penetrate into the nature of analysis, the firmer grows my conviction that analysis is a continuous struggle with a resistant patient who does not want to get well, however strenuously he may protest the contrary."[6] Our data would show that this is not true of all patients. Suppose, for instance, that one of the patients mentioned above who was honestly struggling to conquer her phobia, had been taken to a psychiatrist for assistance: the psychiatrist would have been dealing with a patient who wanted to get well. The more reasonable assumption is that a patient who comes for help wants to get well, and one should go on this assumption until it becomes in some way evident that he does not want to get well.

From time to time one will find that while a phobia is a disabling disorder causing a great deal of discomfort and annoyance, it also has some definite value to the patient. The result is that the patient wants indeed to be free from his phobia, but at the same time does not want to relinquish the

[6] Wilhelm Stekel, *Technique of Analytical Psychotherapy*, New York, 1940, p. 369.

advantage which all unconsciously he obtains by clinging to his phobia. Thus, one of the patients mentioned below* had a fear of going into the streets alone. The result was that he had to have his wife always with him. She accompanied him to his office; if he left it during the day, she had to go with him, and she had to bring him home in the evening. The analysis revealed that the patient was jealous of his wife and of the time she gave to anyone besides himself. He felt that her daughters by a former marriage drew too much of her affection to themselves and away from him: if she no longer had to be with him, she would spend her time with them. His phobia enabled him to keep his wife all to himself and so he fought against getting rid of it.

Again, a persisting phobia is a mental burden from which the patient may get no value whatsoever. This is illustrated in the following case, which is also interesting from the point of view of therapy. When the patient gained insight into the mechanism of the phobia, there was a rather intense abreaction, followed by prompt disappearance of the phobia.

The patient was a married woman of 26 who came to the Child Center with the following complaints:

[1] I have been just scared to death about something all my life and I don't know what it is.

[2] I have been bothered by frequent headaches for nearly two years.

[3] A queer dream all my life that I cannot explain. In this dream, as a child, I just took off and flew, now I dream that I am a pilot in an aeroplane. The essence of the dream is the idea of flying. When I am in a fever I often dream of being in a fire, just a roaring, crackling sort of flame. I am in the midst of it, but I do not feel intense heat, merely warmth.

The superficial personal history of the patient, obtained by asking about the various events and dates of her life, threw no light on her current difficulties. An attempt was made to probe deeper by free association. This brought out the existence of much tension in her home before she left at the time of

* See below, pp. 113 ff.

her marriage. This tension seems to have been due in the main to constant quarreling between her father and mother. Also, the patient deeply regretted having, because of laziness, as she termed it, blocked her father's effort to put her through college, and having spent her time in dancing and going to the movies.

The patient was then asked to write out a history of her emotional difficulties, a technique of psychotherapy which has been advocated by Adolf Meyer. It is rather interesting to note that in this case, the history, written by the patient at home, was the starting point in a rapid clearing of her difficulties. But we must first go back to the letter she wrote when asking for help at the Child Center.

She spoke of being an only child. But her parents had decided to raise in the home three of her boy cousins who had been left orphans:

> The eldest was 11 when my parents took them, eighteen years ago; the second was six months younger than I, and the third four years younger than I. They had all been very ill of typhoid, and the baby was quite helpless when he came to us. For as long as he was with us, he was the center of my world.

In the interview that took place when she brought in her emotional history, she told how she was looking on when her little cousin was burned so severely that he died shortly after. He and some boys had found a can of gasoline and were pouring it out on the ground and setting fire to it with matches. While her little cousin was holding the can, one of the boys held a match over the opening. An explosion followed, and the little fellow was wrapped in a sheet of flame. Both his hands were almost burned off.

In going over her emotional history, she came to the following incident, which she had tried to keep out of her mind for years. The event had happened fourteen years before.

> When my younger brother, the boy who died so horribly, was about 8 years of age, and I was 12, he and the two older boys and myself were in the

kitchen one night. I have forgotten whether we were doing dishes or just what we were doing, but I do remember that there were dishes and kitchen utensils of all kinds near me. The older boys had been teasing me about something, I've forgotten what it was now, but it seems that I had taken quite all I could stand. I'm not very clear about what followed immediately afterwards, but the next thing I knew Frank had one of the heavy two-pronged kitchen forks stuck in his wrist. I know I did not mean to hurt him, I don't even remember picking it up, but I must have done so. It seems, as I look back now, as though all of this unreasoning fear dates from that night. I have an ungovernable temper, and it takes all the strength I have to keep it under any kind of control. The only thing I have found of help is to leave any argument before it gets to the proportions of a fight, and go out and walk until I've calmed down. I've never thrown anything from that day to this, but still I believe I'm afraid of what might happen.

In going over this incident in the interview, the patient manifested what the Freudian would term a marked "abreaction." She became pale, her face wore an anxious expression, and her voice trembled. She expressed the idea that her fear of "something," she did not know what, dated from this incident. There had always been a deep sense of guilt about what she had done, which had been intensified by the tragic death of her little cousin and by seeing those badly burned hands and remembering that she had pierced his wrist with a heavy two-pronged kitchen fork. The incident itself was repressed, but often she was tormented by the idea that she was unable to control her temper and that some day she might kill someone in her anger. Before this incident, she said, she had had no fear of any kind, but afterward her emotional troubles commenced to develop. Whether or not her memory on this point is accurate, and the burning to death of her little cousin, which took place two years later, only accentuated and did not give rise to her vague, unreasonable fear of something, cannot now be definitely determined.

After the patient spoke of her fear that she might kill someone in anger, I explained to her that this was an unreasonable anxiety rooted in the unfortunate episodes she had experienced. I called her attention to the fact that there comes a period in the

maturation of the personality in which normal individuals no longer throw things or strike or carry on like children in their anger. She was no longer a child and had every reason to expect that she would not again behave like a child when provoked to anger.

At all events, the recall and abreaction were followed by a disappearance of her symptoms. When she next visited the Child Center, she was externally quite a different person from the individual we had previously seen. She returned for two more visits, separated by several weeks. She was very cheerful on both occasions. There had never been any recurrence of the vague fear that had bothered her for years: "There has not been a bit of trouble since that analysis. Just knowing what was the matter and being able to face it caused the change."

Thus, it seems that analysis and reliving a traumatic episode, accompanied by an intense emotional abreaction, has *de facto* been associated with the disappearance of the neurotic symptoms. Some years ago William Brown, William McDougall, and C. G. Jung[7] discussed the question of the therapeutic value of abreaction. Jung maintained that the healing effect of abreaction consisted in the assistance given by the physician, which enabled the patient to reintegrate a fragment of personal experience into his conscious life. There is evidence that something of this nature occurred in the present case. There was a sense of guilt over piercing the little boy's wrist with the two-pronged fork, intensified and magnified beyond due proportions by his subsequent tragic death. There was also the patient's feeling that she might at any time wreck her own future by another such emotional outbreak. With the abreaction, the real nature of the incident was opened up and discussed with one in whom she had confidence. Her act in the first place had not been deliberate, and it was only by accident that she had wounded her adopted brother, whom she loved so tenderly.

[7] Cf. C. G. Jung, "The Question of the Therapeutic Value of 'Abreaction,'" *Brit. J. Psychol.* (Med. Sec.) **2**: 22, 1921; reprinted in *Contributions to Analytical Psychology*, trans. by H. G. and Cary F. Baynes, London, 1928, pp. 282 ff.

Her guilt could not really be increased by his subsequent tragic death. Furthermore, the maturation of her own character and the better understanding of herself made her fear that she would some day kill someone in anger, seem unreasonable and groundless. The whole episode had been explained and she had not been blamed as she felt that she should be blamed. She understood the whole situation and now the event could be assimilated to the conscious flow of thought without any further difficulty.

The case is interesting (*a*) in showing the origin of a vague anxiety in an emotional incident which was repressed and at the same time intensified by a second emotional event that profoundly affected the patient; (*b*) because the vague anxiety disappeared promptly when the whole train of events was brought back to consciousness; (*c*) because recall was accompanied by an intense abreaction; (*d*) because analysis was effected not by the usual techniques, but simply by having the patient write out a history of her emotional difficulties.

Some of our cases suggest that personal effort is a factor of importance in the conquest of a phobia. It often happens, however, that the patient comes in with the attitude that the therapist is to do all the work, and he needs only to wait until he is cured. The sooner a patient realizes that he must be active on his own behalf, the more rapid will be his progress.

Analysis will help the patient to understand himself and he will be able to make use of this insight to control his behavior. Human mental activity is intellectual, as well as volitional and affective. Psychotherapy will do well, therefore, to pay some attention to the intellectual element. A beautiful example of the value of developing a new intellectual attitude is given in case 9 above. In this case the mother was the therapist. The possibility of accomplishing this task was dependent on a normal intimate relationship of deep affection and companionship between mother and child. As the girl expressed it: "I am an only child and my mother and I have been very close companions." Something akin to this relationship develops

between therapist and patient as a result of rapport and transfer. If it does not, the therapist will never be able to transmit to the patient any new attitudes of mind.

If one consults the analysis of a phobia in chapter v, one will see an element that has not appeared in any of the cases above. This phobia had a special value to the patient: it made it necessary for his wife to be always with him, and this kept her from his stepchildren, of whom he was jealous. The phobia was resistant to treatment because the patient wanted to hang on to at least its last shreds so that his wife would be tied to him and could not leave him for his stepchildren.

In the creation and maintenance of a phobia we may therefore distinguish the following causes:

a) The *material* cause, the matter, that is, out of which it is produced. This consists in the experiences of the patient's life.

b) The *efficient* cause, which may be sought in the fear aroused by the precipitating incident and the current difficulties of the patient's life. He would not be worried at all if he were perfectly happy and well adjusted.

c) The *formal* cause, that which gives the phobia its individual character, i.e., the peculiar nature of the precipitating incident. Being carried out to sea while bathing in the surf gave a child a specific fear of the ocean. Experiencing a thunderstorm for the first time while left alone as a tiny child resulted in a specific fear of thunderstorms, etc.

d) The *final* cause, the special value that a patient derives at times from his phobia. The existence of a powerful final cause explains some instances of the resistance of a phobia to all manner of therapy.

Besides these fears and anxieties of psychogenic origin, one must admit the existence of anxieties whose basis is physiological. The evidence for such conditions will be found in Part IV, in the discussion of organic emotional disorders. Anxieties of this nature are not to be cured by purely psychotherapeutic procedures.

In conclusion, one might point out the more important findings of our study:

(1) Phobias of a more or less disabling character are fairly common in supposedly normal people.

(2) The precipitating incidents may be of the most varied character, as is evidenced by phobias that have endured in each case from the time of the precipitating incident, without interruption, to the time when the patient's condition was investigated.

(3) Some patients want to get well and actually do cure themselves of these unreasonable phobias.

(4) In some patients there lurks a hidden motive that maintains the phobia and works against all attempts at therapy.

(5) Phobias fade out of a child's life in a happy home; they are perpetuated by an unhappy home life; and they may be resurrected from the past if the individual finds himself in a situation that seems intolerable and from which there is no escape.

PART II

THERAPY BY PSYCHOLOGICAL ANALYSIS

CHAPTER V

FREE ASSOCIATION AND DREAM ANALYSIS

WE SHALL now attempt to develop further our knowledge of psychopathology by the study of individual cases in which some kind of therapy has been carried out. The account of the case will incidentally bring out various points that have to do with psychopathology and psychiatric theory. The main object of this section, however, is to illustrate various methods that may be utilized in an endeavor to deal with the disorders of the human mind.

THE PROBLEM

The patient's predominant symptom as presented at the first interview was a fear of going out alone and of being alone even in his own home. What seemed to him the fundamental cause of his various fears was the idea of being in a situation from which he could not immediately extricate himself if he so desired.

PREVIOUS ATTEMPTS AT THERAPY

Here and elsewhere in the text mention is made of previous attempts at psychoanalytic therapy which ended in failure. We mention this merely as factual material. The previous attempts at treatment which ended in failure may have been the necessary groundwork for any help that the patient obtained from our own attempts at therapy. Furthermore, we have often failed ourselves where others might well have succeeded, and for all we know did succeed.

The patient in this case had been through three attempts at psychoanalysis and had later been given three shocks of metrazol. Prior to the injection of metrazol, he had been given curare to prevent any possible fracture. The metrazol had intensified rather than relieved his abnormal anxieties. One might interject the remark here that if emotional conditions are rightly divided into (*a*) those arising from physiological causes and (*b*) those arising from psychological factors, one would expect that shock therapy would be more likely to benefit emotional states which have developed mainly on a physiological basis. Shock therapy alone is not likely to rid the patient of abiding psychological conditions which give rise to anxiety states.

When the patient first came for psychiatric assistance, his anxieties were a serious handicap in his home and in his business life. He could not go to work unless his father or his wife went with him to his office. He could not stay in the office unless one of them remained in the building. He could not leave the building to go to another office, which he had to do almost daily or sometimes twice a day, unless his father or his wife went with him and stayed while he was doing his work in the neighboring office. He could not take over committee meetings or deal with important men in his line of work without his father's presence. He could not be left alone in his house. He could not take a bath unless someone was within call.

It was with great difficulty that he drove his car alone, usually insisting that his wife or father should go along with him. If, when driving alone, he had to stop for gasoline, he would have a terrible fear. The idea would come to him, "I can't drive off till the tank is full." He would feel like saying, "That's enough. I have got to go on," but managed to wait in agony till the gasoline was in. Once while driving alone he ran out of gasoline. He felt as if he were in a terrible predicament. He could not for a long time force himself to get out and walk to the next filling station, which he knew was not so very far away.

Finally, he mustered up his courage and started out. He was more than half way there when, overcome by a paroxysm of fear, he turned around and went back to the car, only to find himself in the same old predicament. He could not leave the car again and had to wait in the hope that some of his neighbors would come by and help him out. After some time a friend did pass and, stopping his car in obedience to the frantic waving, shoved the patient's car to the gasoline station.

This man's life for some years had been a checkered field of emotional incidents arising from unreasonable fears.

The Therapeutic Procedure

As a first step in psychiatric therapy, it is well at times to have the patient write out a life history with an account of his emotional conflicts, his trials, and the origin of the present illness. The patient complied with this request by the following biographical note, which has been supplemented by statements he gave when the history was taken.

I was born about 35 years ago and was one of a rather large family. I graduated from high school and spent two years in college. My earliest childhood recollections are of angry displays of temper by my father, who was very strict with his children and at times quite mean to my mother.

During my last years in grade school and high school, I had a love affair with an older married woman. This lasted for about seven years. I then met a girl who had been married and fell deeply in love with her. This affair lasted about three years, until she became angry with me and dropped me. I have seen her only once since we parted and that was some fifteen years ago. I have never forgotten her and have suffered terribly over having lost her and I still think of her to this day. I commenced to drink heavily to forget her and drank for about five or six years, at times very hard, doing my best to forget this girl. I made no attempt to meet other girls. This affair was probably the greatest sadness of my life. Drinking also had this charm: under the influence of alcohol I had an unwonted feeling of courage and I took a certain amount of satisfaction in feeling that I had overcome my childhood difficulty, and was ready and willing to fight anybody.

About eight years ago I met my present wife, who was sympathetic and took care of me a lot during my drinking. We decided to marry; after we married, I went to a psychiatrist and stopped drinking at once, and since then

I have drunk only twice. My married life has not been very happy, but far from unhappy.

After I stopped drinking and no longer needed my wife's help, I started to get irritated at various little things that she did. I commenced to realize that I was longing for something that was lacking. There was a great void in my life and there was no ray of hope that this void could ever be filled.

About a year and a half after I stopped drinking, my fears became acute. They developed with a fear that came over me while being shaved. I was tormented by the idea that the barber might cut my throat. Furthermore, while being shaved, I was in a situation from which I could not very well get out the moment I decided to rise from the chair and leave the shop. For who could go about with a face only partly shaved? Then came the fear that I might get hold of a razor and start cutting up the people in the shop.

Then came the fear of fainting on the streets and making a scene and being taken to the hospital in an ambulance. Then a fear of all crowds. And then a childhood fear of darkness was revived and again I was afraid of the dark, and this soon extended to a fear of being alone at night. This troubles me to such an extent that if I am the first to come home at night, I don't dare to go to bed like any normal person, but have to sit up in great anxiety until someone comes home.

My fears go way back to childhood. As far as I can remember, my first fear was of my father. Somewhat later, after having been "licked" by one boy, I developed a fear of getting into a fight with some other boy and then a fear of the dark, or perhaps I have had this latter fear all my life long.

The result of my fear of being alone and of fainting on the streets is that either my wife or my father has to accompany me on every little errand, or, if I am forced by circumstances to walk or drive somewhere by myself, I am in an agony of anxiety. The majority of my fears seem to arise from being in some place or situation from which I cannot get away at once. The idea seems to be that I wish at all times to escape from something; a terrible fear will overwhelm me, to such an extent that I seem about to faint, when I suddenly realize that I am placed in a position which I cannot leave the very instant I want to get away.

It might be worth while noting that the patient had to have his wife drive him for all of his earlier visits for psychiatric treatment; but I felt it wise to avoid studiously even speaking to his wife, or calling her in to get an account of the patient.

ANALYSIS BY ASSOCIATION

After the patient had written out his autobiographical account, the next step in treatment was analysis by associations

developing from words suggested by the patient's history. "Being cut" and "cutting someone else" merely led to the idea of being trapped and unable to get away from something. "Being trapped" called up memories of childhood, when on many occasions he had been locked up in a room because he had disobeyed his father.

There is much in psychological literature to suggest that the severity of the patient's father, and his habit of locking up his son as a punishment, developed a tendency to fear reactions that have burdened the patient all his life long; even up to the time he came for treatment, the fear of his father persisted. He could not talk freely with him. "My father," he said, "has very strong ideas of what should be, and I am still afraid openly to disagree with him on anything."

Had this father complex been the only cause of the patient's present condition, analysis leading back to these childhood memories might have effected a cure, as in various other cases reported in the literature. This simple analytic procedure had apparently very little effect on the patient's condition.

In concluding the interview, an attempt was made to explain to the patient how various fears may rise out of a background of general unhappiness and he was urged to use his ingenuity in order to develop the hidden possibilities of happiness in his present home.

In the next interview he reported that he was no better. He spoke of a hankering for the girl he had formerly loved and a sense of guilt because of not loving his wife as he should. He spoke of a desire to look up his former girl. He was told to write out any dreams that he might have and bring in the record for the next interview. At his next visit, he brought in the following dream:

With Mary [his wife] and went to friends of mine: like a club or something of the sort. I was drinking. She left and I was scared when I found this out and thought I could take cab home. Went to see the man who ran club and went up in elevator to tenth floor. Gave this considerable thought and told elevator boy to wait for me—would just be a minute. Scared of the height.

This dream presents a certain promise of throwing light upon the patient's problems, because he pictures a typical situation in which his cardinal symptom manifests itself.

A little experience with the analysis of dreams will show that some lead back to the past and enable us to understand present symptoms, while others reflect the present and, while giving a more complete understanding of the current conflict, reveal the possibilities which consciously or subconsciously are being revolved by the patient in order to resolve the conflict and find an avenue of escape. This dream turned out to be a dream of resolution rather than one of explanation and interpretation. Let us take the phrases of the dream and indicate in summary fashion the line of thought that the patient developed as he followed his associations with each phrase.

With Mary and went to friends of mine. Two months or so ago I went with some old friends quite a distance to a well known roadhouse, a famous eating place.* Mary went along with us. In all probability I would not have gone to such a place without her, for I am afraid to go places. I would not have the nerve to go to a place where they are drinking without my wife.

Like a club or something of the sort. A lot of people were congregated together. I used to go to night clubs with Jane.† There was always drinking going on in these places. We often went to well known hotels with some men and girls. They did not drink. I never went to a night club with my wife. I talked of taking her to a dance, but I would not enjoy it if I did not drink.

I was drinking. In the last few weeks I have thought a great deal about drinking as a relief from my present difficulties, and then again I think I would rather suffer what I have to suffer than again have to take the consequences of drinking.

* This may be taken as an example of the fact that an incident of the recent past is the starting point of most dreams. According to Freud, every dream has its origin in an incident of the previous day ("Die Traumdeutung," 5. *Gesam. Schrift.*, vol. 2, pp. 165 ff.) The starting point of this dream seems to have been an incident that took place about two months previously. However, we were not studying the theory of dreams, and made no attempt to push the analysis to the uttermost limit.

† The name of the girl who became angry with him and dropped him and for whom he still had a hankering.

The dream presented here a possible solution for his anxieties. If he drank he would no longer have his present fears, he could go out alone and feel again the sense of independence that a little alcohol formerly gave him. Furthermore, the memories of Jane were still with him, and formerly he drank in order to forget that he had lost her.

The patient went on to talk about his self-consciousness and lack of ease when in the presence of others. This troubled him more in the presence of men than of women. And he could at any time get rid of it by taking a drink or two.

She left and I was scared when I found this out. She left because I was drinking and I was left alone without her support and so I feared. My wife has told me that she would leave me if I started to drink again.

Thus, we began to get an insight into one meaning of the patient's fear. He wanted to drink to attain a sense of security, but if he did, he would again get into his old predicaments, his wife would leave him, and there would be no one to care enough to do anything for him.

And I thought I would take a cab home. This is one of the ways I have of escaping fear: getting in a taxi. By so doing I lean on the taxicab driver.

Perhaps going home also meant a flight back to his wife and away from the solution also presented by the dream: a return to his old habits, with the consequent disruption of his present home.

Went to see the man who ran the club and went up in elevator to tenth floor. [In the dream this man was a famous gambler who ran the roadhouse.] I was drunk and had written some checks and signed my dad's name. The elevator boy was colored.

Up in elevator to tenth floor. I could not be going to my dad. But if I could not depend on my wife, I could look to someone else. Could it be my father, or a man I have associated with, or my mother or friends?

The patient was groping about to find the meaning of this obscure personality—the man upstairs who was running the club.

Gave this considerable thought and told elevator boy to wait for me. I have been thinking a good deal the last few years about my condition and my financial problems. My association with my father is unsatisfactory. I will be glad when he stops working and I will be on my own and won't be criticized.

Told the elevator boy to wait for me. I often tell my wife this. Then after Jane left me she married, and I saw her once since her marriage, and told her I would wait till her husband died and that I would come to see her, but I never could.

The patient often thought of leaving his wife and going back to Jane, whose husband had recently died; thus the dream was presenting a second solution for his difficulty—a divorce from Mary and a marriage with Jane.

Scared of the height. I don't like high places. I often think I might jump out of the window.

The man who runs the club and the high places. [Another solution and an interpretation of the "man who runs the club" has now occurred to me, and I present the patient with this phrase and ask him to go on with his associations.] My dad is the man who runs things, but God Himself is above my dad but I am not scared of God, but I might recoil from what God might ask of me. When I speak of God it creates a disturbance. If I go into a church I feel ashamed because I don't want to live as God wants me to live.

Thus the dream has brought out the chief elements of the patient's conflict, and we learn what we had not known explicitly from the autobiographical sketch or from the patient's history—that he is pondering over three possible ways of reacting to his present difficulties: (*a*) obtaining security at certain times and oblivion at other times by a return to his former practice of drinking; (*b*) divorcing Mary and marrying Jane; (*c*) fidelity to God and duty.

When we look over this simple and frankly superficial dream analysis, certain readers will raise the objection that the analysis was not carried back to fundamentals, and some will say that it is therefore useless.

Ratcliff speaks thus of the interpretation of dreams:

Interpretation can be fundamental or secondary, according as to whether it is carried back to infantile origins in a thoroughgoing professional analysis,

or whether it is restricted to immediate motivation, which for the ordinary man is sufficient. With neurotic patients, the dream being a pointer to the buried complex that is their undoing, the analyst must go back to fundamentals, so that the patients may be enabled to relive the repressional experience in the required psychoanalytic way. Thus infantile sexuality must be probed by the patient who wants "derepressing."[1]

All this assumes that the specific source of every neurotic condition is an incident involving some childish manifestation of sexuality, and includes also the more general assumption that the only driving force of human nature is sexuality. These assumptions have led a number of psychoanalysts to keep on prodding and making suggestions to the patient until childhood sexual memories do arise; and then they conclude that they have traced the patient's symptoms back to their origin in infantile sexuality. But the fact that one thought may by association lead to a train of thoughts does not show that the thought from which we started was due in the first instance to the thought at which we stopped the "analysis." Even though relief of symptoms might sometimes be secured in this way, it would not follow necessarily that the relief was due to the revelations obtained by the analysis. Nor can we conclude that because mental relief sometimes follows an analysis of this kind, therefore all neurotic symptoms arise from infantile sexual experiences. Nor can we go still farther and say that in order to relieve the strain of any neurotic condition, "infantile sexuality must be probed." Sometimes the analyst himself forges the association and attempts to impose upon the patient the conviction that the source of his trouble lies in an association that has a remote resemblance to a passage in a dream which appears as a matter of course only to the analyst, whose mind is saturated with the symbols of psychoanalytic literature.[2]

Freud points out[3] that he cannot accept the opinion of

[1] Arthur James John Ratcliff, *The Nature of Dreams*, London, 1939, p. 117.

[2] For a number of farfetched interpretations of this nature, see Ella Freeman Sharpe, *Dream Analysis*, London, 1937.

[3] A. A. Brill (ed.), *The Basic Writings of Sigmund Freud*, New York, 1938, p. 479.

Silberer that every dream or even many dreams may have two interpretations: one termed by Silberer the *psychoanalytic* interpretation, which in the main has to do with a kind of infantile sexuality, and the other termed the *anagogic* interpretation, which is far more important and reveals the profounder thoughts and problems imbedded in the patient's mind.

It will be noticed that the interpretation we obtained from the patient's associations in the dream above is of the anagogic type. We need not attempt to settle the question of whether all dreams have two interpretations. The writer, however, is inclined to agree with Freud in considering this unlikely. There is usually a definite motif that weaves the fabric of the dream and to discover this motif is to interpret the dream. It seems likely that some at least of the dreams presented by a patient deal with the more serious problems of his life at the time, and the interpretation of such dreams is of major importance in psychotherapy. Others may go back to infantile sexuality or be plain wish fulfillment dreams giving an outlet to present drives. Such dreams are of minor importance in psychotherapy.

Not all the branches of the psychoanalytic school accept the Freudian point of view on dream theory and on the etiology of psychoneurotic conditions as based on infantile sexuality. Adler points out that in the past dreams were regarded as foretelling the future. That they have such a function, he naturally denies, but still they do not in his opinion go back to incidents of childhood, but are rather an attempt of the patient to work out a solution of his problems that will clear the way for future action: "the individual's purpose in dreaming is to seek guidance for the future, to seek a solution for his problems."[4] A similar view was expressed much earlier by Maeder, who compares the dreamer to an artist who "seeks in his work the solution of his actual conflict"[5]: in the course of the analysis

[4] A. Adler, *What Life Should Mean to You*, London, 1932, p. 95.

[5] A. E. Maeder, *The Dream Problem*, Nerv. & Ment. Dis. Monog. 22, 1916, p. 3.

the patient learns to look upon the physician as a friend "who helps one to know oneself better and how to rule oneself."[6]

In the dream just analyzed our patient was evidently going over again in a symbolic fashion the serious problem which was with him all the day long. His marriage with the girl he first loved had been frustrated and he had married another woman. He experienced a drive to pick up again the old defense reaction of forgetting by means of alcohol, and so the drinking in his dream is an example of the wish fulfillment element so often to be found in dreams. But the dream itself warned him that if he did this his wife might leave him, and he would be back again in the helpless lonely condition from which he had been rescued by his wife. She took care of him when he drank; but the girl whom he loved, but had not married, had been interested in him only when he was sober. And then this girl, Jane, appeared in the dream under the guise of the colored elevator boy whom he asked to wait for him as he had told Jane to wait until her husband died. And now, as a matter of fact, the husband was dead and Jane was free to marry him if he would divorce his wife.

But the "man who runs the club" intervened and proved to be God Himself; and the patient, though frightened, saw the obligations of the moral law but recoiled in anxiety from the sacrifice that fidelity to God and duty to his wife might entail.

Did not the dream express very forcibly the conflict from which the patient was actually suffering? At the same time, it pointed out the futility of a return to his first attempt to avoid unpleasant memories by drinking, and while it offered him the alternative of deserting Mary and marrying Jane, it warned also against this, for there was Someone, over and above his father, to whom he would have to report when his conduct was not all that it should be.

Would we have obtained any great amount of help in this case by a more fundamental analysis which would attempt to

[6] *Ibid.*, p. 14.

find some association between an incident of infantile sexuality and the anxieties from which the patient was then suffering? Can we really think that the patient was not in truth worrying about his current serious problems, but about some more or less trivial sexual experience of childhood?

But let us now return to an account of our therapeutic interviews with the patient. The dream above described was followed by one about Jane. He could not help thinking about Jane and this gave him a sense of guilt whenever he was in his wife's presence. He had repeatedly attempted to give up the thought of going back to Jane but in spite of himself it kept returning. He ventured the remark that before the analysis of his dream about "the man who runs the club" he had not squarely faced his fundamental problem.

I here took the role that Maeder ascribes to the psychoanalyst, that of a friend who helps the patient to know himself better and to rule himself, and pointed out that ultimate happiness and true human worth were to be attained by giving up Jane and remaining faithful to his wife. This advice was not entirely without effect. For about this time Jane, for the first time in years, attempted to get in contact with him and awakened him by a phone call at about 2:30 A.M. This was repeated on several nights and finally he told her never again to call him on the telephone.

Some psychiatrists would never have given advice of this kind. Thus Freud's general attitude on such problems is just the opposite. He points out[7] that he expressly avoids assuming the role of the mentor. He wants the patient to attain independent decisions, and urges him to postpone a decision on such matters as marriage or divorce till the treatment is ended, except in the case of certain very young or helpless patients, with whom he assumes the role of physician and educator. On this he says:

> Judging from the zeal with which I defend myself against the accusation that analytic treatment urges the nervous person to give his sexuality full

[7] *A General Introduction to Psychoanalysis*, p. 374.

reign, you must not gather that we influence him for the benefit of conventional morality. We are just as far removed from that. We are no reformers, it is true, only observers, but we cannot help observing with critical eyes, and we have found it impossible to take the part of conventional sex morality, or to estimate highly the way in which society has tried to regulate the problems of sexual life in practice. We can prove to society mathematically that its code of ethics has exacted more sacrifices than is its worth, and that its procedure rests neither on veracity nor wisdom. We cannot spare our patients the task of listening to this criticism. We accustom them to weigh sexual matters, as well as others, without prejudice; and when, after the completion of the cure, they have become independent and choose some intermediate course between unrestrained sexuality and asceticism, our conscience is not burdened by the consequences.[8]

Passages such as this have helped to make a number of psychoanalysts take up actively the role of mentor, or rather become a kind of *advocatus diaboli*, and to attack the patient's morality and religion from the very beginning of the treatment. In fact, when Freud says that he cannot spare his patients the task of listening to his criticism of moral principles, it shows that he himself has assumed the role of mentor, but as guide to evil and not to good. So common has this practice become that some lay persons have come to look upon all psychiatry as essentially wicked. But psychiatry is a science and as such is in no way blameworthy in itself; the fault is only with certain psychiatrists. Even the methods of psychoanalysis are good and useful; one can take exception, nevertheless, to the abuse of them by certain psychoanalysts.

At this stage in the treatment, our patient felt that he had attained a better understanding of himself, but as far as his fears were concerned he was neither better nor worse. His most troublesome fear seemed to him to be that of being trapped or caught somewhere. He was asked to think of being confined and to tell everything that came to his mind. This led to many memories of childhood when he was locked up by his father and could not get out and go when he wanted to, of coming home a few minutes late for supper and being sent to bed without

[8] *Ibid.*, p. 375.

anything to eat, of locking himself up in a room when his father threatened to whip him: but he could see no connection between these events and his present fears.

It has been noted that personal effort unaided by psychiatric help is sometimes successful in overcoming a phobia. This suggests that something may be accomplished by stimulating the patient to take himself in hand and act normally in spite of the phobia. Something had been done in the present case to enable the patient to understand himself. Would it not be worth while to stimulate him to act in the light of his newly acquired insight and to carry on in spite of his fears?

At all events, he was told to commence doing some little things he feared, in spite of his anxiety, and to keep a list of such actions as he was able to carry out alone. He kept this record, and for several weeks afterward his sphere of independent activity widened considerably. He even developed so that he was able to come alone to his psychiatric interviews, at first with considerable trepidation, but later without trouble. He was able to drive short distances alone and without anxiety, and when alone to drop into stores, for various purposes, without mental conflict. He carried on various business interviews in his office without having his wife present. He went to church alone.

One day he drove to his office with a friend, but they could find no parking place, so he got out, went into his office alone, opened his mail, and then came down and waited almost ten minutes for his friend to appear with the car. During this wait, his fear was rather severe, but he "stuck it out." Formerly he drove out of his way so as not to be obliged to stop at traffic lights, and would drive for blocks to find a detour around them. But now he was able to omit these detours and had quit "ducking" the traffic lights, as he termed it. He left his office alone and went to a neighboring drugstore. He went with his wife to a neighboring office building and she left him there alone. During this time he had a long business conversation with the greatest ease and secured important arrangements which

meant more business for himself and his father. He began to take on himself also many important business matters that he had formerly left to his father. He went to a business club dinner with a friend, who proceeded to get drunk. This made him feel as if he had been left alone, but he was able to "stick it out" and have a good time without drinking himself. About this time his father died and he was able to take care of the arrangements, drive rather long distances alone, and even one day drove alone to his office. After his father's death he was able to carry out many important business transactions alone and independently, and often without any anxiety.

One day he went to the office alone, stayed there alone, and came home alone and had no great fears. This was a great triumph and he felt that he could keep this up in the future, but he slipped back again into his old practice of having his wife take him to the office.

An attempt had been made in the meantime to find out by his associations what advantage he reaped by maintaining his disability about doing things alone. One advantage proved to be the getting rid of a number of unpleasant or irksome duties and imposing them on his father, and then there was the idea of punishing his father with his fears and disabilities and so getting even with him for all his cruelty to him in his childhood, and of revenging himself for his father's uncompromising attitude down to the present.

For the next interview after this analysis, about three months after the initial interview, the patient came to the clinic alone for the first time. In previous interviews he had always been accompanied either by his father or by his wife. Furthermore, he expressed the idea that he had improved considerably, his interest in Jane was waning, and he was getting along better with his wife. He was, however, still "scared to death" of his father, though now sharp words had replaced the old whippings and for the past few years even the sharp words had been few and far between.

In the succeeding interviews his associations led him back to

memories of Jane, to ideas of independence and freedom from the necessity of being always helped by his wife and his father, to the thought that if he only had the proper faith he would depend on God, and then in the next instant to the thought of the old freedom from fear he had when he was drinking.

Later we again tried to find out his associations with the ideas of advantage and disadvantage relating to his present life of fear and anxiety. Again the idea came to his shirking unpleasant responsibilities, and to the motive, "Deep down I feel a desire to be revenged on my father for his cruelty and to make him do what I do not want to do, or to hurt his feelings in the most unkind way possible by making him see that I am an utter failure."

Toward the end of this interview I said to the patient, "Now you understand your condition. What are you going to do about it?" I explained that a psychiatrist can only help the patient to see himself in a true light, but the patient must work out a solution.

It might be well to note here some ideas of Otto Rank on the relation between the patient and the therapist. According to this psychoanalyst the patient, when he comes for treatment, has a definite "will to health" or he would not come. But when he starts the treatment, this will to health becomes less and less:

> For the first thing the patient does when he begins treatment, is to project his will-to-health on to the analyst, who represents it as it were, just by virtue of his profession. That is, the patient himself no longer needs the will to become well, as the analyst must and will make him sound.[9]

What Rank means by will to health is an effective willingness and effort on the part of the patient to get well. According to him, the success of the therapeutic process

> depends on just this, the ability to allow this will-to-health to be preserved and strengthened in the patient himself, instead of permitting it to be projected upon the analyst.[10]

[9] Otto Rank, *Will Therapy*, New York, 1936, p. 25.
[10] *Ibid.*

This is one of the points on which Rank departs from Freud, who recognizes no independent power of control over emotional drives, but only ubiquitous sexuality, whether undisguised or sublimated. This power of will is denoted by Rank as

> the organ of integration of the impulsive self and its constructive capacity for ruling, developing, and changing not only the world but the self.[11] . . . [It] is not sexuality as psychoanalysis assumed, but an actually anti-sexual tendency in men which we have characterized as a voluntary control of the instinctive life.[12]

Rank has pointed out an important element in the treatment of any mental patient: the stimulation of the patient's interest and effort in doing something to cure himself. With many of the minor problems of children the battle is won when the child takes himself in hand. Adults with long-standing neurotic habits do not yield so quickly. Furthermore, they do develop the idea that they need do nothing themselves except submit to being analyzed, and expect all their difficulties to disappear through the efforts of the analyst, without their putting a shoulder to the wheel and trying to help themselves. Unless this attitude is corrected, the patient is likely to hang on to his neurosis.

It was my impression that our patient's improvement was accelerated after I made him squarely face the fact that he himself had to do something about fighting for freedom from anxiety. That he did throw himself into the task is evidenced by the many examples cited above of the things he undertook to do alone. Analysis did more than merely uncover a complex with the result of crumbling a phobia, by which the patient might attain a certain measure of freedom without any personal effort on his part.

We continued our attempt, however, to analyze by association the patient's various fears. In one of these attempts he attributed the origin of his fear of walking in the street to the

[11] *Ibid.*

[12] *Op. cit.*, pp. 227 ff.

fact that he had had his glasses changed and was frightened while walking in the street when he noticed that the pavement "seemed higher off the ground." Stepping off the curb to the street had made him stumble and he was frightened. Further association led to the memory that at this time he had commenced to think more and more about going back to Jane and leaving his wife, and then the idea came that the conflict over Jane had given rise to a desire to faint on the street which appeared as a fear that he might die on the street. This, he said, came from an intense desire to see Jane. I then asked: "How on earth could fainting on the street lead to your seeing Jane?"

He replied that the thought in his mind at this time was that if he were taken to the hospital, she would be able to come to see him there. She could not come to his home and he could not go to hers.

"Then I felt too," he said, "that if she looked me up in the hospital, I would run no risk of having my pride hurt, as I would if I phoned her and she refused to see me."

His fear, therefore, seemed to be perpetuated by a subconscious desire to get to the hospital in order to see Jane. The unreasonableness of the unconscious drive was apparent to the patient, because he laughed and said: "After all, I might get to the hospital and she might never hear about it, or if she did she might not come."

In the following interviews his conflict about divorcing his wife and marrying Jane came more and more into the foreground. His efforts to overcome his fears distinctly waned. He no longer went alone to the office even sporadically. One day he asked: "If my future happiness depends on my marrying Jane, would I not be justified in getting a divorce?"* And then in the next instant he said: "I would never leave my wife."

* This is an example of what in psychoanalytic literature is termed rationalization. The term was introduced by Ernest Jones and accepted by Freud, and rapidly came into general use among members of the psychoanalytic

I urged him to do everything in his power to make his wife happy and to keep a record of what he did as he had of the things he had done alone.

In the next interview he brought in a few examples of general helpfulness and in the course of the interview he said: "I see the source of my whole trouble: I won't give in. I won't give up Jane and so my conflict and my fears remain."

A little later he denied that his desire to see Jane had anything to do with his trouble. "I think all this stuff about Jane is bunk. If I didn't care what happened to me or what people thought, I would be well. I was terribly afraid of my father and that fear has been transmitted to other people and other things."

An effort was made to bring about some relief by abreaction. The patient was made to live through, in imagination, a trip from his office through the crowded streets to another office. No attempt was made to induce even a mild degree of hypnosis, unless telling the patient to close his eyes while attempting this could be interpreted as such. The patient experienced considerable emotion while making the imaginary attempt—really felt dizzy, had a lump in his throat, seemed to be terribly weak, etc.

He was asked to jot down a brief description of his feelings when alone at some time, and to attempt to go on the street alone. The following extract indicates his emotional condition, when he was alone, and some of its ideational content.

I am shaking somewhat and afraid, but there seems to be no particular thing of which I am afraid. My hands are terribly wet. There is a peculiar feeling in my throat and stomach and I am dizzy. I am all alone. My wife

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school. The term should be used to designate an attempt to find reasons that would justify a course of action that the patient wants to pursue in spite of his moral obligation. Unfortunately, some writers leave no room for logical conclusions from the evidence, but seek to explain all processes of reasoning as a drive of the ego to defend the id. (See William Healy, Augusta F. Bronner, and Anna Mae Bowers, *The Structure and Meaning of Psychoanalysis*, New York, 1930, pp. 254 ff.)

has gone to the store. When I get a chance I plan to get in touch with Jane. I am afraid I am going to go back to her. I don't like to talk openly about her.

He made no attempt, however, to go into the street in the crowded city unless accompanied by his wife.

Some time later the patient came in and said: "I have just had a peculiar experience: I came face to face with Jane while I was walking on the street with my wife. She looked as if she wanted to speak to me, but being with my wife I passed on. Her appearance was a great shock to me. Her face was blotched and had a hard, dissipated look. She has become very fat, so fat that she seemed much shorter than the little girl I used to go with. She was no longer the innocent child, but the hard, experienced woman of the streets who had long ago lost the bloom of youth and innocence. I have been harboring a secret desire to see her. I did see her and she surely is not what I pictured her. I was foolish to hang on to that desire to see her. There might be after all a connection between my desire to see her and my fear of fainting. The thought of fainting comes up in me now as a possible way of seeing her. It came to me when her husband was still living. I thought that if she still cared and read or heard of my having fainted on the street she would make an effort to get to the hospital to see me. It was the only way I would ever have of getting a chance of seeing her."

"Do you still want to see her?" I asked.

"The desire has lessened quite a bit, for she is not as I pictured her. She is fat and hard and dissipated-looking, but her eyes are still blue."

He went on with the recital of his encounter.

"After I got home," he said, "I experienced a feeling of release. It would be ridiculous to faint on the street now—I might not see her if I did faint, and even if she came to see me, she would not be worth seeing. My wife suddenly became more attractive. She looks innocent and pure, but Jane is a

hard, dissipated-looking woman of the streets. Being with Jane now would only lead to sadness; she is not the wonderful-looking little girl that I remember."

In this same interview, I tried to find some cause for the strong fixation of his affections on Jane, and asked him to give me all his associations with the phrase, "personalities Jane suggests."

"No one," he said. "Once I thought she reminded me of my mother, but I do not see that now."

"How did she once seem to be like your mother?"

"She was kind. She put up with me a lot—for example, with my drinking, though she never actually took care of me when I was drunk. From time to time we would have a fuss but I would go back to her. Jane's love for me was great at one time; and so was my mother's love great. Both have blue eyes. Their faces are shaped somewhat the same. Jane has the general figure of my mother, only smaller."

I then explained to the patient the concept of "identification" and pointed out that it meant practically that when a child was fond of a parent, a person who resembled the parent might in later life seem strangely attractive to him. Unconsciously he would love the person who resembled the beloved parent as if that person were the parent, and in this way he might develop a blind, unreasonable attachment which could mar his whole future, and all the while he would not know just why his blind attachment was so strong. It seemed to me that the patient's attachment to Jane was based on just such a pathological association, and that the normal development of his future life depended on his becoming free from his blind attachment, and so I said: "Your mother is not hard and dissipated. Therefore Jane is not like your mother."

The patient then mused on: "She had a dull, dissatisfied look, not vivacious as formerly. She seemed much shorter than I remembered her. She is not the wonderful-looking girl, pert and saucy, that I remember. When I saw her on the street I

had the familiar sense of tightening of the throat and feeling of tenseness in the abdomen. The sense of release came after I got home. I let my wife go out and leave me alone; and I came over here all alone without any trouble. For some reason it upsets me now to talk about Jane, and I have a sensation of tightening in my throat. For some reason I do not like to talk about her."

I had hoped that this experience was going to terminate his fear of being alone on the street, and that he would be able to go about alone as he had occasion to do so. But it did not. He later reported an extension of his ability to go to various places alone. But to go to his own office, or from his office to another building where he had various duties pertaining to his business, remained about as difficult as before.

A little later he came in saying: "This idea of wanting to faint on the street and so have Jane visit me in the hospital was all the bunk. I made up my mind to go and look her up and talk things over with her and if I wanted to marry her I would divorce my wife and marry the girl I loved."

He went to the address he had, but found out that Jane had moved. After that the desire to find her vanished and she no longer seemed to play any role of significance in his life. In one of the interviews about this time I asked him: "What advantage do you reap out of your inability to go places alone?"

According to all the laws of polite psychology, it was high time for the patient to get well. Complexes of various kinds had been uncovered; he had been brought face to face with his mother fixation but, though his sphere of freedom had been considerably extended, he was not yet entirely emancipated from his phobia. The analysis must therefore be pushed farther.

Somewhat to my surprise, the patient answered me as follows: "The possibility of keeping my wife with me and thereby keeping her from spending as much time as she would like with her children" (his wife had several children by a

former marriage). And then, as if to gloss over this selfishness, he added: "I would like to have someone around to help me if I should be hurt."

The idea flashed across my mind: "Perhaps after all a castration complex needs to be uncovered." So I asked him to give his associations with "being hurt."

"Being cut with a knife," he responded.

"Did anyone ever threaten it?"

"No. But that is one reason why I am afraid to go to the barber."

"Were you ever threatened with being cut if you did not behave yourself?"

"My dad hit me on the knuckles with the handle of a knife when I was wiping my dirty hands on the tablecloth. I don't like to handle knives."

"Did your dad ever threaten to cut you?"

"I don't remember anything about knives at all."

"Did your mother? Not that she meant it—but as a child you might have thought so."

"I have no memory of such a thing at all."

"Think."

"No such memory."

While the patient's answers gave no clear evidence of the presence of a castration complex, they did not exclude it as a possibility. But in matters of this kind, only positive findings can lead to a definite conclusion. It would seem, however, that internal family difficulties had more to do with the patient's phobia than a forgotten castration threat in childhood.

An attempt to find evidence of his ever having been threatened with a knife when on the streets led also to negative results. But at the next interview he reported that he had gone to the barber shop without fear.

I had suggested that he start going alone between the two buildings in which he transacted a good deal of business. He made a compromise. He started out now from his own office

building with his wife, and she left him halfway. When he wanted to return from the other building, he phoned to her and she met him halfway.

In a later interview, I again asked him to develop his association, explaining why he wanted to have his wife with him practically all the time. He answered: "So that she may get me to a hospital if I faint."

"That is a superficial reason. What else is there to it?"

"If I have her with me, I am taking her away from the children, and she must pay more attention to me than to her children [the patient's stepchildren]. There is a certain amount of jealousy on my part. I want to deprive a certain one of the children of her mother."

"Why?"

"Because I do not like her. There is hatred connected with her. I don't like her husband, and the things this girl does get on my nerves. She lets her mother do things she should do herself. I look for things in her and criticize even little things."

"Give me an example."

"She eats a lot of butter. I like another daughter and her husband. But I seem to take joy in depriving all the children of their mother. If I got so that I could go out alone, she could go where she wants and most of the time she would be with her daughters. When my wife leaves me and spends some time with her daughters, I take it as a piece of personal neglect. But when I want to go out with a friend and run dogs, I don't reflect for a moment about leaving her alone. My feeling toward my stepdaughters has created an attitude in my wife that she has to look out for her daughters because I do not like them. It has increased her mother instinct and she tries to spend even more time with them, to the neglect of me. My phobia blocks her to some extent. Maybe after all I am keeping the phobia to keep my wife with me all the time and so deprive the children of her as much as possible."

I then explained to the patient that analysis gives an insight, and it is then time for the patient to do something about this new light on his behavior. I said: "What are you going to do?"

The patient answered: "Try to be sociable with the children when they are around. Then I won't object to my wife going to them. I will start this afternoon."

In the next interview he reported having been particularly nice to the children for a while and then for some reason he quit. I said to him: "You are still hanging on to that desire to keep your wife with you and so keep her from her children."

"Yes," he said, "that seems to be at the bottom of it. I never realized it till the last interview. I need a complete change of myself."

"You yourself have to start in and make the change."

"How can I? I have treated them so badly, I can't turn around now and treat them kindly. It's pride."

He reported in the next interview that to the great satisfaction of his wife he had surprised her by certain acts of kindness to the children.

In a later interview I again tried to get back to the threats and fears he had experienced as a child. A certain few psychoanalysts take a rather extreme position on the importance of pushing the analysis back to early childhood. Sadger[13] takes a very extreme position, maintaining that it is even necessary to trace the analysis back to the stages of the spermatozoon, the ovum, and the embryo. He maintains that even in these embryonic and pre-embryonic stages there can be an awareness of an attitude of acceptance or rejection. He feels that when the analysis stops at early childhood, the patient will later have a relapse, and in order to exclude the possibility of relapses one must push the analysis back to prenatal mental life.

Such an extreme position seems a kind of *reductio ad ab-*

[13] J. Sadger, "Preliminary Study of the Psychic Life of the Fetus and the Primary Germ," *Psychoanalyt. Rev.* **28**: 327, 1941.

surdum. At all events, much can be accomplished without forcing the analysis back even to early childhood. In the present study, we followed the patient's associations and made no strong effort to drive them in a direction in which they did not go spontaneously. It is quite possible that the analysis could have been pushed back to childhood, but whether or not more would have been accomplished by such a procedure is a matter of considerable doubt. The patient's associations never led him to events of early childhood. In the present interview he spoke of the shame he had had in the company of girls on account of a severe facial acne. He also remembered an incident when, as a young man, and before he himself drank, he had gone out with a companion who was drunk. They went into a Negro bar in an alley where there were a couple of hard-looking Negro men. His companion threatened to cut him with a knife if he left the place and he had to stick it out in great terror. When the patient was recalling this incident, I noticed that he was panting, and asked if the mere memory of the incident made him nervous, and he answered: "Yes, there is a peculiar sensation in my stomach and throat."

A little later the patient started going to his own office alone on a number of occasions, but was unable to do so every day.

In an interview about this time, there occurred the following conversation, which may be looked upon as analysis by cross-questioning.

"To what extent do you look upon your wife as a mother, rather than a wife?"

"Not at all."

"Your wife has been a being that protected you?"

"Yes."

"That's a mother's function, is it not?"

"Yes," he said with a kind of reluctant drawl, and added, "but a father's function too."

"Have you any memory of cravings when you were a child for someone to take care of you?"

"No, I was more the other way. I got out by myself and did things."

"When did this personality that wanted to be cared for develop?"

"When I was drinking. I wanted someone to take care of me when I was drunk."

"Then your wife is that person who cares for you?"

"Yes, and she did take care of me too when I was drinking."

"Why is it so hard to let her pass from the mother role to the wife role?"

"If that occurred she would look upon me as the one to support her or protect her, rather than look upon it as her office to protect me."

"Why not?"

"It has always been the other way."

"Why not the normal way—the man protects the woman?"

"That is the way it should be," said the patient.

"Why then this opposition?"

"I don't feel strong enough to do without protection."

"How do *you* need protection?"

"I feel like I need protection from this fear. The fear engenders the desire for protection."

"And does the desire for protection engender this fear?" I asked.

"I don't think so."

"Are you sure?"

"Yes."

"You don't get drunk now and so you don't need protection."

"There is really no reason why I should have protection," he admitted.

"But you don't want to do without protection?"

"That's true, I still want protection."

"Why is it so satisfying to you to have protection rather than to give it?"

"I don't know why." The patient mused a bit and then said: "Maybe because I missed it in the younger part of my life and feel that now I am entitled to it."

"Haven't you had enough now?"

"Yes, I sure have."

The following week he reported that he had gone alone to his office but that when alone without his wife he got panicky several times. In a later analysis he associated the fear of being alone with the possibility that his wife might leave him permanently if he should start to drink again.

He reported some improvement in the next interview. He could stay in his office or in another building all day long without having his wife come in at all. But he still liked to have her in the car when he drove to work in the morning. In this interview I said to the patient, "You are having a hard time growing up and becoming independent."

"Yes," he said hesitatingly, and recalled how he had depended on his mother for protection from his father.

"Then is this phobia merely one of depending on someone for protection?"

"Yes. But it may be unconsciously an attempt to find means to punish myself. The unconscious mind takes this course and dictates my actions."

"Why?"

"I consciously feel that I should be punished for not loving my wife. For here I am, married to a good woman, and there is quite a bit of friction between us. I don't love her as I should and feel guilty for not loving her. To pay the debt for this guilt I take this means of punishing myself. So I can't go alone whenever I want to. If I were intensely in love with my wife, the phobia would never have existed. I overcome this feeling of guilt by rationalizing that I am treating my wife in a normal manner, providing a good home and bearing all the expenses of comfortable living."

"Where did you get this theory?" (This looked like an attempt to gloss over his fundamental selfishness.)

"From reading a book, *Faith Is the Answer*, by Peale and Blanton[14]—the chapter on "Fear and Anxiety."

"Which would be better—to punish yourself or to be specially kind to your wife?"

"To be kind to her, but if I were I should have a feeling of falseness and hypocrisy. Thus if I brought her home some pretty flowers or a nice box of candy, such an action, coming from me, would not ring true."

This looked like an attempt to evade the true reason, so I asked, "What other reason? What you have said might be merely an attempt to excuse yourself."

"If I were specially kind to her I might not be the boss."

"Have you got to keep the phobia to be boss?"

"No! But I do like to be boss. When she comes to the office, I like to tell her what to do, and she resents it. She is not very efficient in office work and I get mad because she does not catch on."

I then explained to the patient something of the Benedictine spirit of peace and kindly gentleness, and suggested that instead of saying to his wife, "Do this," he should ask her, "Would you mind doing this?" He admitted that such a request would never meet with a refusal. And then I went on to show how he did not have to boss his wife by means of a phobia. I told him the story of the hermit whom St. Benedict met, who had had himself chained to his cave. St. Benedict told him to break the chains, for the hermit of Christ should be bound by the bonds of charity rather than by iron chains; so his wife should be bound to him by love and not tied by the bonds of a phobia. We had a little further chat and I told the patient that it was time now for him to understand himself and go wherever his interests called him, without forcing his wife to go along with him. He seemed to understand and said that he agreed with me thoroughly.

In the next interview he remarked that his wife had noticed a great improvement in him. Some time before, they had gone

[14] S. Blanton and N. Peale, *Faith Is the Answer*, Nashville, Tenn., 1940.

into a large department store and he had been "scared to death" and had had to hold on to her all the time they were in the store. But a day ago they had gone to the same store and he did not have to hold on to her at all and seemed free from fear. He was going alone into the downtown streets every now and then, but not constantly. So we tried again to follow his associations in the hope of finding some uncovered complex relating to his fear of being in the street; but after wandering through a number of familiar episodes, he wound up with the idea of fainting so as to get to a hospital and have Jane hear about it and come to see him. But he said: "I now no longer have any great desire to see Jane."

In the next interview he spoke of his desire to mix independently in various groups—at church, in clubs of various kinds, and at ordinary social functions—and remarked: "I feel much better, though the things I am doing are not easy. I have been living a life of 'being protected.' When I grew out of adolescence, and had to face things, I couldn't because I had not been drilled in that art when younger. Dad took me to school. I got out of doing the things I did not want to do. And so it came about that I fell back on my wife for protection. My wife thinks it is wonderful that I can go to many places by myself and she now pushes me on to do various things alone. My affection toward her has grown, and I show it by thinking of various ways in which I can help her. But I still get her to go to a number of places for me, because I am afraid to go and get what I need all alone by myself."

When we commence to review this case and look for the factors in its development, it would seem that the early origin of the patient's condition is to be sought in the father's frequent and unreasonable outbursts of anger. Analogy with various states of anxiety suggests that the association between the many occasions on which he had been locked up by his father and his later fear of being in some place or situation from which he could not get away, was the fundamental cause of the main form in which his anxieties appeared. The time when he was in

some kind of dive in an alley and was forced to stay, under penalty of being cut with a knife, may have had something to do with the particular fear of the barber's chair.

It will be noticed, however, that between the childhood experiences with his angry father and the onset of his phobias there was a period of normal mentality relatively undisturbed by excessive fear. It was only when he became very unhappy after being rejected by a girl with whom he was intensely in love that his mental difficulties arose. He attempted to find an escape in excessive drinking, he married and stopped drinking, but was not happy in his marriage, for the old attachments still persisted, and a year or so later his fears became acute.

In philosophical terms: The efficient cause of his anxieties were worry and discontent proceeding from a present unhappy situation; the formal cause of his anxieties was the type of fears that he was subjected to in childhood. If the patient had been perfectly happy, he would have had no cause to worry about anything. But being unhappy and not attempting to face the situation and make the best of it, he referred his anxiety to something else. This something else was a situation or event that bore a resemblance to the fears of his childhood.

If this had been the whole story, the patient's condition would have cleared in the first part of the analysis, in which these various scenes were rehearsed. But this was not the whole story. In our attempt to understand the patient and his difficulties, dream analysis showed that the patient was turning over in his mind three solutions to his problems: (*a*) obtaining security at certain times and oblivion at others by a return to his former habit of drinking; (*b*) divorcing his wife and marrying the girl who had left him; (*c*) being faithful to God and duty.

But the patient was unable, with the insight thus far obtained, to lay aside his fears entirely and be a normal man. This suggested that over and above his actual unhappiness and the analogy between the present form of his anxieties and the fears of childhood, the patient reaped some kind of value from his behavior—so that over and above an *efficient* and a *formal*

cause, our patient's condition had a *final* cause, if we may express ourselves in the language of philosophy.

Various ulterior motives for perpetuating his anxieties appeared in the course of the analysis:

(1) A desire to make his father do things that he himself did not like to do, not only because of his fears but also because of a certain natural laziness and selfishness. This was not only an outlet for this very laziness and selfishness but also the satisfaction of a desire to be revenged for what he regarded as his father's cruelty to him when he was a child.

(2) A subconscious desire to get to a hospital by fainting on the street, as one way in which it might be possible to get the girl who had rejected him to visit him and perhaps sympathize with him and talk things over.

(3) A desire to keep his wife so exclusively to himself that her children (the patient's stepchildren) would be deprived of her company. In regard to one of these children the desire was accentuated by a feeling of personal dislike and hatred that had developed a drive to make her feel unhappy.

(4) A craving to experience "the satisfaction of being protected" so as to make up for the lack of protection given him by his father in childhood.

(5) A desire to be the absolute boss of his wife. To attain this end he sought to control her life and tie her to himself by the demands of his phobia.

In the course of this analysis we found no clear evidence of a castration complex having an essential connection with the neurotic condition. We did find evidence that the patient's attachment to the girl who had rejected him might have been based on various points of resemblance between the girl and his mother.

The appeal to the personal initiative of the patient, as suggested by Rank, seems to us to have been a factor in the patient's improvement. Analysis, however, helped the patient to understand himself and so to manage himself more in accord with the dictates of reason.

Chapter VI

INTERPRETATION OF THE LIFE HISTORY BY FREE ASSOCIATION

The patient was a young man in his early thirties with a mild suicidal trend. He had apparently a brilliant mind, had been given excellent training, and was well prepared for his professional career. His physical health had always been excellent; but in various difficult situations in his past life he had manifested unreasonable anxiety and finally sought help from a psychoanalyst. Later he became an outpatient in a psychiatric clinic for three months, and then spent a year and a half in a mental hospital. He left the mental hospital still suffering to some extent from the same emotional tension that had driven him to seek psychiatric help in the first place.

After being discharged from the hospital, he left his home and entered upon his professional career in another city, where he obtained a small salaried job which he felt did not measure up to the expectations of one whose career in college had been so brilliant in many ways. Here he soon felt obliged to seek psychiatric help, for which at first he was able to pay; but later he had to be taken on as a free patient in a mental clinic. Again he was disappointed with the results, and finally felt so unhappy and tense while at work that he asked for an extended leave of absence. But this situation only added to his mental difficulties. He was earning no money. His father had suffered financial reverses and could help but little; furthermore, knowing his father's circumstances, it caused him great pain whenever he felt obliged to go to him for help.

The Problem

From this situation the patient's mental problems easily emerged. He felt a strong drive to suicide, so strong that he contemplated again entering a mental hospital. He was sad,

tearful, and anxious. Not being obliged to get up and go to work, he stayed in bed every day on into the afternoon, spending the morning in vain sex imaginations often accompanied by masturbation. On getting up he would go out for a while, and with nothing to do or think about, he would return to pace the floor of his hall bedroom, where he lived with little contact with other members of the rooming house; nor did he have many associations outside the rooming house. He had relatives in a not far distant city and for a while visited them with his oft-repeated tale of woe. Soon he felt that he was no longer welcome, and so it came about that his social outlet was limited to but one person, his girl friend. To her he went and wept about his woes and she was ever kind and sympathetic. But there was this difficulty: the patient's father was irreconcilably opposed to his son's marrying such a girl. The father felt that the girl was distinctly below the level of his own family and advised his son to have nothing more to do with her. The patient had the profoundest respect for his father's judgment and did not like even to entertain the idea of doing anything which would wound his father's feelings. The girl seems to have been a respectable woman a little older than the patient, but in some way distinctly unattractive to others. Later I prevailed upon the patient to get out of his solitary room and take an apartment with some other young men. He did so and after he had been living with his new friends for a while, he remarked one day that the boys said they liked him but did not like his girl.

And so the patient was not only unhappy about the development of his professional career but also effectively blocked in his matrimonial aspirations. He was so interested in this one girl, whom his father would not have him marry, that no other girl attracted him in the least. It is quite possible that this severe conflict made him all the more discontented with everything else, and so his daily work became such an intolerable burden that he felt obliged to ask for an extended leave of absence without pay.

Such was the situation when I was asked to see the patient. The outlook was dark and I had little hope of accomplishing anything, but felt that something should be attempted to save the patient from a return to a mental hospital and perhaps the loss of a promising professional career.

PREVIOUS ATTEMPTS AT TREATMENT

Before instituting treatment it is often advisable to see what has already been done and to study the patient's attitude toward previous types of therapy. The subject in this case had been through six months of intensive psychoanalytic therapy. This treatment, however, had to be discontinued because of his father's financial reverses. He felt rather bitter about psychoanalysis.

"Analysis," he said, "did me more harm than good. It robbed me of my self-esteem. I was led to think or to see certain strong feelings I had about my father. In the analysis certain things that were well forgotten were brought out. That did more harm than good. The things I learned about myself were not very pleasant."

These statements are quoted as merely expressing the patient's attitude of mind. It may be that the psychoanalysis he went through had cleared the way for further treatment. The patient's statements must not be taken as implying that the author of this text is opposed to any and all attempts at psychoanalysis.

During his stay in the mental hospital, the patient had worked in the occupational therapy shop till he was disgusted with it, and while talking to me he would pound the table and rant about the folly of spending hours hammering out such a thing as an ash tray which in the first place you don't want, while in the second you could easily buy a better one for ten cents.

Perhaps we can learn from the attitudes of patients. Occupational therapy should pass beyond the stage of a general

attempt to arouse interest in action of some kind, to providing the patient with the means of further education or the possibility of acquiring some art or technique that might be useful to him in his future career. Thus, a young Anglican minister was sent to a mental hospital where occupational therapy had become educational therapy. Here he started to learn to play the piano, for he felt that such an ability would be of considerable help to him in his future work. It should be possible to use teachers in mental hospitals as well as the present type of occupational therapist. Perhaps training as a teacher in some line should be part of the curriculum of the occupational therapist.

And then, one may ask, is it necessary to open up all the closed chapters in every patient's history, no matter what his symptoms? Freud himself points out that the technique of psychoanalysis was built up by the successful handling of a certain type of case:

> Compulsion neurosis and hysteria are those forms of neurotic disease by the study of which psychoanalysis has been built up, and in whose treatment, as well, the therapy celebrates its triumphs.[1]

This therapy is outlined thus by Freud: The symptoms of a neurotic individual have a meaning, just as do common everyday errors and the items of a dream. The task of psychotherapy is to relieve the patient of his symptoms by enabling him to understand and interpret them:

> We have learned that the meaning of a symptom is found in its relation to the experience of the patient. The more highly individualized the symptom is, the sooner we may hope to establish these relations. Therefore the task resolves itself specifically into the discovery, for every nonsensical idea and useless action, of a past situation wherein the idea had been justified and the action purposeful.[2]

In the examples cited by Freud, the analysis regularly leads back to an incident with a strong sexual coloring. Hence a

[1] *A General Introduction to Psychoanalysis*, p. 222.
[2] *Ibid.*, p. 232.

number of psychiatrists lay great stress on uncovering all the details of a patient's sexual life, and sometimes try to impose upon the patient their interpretation of his behavior. Freud seems to have been in the habit of attempting to suggest and impose his own surmises on the patient:

> In the working out of the interpretations I had to hint and suggest to the girl, and was met on her part by either positive denial or mocking doubt. This first reaction of denial, however, was followed by a time when she occupied herself of her own accord with the possibilities that had been suggested, noted the associations they called out, produced reminiscences, and established connections, until through her own efforts she had reached and accepted all interpretations.[3]

The passage is a very illuminating exposition of Freudian technique. It would seem, however, that some psychoanalysts, at times, failing to lead the patient on to the second stage of cooperation, nevertheless impose their interpretation of the symptoms on the patient. This seems to the patient artificial and unreasonable and he develops an antagonistic attitude toward all manner of psychoanalysis. At all events, our patient had this antagonistic attitude toward anything like psychoanalysis, and it was thought that any therapy approaching psychoanalytic treatment would have to be undertaken with considerable caution.

Essentials of the Treatment Undertaken

The patient's history was taken by a psychiatric social service worker. In this interview the patient sat down abruptly, pounded on the desk with his two fists, and cried out with considerable vehemence: "Something has to be done about me!"

Much the same performance was repeated in his first interview with the writer. And so the first step in treatment was to explain to the patient that psychological treatment does not consist in the psychiatrist's doing something about him, but in helping him to understand himself and his problems in order

[3] *Ibid.*, p. 229.

that he himself may be able to do something about himself.

The first interview therefore was taken up with explaining to the patient that the treatment would consist in an attempt to enable him to understand himself better and so to help him to manage his problems and organize his life. At the close of the interview he was asked to write out a history of his life, paying particular attention to all the difficult problems he had encountered and the way in which he reacted to each. This element of therapeutic technique has been emphasized by Adolph Meyer.[4]

The patient wrote a very superficial personal history, but we accepted it as it was, and then, taking a phrase, asked the patient to give expression to all the memories and associations that came to his mind. In other words, the Freudian method of free association was grafted on to the patient's life history.

This technique of giving the patient a point of departure for his associations has been used, as a means of shortening the analysis, by Henry V. Dicks.[5]

This procedure revealed an early conflict. The patient's mother had insisted on dressing him long after most boys dressed themselves. This gave him a craving for independence. On the other hand, he wanted to and did fly from effort by having his mother do everything that required any exertion on his part. There was an evident analogy between this early attitude and his present tendency to avoid effort and become exasperated because nobody was doing anything about his hopeless situation. The patient saw this, became very much provoked, and, using some of the terminology acquired in his previous analysis, hammered the table with his fists and fairly shouted: "I know perfectly well that I am regressing to an infantile level, but what good does it do me to know it? What are you going to do about it?"

[4] Cf. Frank E. Howard and Frederick L. Patry, *Mental Health*, New York, 1935, pp. 334 ff.

[5] *Clinical Studies in Psychopathology*, p. 14.

He was reminded that the psychiatrist could do nothing about the patient's difficulties, that his first function was not to advise but merely to help the patient to understand.

A little later the patient mentioned the fact that he had a frequently recurring dream of being at bat in a baseball game and making a long hit not by intensive effort, but by directed effort. He then experienced in the dream a wonderful thrill which seemed to come from producing an almost magical result by using with grace and ease powers that he possessed without ever having realized it. I then ventured the information that some psychologists think that a dream at times gives an inkling of the way in which a patient should attempt to solve his difficulties, and said to him: "If this is so, what suggestion does your dream give you?"

The patient at once began to expatiate on the unmerciful effort it took for him to get up in the morning and on how he felt that he would never be able to go back to his old job or any other job for this very reason. The interview was then closed with the remark that the problems in the patient's life were to be solved not by intensive exertion but by directed effort, and that he had to find the way himself. He replied with some enthusiasm: "Things look more hopeful. It need not be so awfully hard after all."

The next interviews were taken up with getting his train of associations started with such words or phrases as "independence," "not wanting a job," "sleep," etc.

From these associations it was learned that the patient craved to be the guiding head in a little family of his own; but all hope of this was excluded by his present lack of employment. On the other hand, there was a positive drive to avoid all employment and live a life of sexual dreaming. Such a life would make him utterly dependent on someone, as he had once depended on his mother, and would besides give unlimited opportunity for the indulgence of sexual phantasy. This drive to dependence had its outlet in crying and whining to his girl

about his many troubles, and the long morning hours in bed gave plenty of opportunity for the play of imagination.

It was found also that his sexual phantasy had often a distinctly sadistic trend. His sadism was based upon a desire for revenge upon the whole female sex. He had been rather precocious as a child and wanted to kiss little girls with whom he played, and had been repeatedly rebuffed. This made him think he was physically unattractive, and he reacted with a desire to get even by some kind of cruelty, which so far had been practiced only in his daydreams. His sadism was somewhat larval and infantile. One frequently recurring sadistic phantasy was to imagine that he was sitting at table with his wife and in front of her there would be a large dish of steaming hot oatmeal. He would rise from the table and force his wife's head into the steaming porridge, messing up and burning her face. Thus he revenged himself on the little girls who did not like his face and would not kiss him.

When asked whether or not he could imagine himself doing anything like that in reality he said that it would be utterly impossible. Perhaps the expression of these sadistic dreams and the whole psychological study of the patient has cut short a larval sadism before it could take on a serious form and pass from phantasy to sadistic crime in the world of actuality.

At all events, in later interviews the patient reported that sadistic phantasies had ceased to occupy his mind when he stayed in bed in the mornings. In their place a more harmless type of wish fulfillment phantasy had arisen. He thought of himself as walking along the streets and being pointed out as a prominent radio performer or a celebrated actor, etc. This he termed, with some disgust, "adolescent stuff that I should have discarded long ago." Nevertheless, he had serious intentions of throwing up his professional career and becoming a radio announcer or an actor. Such a solution to his difficulties would have been happier than turning to sadistic crime, but considering his years of study and preparation, the barter he contemplated was not a rational bargain.

About this time the patient left his hall bedroom and went to live in an apartment with three young men. He started to rise somewhat earlier and to make various visits, seeking a professional outlet that would offer him a better salary and more room for advancement. He commenced also begging for advice and help in his problems. I tried to give this advice indirectly by asking him to think of things that it might be worth while to do in the evening when he went back to work. He thought of (1) teaching, (2) exercise in a gymnasium, (3) membership in a society of actors, (4) social life of some kind, and (5) reading.

But thinking of outlets and making use of them are two different things. The patient never went anywhere except to see his girl friend, and, outside of ice skating with her, had little or no physical exercise. Still, he was rising somewhat earlier (about 10:30 A.M.) and he got some exercise in making visits in search of a professional opening. But his emotional tension had diminished and in the psychiatric interview he seemed almost a normal personality.

About this time I thought that benzedrine sulfate might ease the morning rising and told him to take a 5-mg. tablet immediately on rising. In the next interview he reported that the general effect of the tablet was to make him feel more hopeful and much more ready with his answers in an interview. Furthermore, he never even thought of the intense fatigue he complained of in his previous visits. But he still maintained that nothing appealed to him and that he was unsuited to his profession, and still felt an inclination to spend his waking hours in phantasy and vain imagination.

In the next interview he came in bubbling over with enthusiasm. He had entered a general information quiz contest on the radio and won the prize. This item of success was a valuable tonic and perhaps aided in his resolution to go back to his job. I presented him with his fundamental conflict: "Your present life of sleeping late is merely seeking an unwholesome outlet for sexuality. If you persevere in it you will never attain

to your idea of a little social unit, your own family, in which you will be the guiding spirit. What are you going to do about it?"

"Make sleep less attractive and work more attractive," he replied.

I asked how, and to my great surprise he answered: "Terminate my leave of absence and go back to my old job."

But in the next interview he reported that he had failed to take the necessary steps. He told me how much he hated his present work, how his classmates (whom he had outstripped in college) had gone far beyond him. They told him that it was a shame for him to be working at such a salary. He wanted to give up his profession and at the same time wished that he could put any such idea out of his head. Repeated requests that he write out dreams had been left unheeded; so this hope of deepening the analysis had faded.

Nevertheless he reported in the next interview that he had phoned about terminating his leave of absence. Ever since then, however, he had experienced a flock of physical and mental symptoms. He could not sleep. His food disagreed with him. He had a panic every time he attempted to pick up a pen. Every time he thought of going back to work he had an intolerable sinking feeling. He felt certain that he was not fit to be a member of his profession at all.

In the midst of this session I remarked that I could get an interview with a man of great prominence in his field, and that I would be glad to call on this man and ask him to interest himself in opening the way for the patient to get a better position. At once there was a remarkable change in his attitude. All of the anxiety and depression disappeared and was replaced by a happy exuberant enthusiasm. When he was leaving I gave him a prescription for 10-mg. tablets of benzedrine sulfate and told him to commence work again and to take one tablet on the morning he went back to his old job, and occasionally thereafter as he might feel the need.

He went back to work in reality this time. Some two

months later he was found to have been working regularly. The erotic daydreaming had ceased. There was simply no drive to indulge. There were no frightening blank periods such as formerly came over him. He had opened a savings bank account and this was beginning to grow. I had carried out my promise and visited the man of influence, and later the patient received an encouraging letter. Nothing came of it in reality, but the incident was a very helpful tonic to his spirits.

Some three months later the patient was again in a slump, but he did not quit work. A couple of weeks later he returned saying: "My spirits have changed. The blues are gone and the red-letter days are here."

In the depths of his slump he had gone into the office of the management with the idea of resigning his position. But to his great surprise, they talked about raising his salary, and there was a sudden bull movement in the emotional stock market.

From time to time after this he came to see me to tell me of the difficulties between himself and his father over his marriage with his girl friend. He could not bring himself to marry her in the face of his father's opposition. No attempt was made to analyze his difficulty about the marriage situation and he was left to work out this problem for himself. He told me later that they had agreed to quit seeing each other. But he had been unable to get interested in any other girl. Later he was offered a very excellent position in another city, having worked without remission at his "detestable" job for over a year after his return to it, without any serious difficulty.

SUMMARY OF TECHNIQUE

When we look back over the technique of treatment in this case, the following elements seem to stand out:

(1) One might mention in the first place a factor whose influence it is hard to measure. Let us term it the psychiatric attitude in dealing with the patient. This consists in a friendly, sympathetic, but objective consideration of the patient and his difficulties. There is no mockery of his folly, no scolding

because of his lack of cooperation, no attempt to preach to him and lay down the law to which he must conform. Perhaps some will criticize me precisely because of this. But there is no obligation to "cast your pearls before swine." This phrase implies no contempt for the patient, but merely expresses the idea that it is better to withhold advice when it will not be appreciated, and that any attempt to force it on him will terminate the possibility of influencing him. One of the interesting developments in this case was that the preliminary refusal to give any advice led later to the patient's pleading for help and suggestions. Had one started to give advice in the first place, the patient's attitude of mind would not have been receptive; furthermore, something had to be done to enable the patient to do what it was perfectly clear that he should do.

(2) The most time-consuming element in the treatment was something very much akin to psychoanalysis: a free association technique grafted on to phrases in the patient's own account of his personal history. This served to disclose the conflict between work and regression to an infantile level of dependence saturated with sexual dreaming with a sadistic trend. The patient, by means of the analysis, attained a clear realization of the incompatible driving forces in his mental life. The conflict was brought out into the open, and as a result the sadistic element disappeared at once; the drive to seek his early infantile dependence was a bit slower in being overcome. It seems to the writer that this analytic procedure was the major factor in the treatment of the case. Whether or not it would have been successful without any subsidiary factors, cannot be determined.

(3) A third point was the use of benzedrine sulfate to overcome a sense of fatigue and make the task easier for the patient to accomplish. It is not likely that this drug would have had any influence in changing the patient's behavior, had nothing else been done. It probably hastened the patient's return to a normal adjustment to his position in life.

(4) A fourth factor may be termed situational therapy. Under this heading comes the attempt to get a man of influence interested in the patient. This attempt had the effect of a strong emotional tonic on the patient. To this must be added, first, the providential fact that when the patient went in to resign his position, the manager talked to him about a raise in salary, and, second, the final offer of an excellent position in another city.

(5) An important element in the therapy was the gradual leading of the patient out of his condition of volitional lethargy on to the personal management of his own affairs. Otto Rank has pointed out that one can hope for little improvement as long as the patient expects to do nothing himself and to have an analytic process remake him without any effort on his own part. This was our patient's attitude at the start of the therapy, but little by little he made one effort after another, until he had adjusted himself to a rather unhappy situation. It is scarcely likely that volitional effort would have accomplished this without the various aids we have mentioned. On the other hand, had these aids been given to a patient who persisted in a passive inactivity, they might have been given in vain.

(6) Finally, one might mention the suggestions and assurances he received in the course of the treatment, and last of all the unrewarded efforts of his girl friend. Her interest and sympathy sustained him in his hour of need, and without it his suicidal trend, which made one psychiatrist hesitate about attempting extramural psychiatric treatment, might have necessitated his removal to a mental hospital.

As to the time involved in the treatment of this case, the patient was first seen about two or three times a week for two months, at the end of which time he returned to work. He was then seen once or twice a month for six months, and then about once a month for another six months, at the end of which period the case was closed.

PART III

MISCELLANEOUS TECHNIQUES

CHAPTER VII

MENTAL DISORDERS SECONDARY TO ORGANIC CONDITIONS

NEUROSES IN ASSOCIATION WITH THYROID DISORDERS

OCCASIONALLY anxiety manifestations may be secondary to an overactive thyroid and may be relieved by the administration of iodine.[1] In all probability one will seldom find that the overactive thyroid is wholly responsible for the mental symptoms. It merely intensifies the affective reaction and the physiological resonance due to the ordinary stress and strain of life. However, it would be a mistake to overlook the organic factor in such conditions and initiate a long psychotherapeutic procedure, when much simpler methods would bring the condition under control. It is always desirable to have a basal metabolism test in any patient suffering from an emotional disorder.

Hypothyroidism as well as hyperthyroidism may be associated with abnormal emotional manifestations.[2] Howe cites a case in which the symptoms consisted in depression, fatigue, headache, and swimming feelings, which all disappeared after a few weeks of treatment in which the administration of thyroid was adjusted to the patient's tolerance. The following history affords an example of a similar case.

The patient was a single woman of about 34 who had left her own home to accept a position in a distant city where she had

[1] Eric Graham Howe, *Motives and Mechanisms of the Mind*, London, 1931, p. 13.

[2] *Ibid.*

no friends nor social contacts of any kind. Her schooling had extended only to about the third year of high school. It had been broken by frequent spells of tonsillitis, terminating finally in an acute rheumatic condition, after which another physician was called in and at long last the tonsils were removed. Her health then began to improve and she became interested in the piano and voice culture. She attempted to make a living as a music teacher but failed completely. Out of work and not welcome in her own home, she gave up music and learned to work a card-punching machine, eventually getting a position at this work which made her financially independent. But, though able to live in simple comfort, she was alone and without friends.

THE PROBLEM

The patient came to the clinic complaining of a feeling of being thwarted, sad, and emotionally blocked. She said that she had never experienced human affection and was now developing a homosexual trend. The feeling of being thwarted is sufficiently explained by the above outlined items of her history. The homosexual inclination turned out to be nothing more than a blind groping for affection, devoid of any actual homosexual experience.

At various times in her life she had "fallen in love" with girls. When she was 10 she became very much attached to a little girl of 4 or 5. At the age of 12 she fell in love with her eighth-grade teacher, but was very careful to keep the latter from having any inkling of her affection. Later on she became very fond of a nun to whom she went for advice and consolation, but tried very hard to keep the nun from realizing how she felt toward her. When she went to work she fell in love with the woman in charge of the office, the very first time she saw her. She felt that she could do anything for this woman, but the attraction never led to anything more than working very hard to please her. She never met her or spoke to her outside of the

office. A year or so later she had occasion to call upon another woman official at her place of work. She expected to see a dignified woman with gray hair, but, to her great surprise, met a young girl "with brown eyes that seemed to speak." Again she was in love, but the love affair remained utterly unperceived by the "brown eyes" and contacts were limited to passing each other in the halls. Then the girl with brown eyes left the building and took a position elsewhere. In some way this deepened the patient's sense of isolation and emotional blocking. When she went back to her room after work she felt very lonely. Life seemed unendurable, and, having heard about our work, she wrote for an appointment.

On her first visit to the clinic she appeared sad, depressed, inactive, with a tendency to sudden apparently unmotivated sobbing. She spoke of being irritable with those with whom she worked and of manifesting her hurt feelings in anger on a number of occasions.

THE TREATMENT

Considering the patient's situation in life, one would not expect that it would be possible to be of any great help. The problem seemed to be one of a general blocking of all emotional outlets and there was little hope of opening the patient's future to something worth while. But if one stops a moment to think, he will realize that there are thousands of women in similar situations who in one way or another manage to carry on. The physical examination in the clinic suggested a hypothyroid condition. The pulse was moderately slow (68). There was a moderate degree of adiposity (the patient's height was 5 feet 3 inches, her weight 141 pounds), and a puffiness about the forehead and eyes. The basal metabolism was taken and found to be −14. In this case we administered thyroid, on the basis of its being a good principle to attempt to correct any physical defect that may be present, even when the main problem is mental. She was first told to take a 1-gr. thyroid tablet every

evening. This dosage did not raise her pulse rate and it was increased to a grain morning and evening. Her condition commenced to improve soon after the start of thyroid therapy. About a month later she said that she had picked up her social contacts again, had been to a bridge party one evening, and on another had played an accompaniment for a violinist.

Furthermore, she was commencing to practice on the piano again in earnest. She felt more cheerful when at work and the feeling of having been thwarted in life was disappearing. About two months later she seemed quite normal. Instead of losing weight under the thyroid treatment, she gained about 5 pounds. She was feeling happier, had a good appetite, and ate a good deal more than when she was sad. About five months after her first visit, her father died. She had also dropped the thyroid for some weeks and her weight had gone up to 150 pounds. After the death of her father, the old depression returned but did not last more than a couple of weeks. The patient was seen only ten times in seven months and at the end of that period was to all appearances mentally normal.

Besides the administration of thyroid, the treatment consisted in encouragement, stimulation toward finding an outlet in life by resuming her music, and the suggestion that she lead a devout religious life even though she was living in the world. Furthermore, a facial eczema was treated and the patient's physical appearance was greatly improved as a result of this and of the disappearance of the puffiness about the eyes and forehead, following thyroid medication. After the change in the physical and mental status of the patient, a chronic sour, discontented expression gave way to one of normal cheerfulness. The changed inner attitude manifested by the transformation of the facial expression must have made the patient much more acceptable to those in her environment. And this reacted also upon her mental life, for anyone feels much happier when accepted rather than rejected by others.

It is scarcely possible that what was accomplished in this case

would have been attained if some physician had merely had a glance at the patient, taken her pulse, and written out a prescription for thyroid. On the other hand, one often taxes his ingenuity to find outlets for a patient in an impossible situation and suggests and persuades without helping the patient in the least.

One of the interesting conclusions suggested by this case is that some patients may be cured even though the environmental situation is hopeless and irremediable. In spite of this, they can be made strong enough to put up with an unhappy lot and, notwithstanding severe trials and loneliness, to lead a peaceful and happy life.

Disordered Heart Action and Neurotic Personality

The patient was a young man of 22 who had finished high school and worked until January, 1940. Prior to this, however, he had developed a tubercular infection and since January, 1937, had been going to a specialist every two weeks in order to maintain a pneumothorax and so give the tuberculosis a chance to heal.

In January, 1940, he had an attack of influenza which was said to have been treated with neosulfanilamide. He recovered and returned to work, but soon after resigned his position because he felt sick all the time and, furthermore, did not like the work he had to do. He then got another position, but suffered from palpitation of the heart whenever he went to work, and on that account resigned the new position.

Since then he had gone through a period of physical weakness and emotional disorder. He had gone from one physician to another, undergoing all manner of special tests, but no doctor could find any organic trouble. The general opinion expressed to the patient was that he was suffering from the effects of an overdose of sulfanilamide. During these months he went through what he termed a period of "morbidity." By this he meant that various ordinary actions gave rise to uncomfortable

associations. For example, lying on a couch made him think of a coffin; seeing a man cutting grass made him think of digging a grave. This "morbidity" lasted only about three weeks and was no longer troubling him when he first came to the clinic.

THE PROBLEM

The symptoms he mentioned when he came to the clinic were indigestion, i.e., lack of appetite and a feeling of abdominal distention, and attacks of palpitation of the heart. Sometimes, he maintained, his heart raced away all day long. The result was that he could not go to work, and though his family was in real need of his financial assistance, he had to be supported by the family instead of contributing to its support.

Except for the pneumothorax and a pulse of 100 when the patient was sitting, the physical examination was essentially negative. The lung specialist reported that the tubercular lesions of the left apex had healed.

THE TREATMENT

The treatment in this case consisted first of all in putting the patient to bed for a week. This was done partly from the point of view of caution. Granted an organic cardiac and pulmonary condition, rest in bed should be helpful. However, the main idea back of the order to go to bed for a week was psychotherapeutic. It seemed likely that the attacks of palpitation were due to a condition of anxiety in a neurotic individual who was unnecessarily disturbed about his physical condition. If rest in bed could serve not only to quiet the heart action but also to give the patient a sense of security arising from a feeling that something had really been done to alleviate his condition, perhaps his unnecessary anxiety would disappear.

At the end of a week the patient returned to the clinic. In spite of the week's rest in bed, his pulse was still 100 when he was in the sitting posture. He was told to drop smoking and to spend another week in bed, except for an afternoon walk

of about three-quarters of an hour. He returned the following week with a pulse of only 78. He said that he had been bothered occasionally by a fast beating of his heart, which made him feel as if he were working against some kind of pressure. An appointment was made for him with a cardiac specialist. He was told to stay in bed till he saw the specialist, but if the specialist said that his heart was normal, he should go to work the next day.

The next week he returned in high good humor. The specialist had taken an electrocardiogram and given him a thorough examination. He was finally assured that his heart was in excellent condition. He had worked now for two days without difficulty and in the month that had elapsed since his first visit to the clinic he had gained 14 pounds.

A report nearly two years later said that the patient was still working, to the great joy of his family.

In considering the treatment of this case, one might ask: Could not the same results have been attained without the rest in bed? The answer is: In all probability, yes. Psychoanalysis could have cured the patient. It would probably have taken a much longer time, however, to attain the symptomatic recovery that was brought about in approximately a month by the suggestion-rest therapy that we employed. Four sessions, each a week apart, would ordinarily afford only a meager beginning in any form of analytic treatment. Simple persuasion and reassurance alone might have attained the desired result. But it would seem that the suggestive rest therapy helped toward the acceptance of our efforts at persuasion and reassurance, which might well have failed had they been employed alone.

But, it might be said, "you have only relieved a symptom; you have not cured the patient." This may be so, but it is a matter of some importance to get a patient back to work and making his contribution to the support of the family. Sometimes these patients with whom one has attempted only a symptomatic cure carry on after that and fulfil very important func-

tions. I have in mind now a case of hysterical aphonia. The symptomatic cure took less than half an hour. But the patient has been a normal, wholesome person for nineteen years. It seems that patients at times attain a certain amount of insight through a symptomatic cure which prevents a relapse, and then they are in some way enabled to go on by themselves and meet the experiences and trials of life in such a manner that their personalities attain a normal type of development.

Chapter VIII

GENERAL REORGANIZATION OF THE PATIENT'S LIFE

THE PATIENT was a married woman about 36 years of age whose marital life had been rather unhappy from the very beginning. She had graduated from a Catholic college and had been in her school days very devout. Later for some time she went to Mass and Communion every day. Her one child died shortly after birth and for days afterward she cried and mourned its loss. She had, however, been generally healthy and had never suffered from any serious illness.

The Problem

What brought the patient to seek psychiatric assistance was the presence of "terrible fears." If she had to go to the bank, for example, she felt overcome by a fear of fainting. In spite of her fear, she went where she had to go without ever fainting. But the fact that she had repeatedly gone to various places without fainting did not prevent a state of acute anxiety from arising when duty called her out again. Furthermore, she was tormented by a constant fear of dying. If she happened to be in a store and saw a man enter, she had a fear that he was going to hold up the store. For a long time she had been troubled by a fear of not doing things properly, but lately she had become indifferent and just did not care how she did them.

Prior to her marriage she had never suffered from any fears. She had married her husband thinking that he was able to support her, but very soon found that he could not and had not the least shred of business ability. To her surprise, she had to pay for their first meal together, take care of the expenses of their honeymoon, and pay the rent when they first attempted to start housekeeping. Her money soon gave out, and, to her

shame, she had to go back to her former home. Later her husband got a position and they resumed housekeeping. She worked also and had to take care of all practical arrangements. Her husband became cold and indifferent toward her and she toward him, and so they established themselves in different rooms. It was merely for the sake of appearances that they did not separate but lived together, tolerating each other's presence in the same house. She found some outlet for her affections in a widowed friend of her husband's who often took her out to dinner or to the theater; this relationship had not developed into anything seriously objectionable. She had formed the habit of drinking herself to sleep every evening, and smoked a package or so of cigarettes every day. In the first interview she appeared sour, irritable, and discontented. Though 5 feet 8 inches in height, she weighed only 108½ pounds.

The Treatment

It was thought that the patient's difficulties arose out of her immediate situation and that they might be dissipated by a thoroughgoing reorganization of her whole life. It would have been in harmony with Freud's earlier teaching to say that the patient's fears were due to a blocking of libido and to have looked for little help from a reorganization of the patient's life which would leave all the outlets of libido completely closed. In one of his earlier works, Freud said: "So far as I know, the connection between sexual restraint and conditions of anxiety is no longer questioned even by physicians who have nothing to do with psychoanalysis."[1] But later on he came to the conclusion that anxiety precedes repression: it is a fear of losing love.[2]

The patient owned that she often contemplated a simple at-

[1] S. Freud, *A General Introduction to Psychoanalysis*, p. 347.

[2] W. Healy, A. F. Bronner, and A. M. Bowers, *The Structure and Meaning of Psychoanalysis*, p. 409.

tempt to solve her problem, i.e., divorcing her husband and marrying his friend, who, with the husband's full knowledge, was taking her out in the evenings and giving her some little relief from the tension of her home life. As a matter of fact, this relationship had been quite innocent and harmless, but she had lost all affection for her husband and was deeply in love with his friend. Judging by the accounts of other patients, there are some psychiatrists who might have held that the blocking of the libido was the root of the patient's anxieties, and they would have attempted to cure the condition by persuading the patient to divorce her husband and marry the man she loved. Apart from religious and ethical considerations, one might well ask if such a naïve and simple type of psychotherapy will in the long run shed luster on the profession of psychiatry: after the years of the psychiatrist's general medical and special neurological and psychiatric training, he has nothing more to offer the patient than to urge and persuade her to follow the very solution which her predicament has suggested to her own mind as the easiest way out of her difficulties. Would it not be a work demanding somewhat greater skill to attempt to adjust the patient to her difficulties without having her run counter to the obligations of the moral law and try to get rid of ideals and principles which perhaps cannot be uprooted from her mind?

I remember Dr. William A. White taking part in a discussion on the attitude of the psychiatrist toward the patient's religion. He maintained that the patient has to live with his religious principles and with the members of his family after the psychiatrist discharges him. If the psychiatrist attempts to attack the patient's religion and succeeds in having him lay it aside and live in conflict with its principles, he will in the long run create more problems for the patient than he will solve. And so he concluded that when the patient has definite religious and moral convictions, the psychiatrist should attempt to adjust him within the sphere of life to which he belongs. Others in the discussion expressed themselves as heartily agreeing with

Dr. White, while others held that the fundamental difficulty in any mental patient who has religious convictions is precisely the patient's religion and the first point of attack should be to analyze away the religious principles.

The attempt at therapy in this case was frankly an effort to develop and strengthen the patient's religious ideals and practice and to lend support to the mental reorganization of her life by general hygienic measures. As a matter of fact, this introduced still more blocking of sensory impulses, though it opened a pathway to the higher plane of religious life.

First, as to drinking herself to sleep every night. This I looked upon as dangerous in the long run, fearing that it might lead not only to chronic effects, because Anstie's coefficient was already being exceeded, but also because in all likelihood the present evening indulgence might lead to repeated drinks throughout the course of the day. Perhaps some would say to me, "Have a heart, the poor woman needs some outlet." And so she does, but let us try to find one above the sensory plane.

Then as to the smoking. There is good experimental evidence to show[3] that smoking increases the physiological emotional strain. Just like any severe emotional experience, it stimulates the adrenal glands, causing an outpouring of adrenalin into the blood and so a whole series of physiological effects. Neurotic individuals had best spare themselves this added strain upon the endocrine balance. Therefore, at the risk of introducing another blocking, I urged giving up smoking.

The main element in the therapy was an attempt to deepen the patient's religious life. We had a talk about the meaning of the Mass, the life of Christ, and various spiritual ideals. I suggested that she read St. Francis de Sales' *Introduction to a Devout Life*, and if she was not too tired and sleepy in the morning, that she go to an early Mass on weekdays as well as Sundays. To stimulate appetite she was given thiamine hydro-

[3] This is summarized in T. V. Moore, *Principles of Ethics*, ed. 4, Philadelphia, 1943, pp. 65 ff.

chloride (a 3-mg. tablet three times a day before meals); and to break the strain of the day, she was told to take a siesta every afternoon.

It was several weeks before she commenced to drop the evening drinking or significantly to reduce the amount of smoking. St. Francis de Sales interested her from the very start and she soon commenced to go to Mass occasionally on a weekday morning, but soon dropped it again. The smoking was reduced and resumed again. The drinking practically ceased. Her attendance at weekday Mass fluctuated. But in the course of about three months she became entirely free from tension and sadness and gained 8 pounds. About two months later she had a gastro-intestinal upset, smoked a good deal, and was sour and irritable for several weeks, during which time she lost nearly 3 pounds. After another two months she had resumed her "religious life," had regained the lost weight, and said she was feeling perfectly happy and well.

But then she and her husband had to give up their comfortable house and she became very much discontented in a much smaller house. About two months after the period of feeling perfectly happy and well, she phoned saying that she was going through an acute emotional crisis and wanted an immediate appointment. It was impossible to see her for a couple of days, and when she came in she said that she was over the crisis.

Trying to seek a cause for the acute emotional upset, I found that it came on just after her husband's friend with whom she is in love became acutely ill and she thought he was going to die. The danger had now passed and she was feeling better. She had lost about 2½ pounds and had not been to Mass on a weekday for six or eight weeks. We had a talk about spiritual ideals and she was urged to cooperate with me in developing a strong and stable character that would not become emotionally upset. She left feeling quite happy and content and ready to face her problems again.

She has since remained fairly well adjusted and more or less resigned to a situation which is far from the ideal of married life.

Chapter IX

MENTAL DIFFICULTIES ARISING FROM PROBLEMS OF MARRIED LIFE

Fear of Inflicting Injury

THE PATIENT was a married woman about 33 years of age, tormented by a fear that she might kill her children; and, though a Catholic, she felt so bitter about the attitude of the Church on birth control that when she was saying the creed she was in the habit of adding a statement to express the fact that she rejected the Church's teaching on birth control.

As a child she had been sensitive and timid, and excessively cared for and protected by her mother. The timidity vanished when her interest in school activities became keen, in about her thirteenth year. She was very successful in her high-school studies, was president of the senior class, and graduated with honors. She worked as a secretary and at about 19 fell deeply in love with a young man, but difficulties arose between them and much to her regret they drifted apart. About three years later she married another man, not so much because she loved him but because he loved her. The conflict caused by her love for the first boy and her intention to marry the second made it almost impossible for her to eat for about a week before the wedding.

When her first child was born, about sixteen months later, she was extremely happy. She was now living out in reality the dream of her childhood from the time she was first able to play. But when the child was about 2 months old, the patient was on her feet a good deal while doing Christmas shopping, and she had what she termed a collapse, spent a month in bed, and was not herself again for a whole year. The symptoms were not mental, but physical, and consisted of nervous chills and a feeling of extreme weakness. About two and a half

years later a second child was born and she entered upon a very happy, peaceful period in her life. "My association with my children," she says, "has brought me my greatest happiness. They have been my chief companions and handling them has never been a problem."

About this time her mother became very insistent that she have no more children. This led to almost total abstinence from marital relations, which, she rationalized, was warranted because of her poor health. This in turn led to a kind of delusion that her husband was indifferent to her and no longer cared for her.

THE PROBLEM

About this time a girl friend of hers, whom she thought much prettier and better built than herself, commenced to call at the house when her husband was at home. She thought a flirtation was developing between them; this, however, seems not to have gone any farther than knowing looks in the patient's presence, and smiles and giggles. Then there came a feeling of inferiority. When she met people socially she was impressed with their greater attractiveness as compared with herself, and that brought on feelings of pain and envy, causing her to demean herself and feel unworthy.

Then there came a mild mental breakdown and she spent two weeks in bed in a general hospital. During this time, however, she lost even more weight, suffered from attacks of palpitation of the heart and perspiration of the brow and hands, and had sinking spells in which she thought she was dying. A young physician in the hospital tried to get her to talk over her difficulties with him, but she was rather reticent. One day in a rather provoked manner he said, "All right then, one of these days I will come in and you will be really crazy—so crazy that you won't even know who I am."

When he left the room, she was in a state of mental panic and could not rid her mind of the idea, saying to herself, "I am

insane, or if not, I shall soon go crazy and be taken to an asylum."

Shortly after this she read in the newspaper an account of how a woman had gone insane and killed her children with a carving knife; ever since, the mere presence of her children had been a torment to her.* At times she felt that she would surely kill them. One night at dinner she looked at the carving knife and then at her little boy and, overcome by panic, she left the table. Sometimes the fears led to vomiting, or when she looked at such a thing as a paring knife she had a feeling as if her "stomach turned over." The thought of suicide came to her mind, but it did not frighten her as did the idea of killing her children.

THE TREATMENT

There had been no previous psychiatric treatment. Her physician wrote that all physical findings were negative. This included Wassermann test, urinalysis, and hemogram.

The first step in the treatment consisted in having the patient write out her life history. When this had been studied, it seemed that the difficulty might be situational and that the chain of symptoms led back to the interjection of a fear of pregnancy by the patient's mother and the interruption of a happy married life in a patient whose childhood dream was to be a mother surrounded by her children. If that was the case, then the re-establishment of the former happy marital relationship might bring about a cure without any deep analysis of her difficulties.

* It often happens that a patient in some kind of acute mental stress accidentally reads or hears of something that seems particularly frightful, and the character of this terrifying incident acts as a formal cause which specifies the particular form of a phobia which from that time on will haunt mental life. The efficient mental cause of the psychoneurotic condition is the acute emotional distress. Without this, it would not arise. The formal cause is the incident that attracts the patient's attention in the midst of the distress. (See case mentioned above, pp. 105 ff.) For definition of the efficient and formal causes, see p. 109.

However, the patient was asked to give her associations with such words as "fear" and "knife" and from these we obtained some items in the account above which were not contained in her original autobiographical sketch. Besides this she was given thiamine hydrochloride (3-mg. tablets, or 1,000 units, three times a day before meals) and ascorbic acid tablets (100 mg. three times a day before meals).

The patient agreed to resume normal married life with her husband and was not seen again for about four months, when she was asked to report again. The fears about killing her children had largely disappeared, but her sense of inferiority was still troublesome.

About six months later she came in for a report. She had been quite free from anxieties but had recently experienced a feeling of tension and palpitation of the heart. Once, at a funeral, however, she had had an attack of claustrophobia and felt that she simply had to leave the church. Her husband whispered: "Sit quietly in your place."

She did so and in a moment the difficulty vanished suddenly and completely and she said: "I felt just like anyone else."

Her home life is very happy and the tormenting fear of killing her children is gone, though sometimes there is a transitory anxiety when she looks at a knife.

Somewhat similar to this case is the following one.

Fear of Self-Injury

A young woman who had been married about a year came for help in overcoming a fear that made it almost impossible for her to hold the position in which she was working, and the debts that she and her husband had incurred made it imperative that she keep on working.

In her high-school days she had been obliged to quit school because she had developed a fear of jumping over the railing at the top of the third-floor staircase. At this time she had come to see me, and by analysis, persuasion, and reassurance

she had been enabled to return to her school and to graduate. To what extent the analysis itself had helped, I am not sure. There was an element which Freud might have evaluated in terms of infantile sexuality. The idea of "upstairs" led by association to an incident of her life at the age of only about 6 or 7, when, as she was running upstairs, a painter working in the house grabbed her and handled her, causing an intense fright which she could never forget. But after graduating from school she had gone to work and got along without trouble until a year or so after her marriage.

THE PROBLEM

For some time before the patient came for help, she had been suffering from an intense fear lest she should fall or jump over the railing of the staircase on the third floor of the office building where she worked. So intense was the fear that it troubled her even at her work when she was nowhere near the dreaded staircase. At times she had to quit work and go home. Finally she came to the conclusion that she would have to seek employment in some place where she would be on the ground floor. Before doing this, she thought she should again seek psychiatric assistance.

THE TREATMENT

In considering the patient's difficulties, I was naturally struck by the reappearance of the old difficulty after some years of quiescence. This naturally suggested an inquiry into her present emotional adjustment. Let us put together in chronological order the various fragments of her problem which came out piecemeal in the study of her case.

A little before her marriage she had let her engagement be generally known, and had been strongly advised to visit one of the social workers of the firm for which she worked, and finally did so. This worker was skilled in making out family budgets. And so the young girl was told how much she could

put into payments for a house, how much she could spend for furniture, etc., until every dollar of her salary and that of her husband was earmarked. She was then told that it was absolutely impossible for her to have children for many years to come, and it was pointed out that if she became pregnant there would be no money for medical and hospital expenses and she would run hopelessly into debt and lose her house and furniture. The worker then explained the mechanical and chemical technique of contraception and told her that it was absolutely imperative that she should practice it.

At first she thought of delaying the wedding, but, moved by the boy's pleading, she married, more for his sake, she said, than for her own. She had always been a devout Catholic; but from the beginning she felt that she had to follow the social worker's advice and practice contraception. It was perfectly clear, she thought, that the budget did not allow her to do anything else. But she lost interest in marital relationships, which had to be approached as if one were preparing for a dangerous surgical operation. After some months she keenly regretted having married. The dream of her childhood had been to have a home and her own children to play with; and this seemed utterly impossible.

It was now clear why the patient's early difficulty had returned. Her emotional life had reached an impossible dilemma. She did not like to face it because thinking about it could lead, in her mind, to no solution. Therefore, she was anxious; the anxiety, however, was not referred to its true source, but to a substitute point of reference, the old fear about falling over the stair rail.

This may be taken as an example of what the psychoanalysts would term *displacement.* Displacement may be defined as "a process by which one idea may surrender to another the whole volume of its cathexis."[1] The term *cathexis* supposes that an

[1] W. Healy, A. F. Bronner, and A. M. Bowers, *The Structure and Meaning of Psychoanalysis*, p. 200.

idea is something like a heavily charged body which, if touched by a conductor, will suddenly discharge along the path opened by the conductor. If now the charged body be connected with another and this other body is touched by the conductor, the latter body will discharge along the path opened by the conductor. And so in some way an association may be welded between two ideas. When this takes place the anxiety, fear, and craving naturally connected with the first idea will be aroused by objects which awaken the second. Psychoanalysis aims at discovering the associations giving rise to the displacement, thus giving the patient an insight into his behavior, breaking up the pathological association, and relieving him of his abnormal anxiety.

Many cases are recorded in which this has been accomplished. The elaborate technique of psychoanalysis is not always necessary to attain this end. The simple conversations we had with this patient seem to have accomplished the desired result. We brought out the history as given above, we touched upon the budget problem, and found out that in some six months she and her husband would be free from debt, so that it was really possible to take up the budget problem again and arrange matters so that the dream of her childhood could be realized and she could have her own children to play with. She was told to drop the mechanical methods of contraception, but to use if she so desired for a while the biological method of rhythm.

The result was a prompt relief of symptoms. The patient took a two weeks' vacation and later wrote to me: "After two weeks away from the office in which to rest, the routine there is satisfying. The stairs have not bothered me at all since my return."

The patient attributed the change not to the simple analysis but to what psychoanalysts would term *transference*. The letter continues: "And I know that it is chiefly because of the knowledge that I am not fighting my difficulties now alone."

Freud says of transference that "it invests the physician with

authority and is converted into faith for his communications and conceptions."[2] That explains to some extent why the patient was so willing to comply with my instructions. An unsympathetic attitude toward her difficulties, a peremptory laying down of the law of the Church, however clear and logical, would have antagonized the patient and she would neither have conformed to the law of the Church nor have laid aside the phobia.

Transference, in popular language, is a realization on the part of the patient that the physician or other person consulted, whoever he may be, is a kind and sympathetic friend who can be trusted and relied upon for sound advice and efficient help. In this sense it is an indispensable condition for all psychotherapy. Without it nothing can be accomplished in a long series of interviews, but with it some simple conditions are cleared up in a single interview.

This case is perhaps remarkable by reason of the brevity of the treatment. Whatever was accomplished was done in only two interviews. Transference and the acceptance of advice do not tell the whole story. Analysis had something to do with recovery. It revealed the displacement. The patient was led to understand the real source of her anxiety, which because of its serious character, and, to her mind, utter hopelessness, she had tried to put out of her mind. And so her fear and consternation over the hopeless tangle of her married life were displaced and flowed out in the old channel of a former anxiety. With this understanding, and a new confidence born of transference, she returned to her office and found that she could really keep her position, for the stairs now no longer bothered her at all.

[2] *A General Introduction to Psychoanalysis*, p. 385.

Chapter X

FAMILY PROBLEMS AND THEIR TREATMENT

1. The Family Romance

Normal family life involves a father, a mother, and a number of children, each bound to the others by genuine bonds of affection. In the ordinary course of events there are any number of family difficulties. Sharp words pass between adults. Little children quarrel and strike one another. But in healthy family life these are transitory episodes that are soon forgotten in the vanishing past and charity lives on without any interruption.

The normal healthy-minded child loves both his father and his mother. If a deep, abiding antagonism develops in a child's mind toward either parent, it is due to some kind of mishandling which arises from parental faults of character and conduct. Mistreatment rather than the mechanism of the Oedipus complex is the ordinary cause of a child's disliking or, to use a stronger word, hating his mother or father.

According to Freud's earlier theory, the boy normally passes through an early stage of sexual attachment of his mother, which results in jealousy and hatred of the father. And, vice versa, the girl develops a love of her father and hatred of her mother. The boy's hatred of his father is termed the Oedipus complex, from the mythological story according to which Oedipus, king of Thebes, learned from an oracle that his newborn son would eventually slay him. Therefore he ordered his wife to kill the child. But instead of doing so directly she told one of her servants to leave him alone to die in the wilderness. This was done, but the child was found by shepherds and brought up by a royal pair who had no children. Later he was taunted with being illegitimate and consulted the oracle at Delphi. Here he was told that he would kill his father and marry his

mother. So he left the only home he knew in order to avoid committing the crime that was predicted. On his journey he met his true father, whom he slew in a quarrel; and going unknowingly to his old home, he killed the Sphinx, a monster preying on the country, and received as a reward the hand of his true mother in marriage.

In his later theory Freud accentuated the ambivalence of the child's emotions, pointing out that every child is influenced by a love and a hatred of each parent which coexist in the infantile mind.[1] This later concept of Freud's approaches more nearly the truth. However, it has scarcely any other foundation than the fact that both men and women have faults of character, and so it is now the father and now the mother who allows personal defects to arouse the antagonism of the child. Eliminate everything in an antagonistic child-parent relationship which is due to unreasonable display of emotion on the part of the parent, and there will be little left to refer to jealousy and hatred arising from infantile sexual attachments.

Strange to say, one major source of difficulty in the parent-child relationship is the fact that sometimes the child was not wanted in the first place. One would think that this original unwillingness to have a child at all would soon disappear after the birth of the child, or that at all events it would not persist for years, causing trouble in the household and blocking the normal development of love between mother and child. It is quite common, however, in clinical experience to find parent-child antagonism associated with an original parental unwillingness to have a child.

2. The Unwanted Child

Let us now consider this very common family difficulty, antagonism between mother and child. One philosophizing on family difficulties from a purely theoretical standpoint might well imagine that a mother would seldom if ever dislike her own

[1] Cf. Roland Dalbiez, *Psychoanalytic Method and the Doctrine of Freud*, trans. by T. F. Lindsay, London and New York, 1941, vol. 1, p. 165.

child. In fact, I came across one person who maintained that mother love is such a strong ingrained natural tendency that such a thing as a mother's dislike for her own child simply could not occur. If we take mothers in general, it is probably true that only a small proportion develop a dislike for one of their own children.

But let us consider that small group of mothers who bring children to a clinic for help in dealing with behavior problems. They constitute only a small portion of all the mothers of the world; but in this group one quite often finds a mother who for some reason or other has developed and is manifesting an intense dislike for one of her children. This dislike is *emotional.* The fact that the mother brings the child to the clinic for treatment indicates that she does want to do what is best for the child. She therefore has a *volitional* love for the child. The existence of this *volitional* love, which may still bloom into a tender emotional affection, is the secure basis on which to establish our therapeutic procedures aimed at creating a new and wholesome parent-child attachment.

Let us present for clinical study a young mother in her twenties. The social worker taking the initial interview describes her as flawlessly dressed and groomed and having lovely blond hair and a face which might be very attractive except for a cold, hard expression. This mother's cold, hard look betrays a personal fault of character that is in large measure the source of the trouble that has arisen between herself and her child.

Tessie, the child, is a "fairly well developed, wiry, blond, pleasant-looking" child of 5. The mother says she is "thin and homely." She terms her a nervous little brat, and goes on to tell how the child says "No" to whatever she is asked to do. The mother feels that she cannot allow such disobedience to pass unnoticed, and so for her refusals the child is whipped. On such occasions she becomes more defiant, screams, shakes, becomes white, and runs to bed and cries.

Tessie has a little sister two years younger than herself of

whom the mother speaks in quite different terms. This child is adorable. "Everyone who comes to the house takes to her at once; she is irresistible." The mother loves to play with her. But Tessie is not responsive to visitors. When company comes she stands in a corner and sulks; if anyone comes near her she says, "I don't like you."

The difference between the two children cannot be attributed entirely to hereditary traits of temperament. Tessie was the first "calamity" of her mother's marriage. For five years before her marriage, Tessie's mother had nursed her own mother. She told the social worker that her mother's death was a great relief to her. Shortly after the death of her mother, she had an acute appendicitis. She married before she had fully recovered from the operation and within a month after her marriage she became pregnant. She felt that this pregnancy had occurred too soon; and so Tessie was from the first an unwelcome child. She was bottle fed and given very little affection from the first. The mother never picked her up and held her in her arms to give her the bottle. She felt that such tenderness was out of place and mothers should not make themselves slaves to their children. And so Tessie grew up without experiencing very much of the love and tender affection that most mothers shower on their children.

Tessie compensated for this lack of affection by creating an imaginary playmate, or an imaginary companion who was much more than a playmate; for at times this alter ego assumed the role of a mother who gave Tessie all the love and petting and kissing that her own mother had withheld, and at others the imaginary companion was a little baby whom Tessie loved and caressed most tenderly.

The chief complaints against Tessie concerned her stubbornness, her tendency to say "No" and "I won't" to every command or request, and the temper tantrums she would display on slight provocation.

The treatment consisted of interviews in which the social

worker talked with the mother and the child played with toys, while the psychiatrist observed and chatted with the child or took part in the play. But in the first interview, when the time came for Mrs. X to go with the social worker and for Tessie to leave her harsh, unsympathetic mother for the psychiatrist,* she clung to her mother as if she had been the tenderest of parents.

To understand the child we must realize that its mind is the playground of opposite and conflicting emotional drives. It loves and hates the same person, but not exactly at the same time. One or the other of the conflicting emotions readily appears, according to circumstances.

Thus in her play Tessie shot with a toy gun at the psychiatrist and said: "You are dead."

"Tell me," said the psychiatrist, "whom else would you like to shoot?"

"My mother," was the prompt and decisive answer.

Again in her play Tessie expressed her ambivalent feelings toward her sister. She started writing her sister's name on the board. The psychiatrist commenced to guess who this person was.

"She is somebody you don't like sometimes?"

"Yes."

"She's somebody who gets in your way."

"Yes."

Various such guesses were indicated to be correct by the child's nodding a "yes." But when finally the psychiatrist guessed, "She's somebody you wish were dead," she turned about quickly and said:

"Don't say that or I will smack you."

Thus again in a later psychiatric interview Tessie said: "I like my sister. She is not bad. I can't play with her every morning because I have to go to school."

* In this case Dr. Frank Cassino, the student Fellow in psychiatry at the Child Center.

And so in spite of the fact that this little 5-year-old sees her sister preferred and hears her praised, she really loves her, even though she gets in her way at times and causes her trouble.

Contact with the psychiatrist allowed the child to express herself freely and to play as she wanted to play without let or hindrance. Play therapy with children often accomplishes no more than this, yet for some reason a change for the better takes place. This is often due to the fact that very little change in the child is necessary. While the child is playing, the mother unburdens herself in another room to the social worker and commences to see her emotional reactions to the child in a new light. As a result she becomes less cruel. Reasonable correction takes the place of unreasonable, angry punishment, and true charity begins to dominate the family life.

Something of this nature took place in this case. In the first interviews with the social service worker, Mrs. X told many incidents of Tessie's stubbornness. She was trying to paint the picture of a hopeless case for which she could do nothing; and in desperation she sought help from the clinic without much hope of really doing anything for Tessie. She maintained that she treated her two children impartially—little 5-year-old Tessie and her 3-year-old sister. But she had only words of praise for the younger child and nothing but blame for Tessie. It is scarcely possible that she could have concealed her antagonism to Tessie and her preference for the little sister so effectively that Tessie did not perceive it. At the same time this rejection of Tessie was the psychological source of the child's stubbornness and disobedience. We like to defy the person who, as we think, hates and opposes us.

One incident the mother recalled showed that at all events Tessie thought that her mother had no love for her. Tessie had a cold and the mother went to the cupboard for a bitter and unpleasant family remedy. Tessie did not want to take it. The mother insisted and Tessie said: "You don't like me or you would not make me take that medicine."

On recalling this incident the mother said that at times she did have a feeling of intense irritation and anger toward Tessie. But she maintained that she had also the same feelings toward the baby. She said that severe dealing with Tessie was necessary because a mother must dominate the household.

One day the mother came in saying that she had given Tessie the hardest whipping she had ever had in her life. Immediately afterward she felt sorry for having done so, but she said: "My blood was boiling at the time and I whipped her so hard I know I hurt her, for she showed signs of feeling sore for some days afterwards."

There is a good foundation for the scriptural proverb, "Spare the rod and spoil the child." But one may well ask whether or not the proverb applies to a little 5-year-old child. There are times when corporal punishment is effective, but it should never be administered in anger. When a mother in a boiling rage starts to whip a little girl, she not only is likely to be cruel in the severity of her punishment, but she may also make the child think that she is "mean" and no longer loves her.

What was the incident that angered the mother and led to the cruel whipping of the little 5-year-old girl? The baby sister had wanted to play with a glass powder jar that the mother prized very highly because it was made in Germany. She feared that the child might drop it and break it and told her not to play with it. So Tessie spoke up: "Take it if you want to! Go on and take it!" and went on saying other things in this vein.

Mrs. X scolded Tessie, who turned around and said, "You are nothing but a mean old stinky anyway."

Then the mother boiled with anger and whipped the child unmercifully.

It would seem that a patient mother with good common sense would have found some other way of handling the situation. Many possibilities will suggest themselves on a little thought.

In dealing with the problem, the social worker asked the

mother: "Why do you think it was that Tessie spoke in that way to you?"

This was done to lead the mother to the realization that action and reaction are equal and opposite in direction; if one shows antagonism to a child, the child will show a reciprocal antagonism. The mother had manifested in various ways that she liked the baby more than Tessie and that there was something in her mind akin to a dislike for Tessie. Therefore, when the mother asked Tessie to do this or that, Tessie showed her antagonism by a spiteful "I won't."

Little by little the mother commenced to realize that she herself had a good deal to do with Tessie's stubbornness, disobedience, and resultant impudence. She noticed too that when Tessie went to visit her aunt, she was as good as gold. After she recounted this, the question was put to her: "Why is Tessie as good as gold when she goes to visit your sister, and stubborn and disobedient as soon as she comes back to you?"

Mrs. X replied: "I think it must be because I am the bear that brings out all the badness in Tessie. It must be myself. I am beginning to think I must be the cause. I wish I knew what to do. I can't change myself overnight."

She was commended for her courage in being able to face herself, and it was explained to her that some mothers are never able to do this and their homes remain scenes of endless conflict.

About this time Tessie commenced to soften up. The mother softened as well. Tessie was given a little more freedom to play in the yard next door with a little girl who, though a bit rough, was very fond of Tessie. At about this point the therapy had to be interrupted because the family was leaving town for the summer. But it had been essentially completed when the mother acquired insight into herself.

Some months later Mrs. X was asked to come in for a report. She was jubilant. Tessie's disobedience had disappeared except for occasional relapses, which after all were only human. Now, if the mother asks Tessie to bring her some little object,

the child seems glad to help her. She no longer whips Tessie at all. "I can talk to her instead," said the mother.

"Does she irritate you?" I asked.

"No, not at all. Three-fourths of the trouble was my own fault. I was more to blame than the children."

The mother's father has commented on the remarkable change that has come over Tessie. Part of the change may be ascribed to the new interest in life that was awakened by her first year in school and a very capable and sympathetic first-grade teacher. The mother was urged to play with her children and let them grow to be her best companions, and the case was closed.

3. The Neurotic Dependent

Quite the opposite of the problems that spring from not wanting a child in the first place are those that arise from over-attachment and an attempt to keep the child ever dependent on and united to the parent. Quite often a child's unwillingness to go to school arises from the fact that it does not want to be separated from its mother. In fact, a whole host of problems of childhood evolve from this infantile dependence of the child on the mother, and the difficulty sometimes persists into adolescence and beyond.

One must remember that the home by its very nature is a temporary expedient. It develops in order that it may disintegrate in due season and give rise to other homes, each destined to disintegration when it arrives at maturity. Like the grain of wheat, the family must die, or it will fail to perform the function for which it is destined. Some parents forget this and strive to keep their children dependent and unmarried, in order that the children may nurse them through senescence and become old themselves in the process. And some children for one reason or another become neurotic because they lack the courage to face the world, and try to avoid conflict by remaining shut up in the home.

Let us consider the following case. The patient was a well built, healthy-looking young man of about 25, who for two years had been hanging about the house complaining of pains in various parts of his body, particularly in the head and the heart. During this period he had been visiting a number of general practitioners and specialists, none of whom were able to give any permanent help. He went to a diagnostic center and was examined by a whole corps of specialists, who, having found no organic complaint, suggested that he see a psychiatrist.

His previous life had been simple and uneventful. After finishing high school he started a two years' business course in accounting, but did not finish. He said that the course was broken off on account of financial difficulties. But considering all the money he spent later on specialists' fees, the financial problem was probably an excuse. Had he qualified as an accountant, he would have had to leave his little country town, break loose from his moorings, and go to some fairly large city and get a job. And so he became instead a rural mail carrier and continued to live at home. His pains developed and he had to resign his job. He then invested some money in developing a chicken farm on the family estate, and so he lived close to his father and mother and sister, of whom he was very fond and who were deeply attached to him. The chicken farm did not yield enough profit to pay his own personal expenses, but it served its purpose—it kept him at home.

But then there developed a complication. He fell in love with a friend of his sister and the girl fell in love with him, and they wanted to marry. The girl was foolish enough to want to marry with no better outlook for support than the chicken farm. And that might have been considered seriously had not the patient's sister noticed that he showed a good deal of attention to the girl, who spent a weekend at their home. His sister turned on him and they had a quarrel about his showing special attention to the friend. The result was that the patient's pain became so great that he could no longer go out with his girl, and

he furthermore became perfectly frigid toward her, even though he could not give her up in his mind and was unable to put out of his head the idea of an eventual marriage.

The patient had entered on an acute emotional conflict. He had a long-standing tender love for his sister and an infantile love for his mother and could not bear the thought of separation from the family circle. He could not marry the girl and live at home because of the antagonism of his sister. He could not get a job, though physically capable, for he could not bear the thought of leaving home even to marry and live in peace with the girl he loved.

And so there was an emotional reaction which brought back his old pains. These pains had subsided after a previous period of psychiatric treatment, which, however, did not solve the crucial problem of his life. Ever since the quarrel with his sister about the attentions he was showing her friend, the old pains had troubled him again. But he said that they were on the opposite side of his head. He described the pains as "a tension between my head and my heart" which, it will be noticed, is a symbolic expression for his conflict between the logical answer to his problem—getting a job and supporting himself and a wife—and the emotional drive to remain permanently attached to his home surroundings.

The treatment consisted in conversation with the patient in which he was encouraged to give full expression to his inner conflict. He told of spells of despondency, and when asked to express what was in his mind during these spells, he spoke of the "don'ts" he had had to contend with from his family all his life. And then he talked of the love he bore his mother and sister and how he could not bear the thought of doing anything to hurt them. And then there was the thought of the girl and his desire to marry her and her desire to marry him. There were various characteristics in the girl that in some way reminded him of his mother, and a certain fear that if he married the girl he would marry his mother. It was pointed out that

a boy deeply attached to his mother is likely to be attracted by a girl who is in some way like her, but that this obviously had nothing to do with marrying his mother; that such a thought was a kind of dream association which had no place in waking life.

He dreaded marriage also because he feared to break away from home. He rightly felt that he could not marry and continue living at home. The conflict led at times to spells in which he thought he was going to die, and then he lost all "sense of consciousness." The spells came on particularly when he thought about getting away from home and attaining his freedom.

The patient was told after a few interviews that he now understood himself and it was for him to utilize this newly acquired insight as seemed to him just and reasonable. Several weeks later he called to cancel his appointment because he had taken a job and gone to work. Some time after this I received an invitation to his marriage, which took place in due season; and, as far as is known, he and his wife have lived happily together ever since.

4. Play Therapy and the Unruly Child

The following case illustrates several emotional mechanisms common in young children. It also presented a problem which seemed to offer little hope for successful clinical therapy.

Mildred was a child of 5, whose problem on admission was soiling and bed wetting, night and day. Her mother was in an insane asylum, her father in prison, and a brother in a public institution for the feebleminded. Mildred herself had an I.Q. of 82 on the Terman-Merrill form L, and on the Leiter performance test an I.Q. of only 44; but the latter test often gives a score well below that of the Terman-Merrill test. Her failures on the performance test were due to lack of attention and of a serious desire to carry through.

Her most troublesome difficulty was the soiling. She not

only soiled the bed on waking in the morning, but also in the course of the day would soil various articles in the room—pots, pans, buckets, or anything that might look like a receptacle, and even the window sill, in spite of the danger of falling to the ground below.

She was a ward of a public agency which had removed her from one foster home and placed her with another woman, who felt that she would be able to train the child in toilet habits. For some weeks after the removal there was marked improvement and it seemed that normal toilet habits were about to be established. A worker called at the home and in the child's presence the foster mother spoke of the success she had had in overcoming the bad habits of the child. There may have been a tone of boasting in her remarks; at all events, Mildred promptly returned to her old habits and commenced to soil all sorts of things in the room, such as a baby carriage, a box for toys, a toy basket, etc. This behavior continued up to the time when the child was brought to the clinic. Whipping had no effect. The foster mother would wake the child early in the morning and spend an hour or more trying to make her empty her bowels; finally the woman would give up in despair and return her to her bed. She would discover a little later that Mildred had soiled the bed.

This type of behavior is a good illustration of *infantile negativism*. It may be the forerunner of a schizophrenic condition. It will be noted that the child's mother was a patient in a mental hospital. The child's behavior represents a type of vanity common in some measure to all men. If anyone boasts that he will make us change our ways, we are likely to become stubborn and show him that it can't be done. This is particularly true of children. In one way or another a parent or teacher expresses to the child the resolve, "I am going to make you change," and the child responds by saying, "You won't."

The fact that the child was almost free of its bad habit of soiling when the foster mother spoke, perhaps boasted, in the

child's presence, of the success she had had in overcoming the child, seems to indicate that we may well regard the resumption of the soiling habit in full force as a manifestation of an infantile drive in the child to show the foster mother that she was determined not to be changed by her or by anyone else.

The whippings proved in this case to be ineffectual. They may well have developed a feeling of antagonism to the person who administered them. It is only natural that untrained little children should often manifest the aboriginal drives of the animal in man. It is natural to want to get back at someone who makes us suffer. And the only way in which the little child can get even with an adult is to find something which thoroughly exasperates the antagonist and to persist in doing it, no matter what happens.

According to Freud, a very young child takes a certain amount of pleasure in soiling, which most adults find it very hard to understand. Were this the only element, one would expect the habit to have died out when the whippings made it no longer worth while. But the foster mother's boasting and the whippings seem to have introduced an element of negativism into the child's resistance, which, perhaps because of a native schizophrenic temperament, was of more importance than ordinarily would have been the case.

Someone will say, however: "Why should anyone put up with such behavior? Whip it out of her and be done with it!" The answer to this is that such measures often make things worse. Frontal attacks are sometimes very costly, and, even when the costs are paid, may fail in the end. One can often succeed in a surprising manner by more roundabout measures.

But how often do we see mother and child locked in irreconcilable conflict! Such conflicts occur more readily between stepmother and stepchild and thus lead often to a demand that the child be placed for permanent care in some kind of institution. Yet with a little tact the bitterest conflict can often be resolved.

In our present case there did not seem to be any very bitter conflict. The foster mother was trying to do her best, and though she thought of returning the child to the agency, she professed what was probably a genuine willingness to keep on trying. It is quite possible, however, that the child in some way got the idea, from a chance remark or threat, that she was not wanted, and so the normal fixation of tender affection on some adult, so necessary to every child, was blocked.

Those unfamiliar with the methods of child psychiatry might well ask: What can be hoped for by bringing a little child of 5 once a week to spend a whole hour with an adult, a physician? Will the child understand anything the physician will say? And if by any possibility it should understand, will it heed? This gives us an opportunity to introduce the student to the technique of psychotherapy with children.

In view of the fact that a child's mental problems have a very intimate dependence on the mental difficulties of the adult who cares for him, the therapeutic process may well take the form of parent and child coming to the clinic together, the parent to be seen by one member of the clinic staff, usually a psychiatric social service worker, and the child to be seen by another member, usually the psychiatrist. This separation of parent and child in the clinic is often an important part of the therapeutic process, especially in the case of the overprotected child who clings to the mother and is fearful of even a moment's separation. This dependence, as we have seen,* unless broken, may grow on into adult years and lead to development of the child into a neurotic individual so tied to his home that he cannot go forth and take his place in the world.

And so Mildred came to the clinic with her foster mother; Mildred saw the psychiatrist, and the foster mother was interviewed by a psychiatric social service worker. The first psychiatric interview was initiated by asking: "Would you like to see my dolls and their pretty doll house?"

* See above, pp. 186 ff.

The clinic has a rather large playroom with a doll house consisting of a bedroom and kitchen, each room appropriately furnished. In the playroom there are also a couple of workbenches, blocks, games of different types, toy soldiers and figurines of various kinds, a small children's library, a blackboard supplied with colored chalk, water color paints, an easel, a table and chairs, a box filled with sand, a toy spade and bucket, and a basin with hot and cold running water.

Mildred toddled along to the playroom. When she saw the dolls she picked one which was decidedly the prettiest, and said, "I am going to keep this one." She merely hugged the pretty little doll and did not indulge in anything like active play, then after a few minutes said, "I want to go upstairs."

So I said, "Come on, let's go back upstairs," and then, "Oh, would you like to see some toys?"

Of course, she wanted to see the toys. At once she became interested in the blocks and was very much delighted in building a wall with them. Then she said: "I want to play with the dolls."

I picked up from the crib the doll she liked best and said, "Do you think this dolly has been bad?"

She nodded her head and said, "She is a bad dolly. Whip her."

I said, "She is such a nice dolly, I don't want to whip her. Do you really think she needs to be whipped?"

She nodded her head vigorously and said, "Yes!"

Whereupon I said, "No, I think I shall ask her to be a good dolly."

Perhaps this forcing of the problem in the first interview was unwise. The taking of the doll from the crib and asking if she was a good dolly must have brought up in the child's mind the problem that had brought her to the clinic.

When the child informed me that the dolly had been bad and should be whipped, she revealed something which up to that time had not been mentioned by the foster mother. Chil-

dren in their play often attribute to a doll their own faults of conduct and administer in good measure to the doll the kind of punishment which they themselves have received. From the child's play one often gets a good idea of the way in which the child has been treated by parents or teachers. Thus one child, naming the dolls and giving an account of their conduct, said of one, "Mary has been very, very sassy and you must scold her."

Another child, who had often been a truant, while playing school picked up a figurine representing a boy, stood it up before the teacher's desk, and said, "You must write 'Egypt' three thousand times," and then turned to me and said, "You know, I had to write 'Egypt' a hundred times."

And another, whose father was often drunk and caused endless trouble at home, when fixing up the doll house said, "The house is just for me and my children. There aren't going to be any fathers in my home."

We must not be surprised at all if little children wreak on their dolls in good measure the punishments that they have received from their elders. It is one of the fundamental principles of child psychiatry that children, until trained to think otherwise, want others to suffer all and more than they have suffered themselves. It is an acquisition of intellectual character when a person really feels that he would do anything in the world to spare others the trials through which he himself has gone. But unless one rises to the level of this principle, there is a pathological defect of development in his moral and intellectual character.

Two or three times during this first interview Mildred appeared a little frightened or tired and said, "I want to go upstairs."

This was always answered at once by, "Come along, let us go," and then, "Would you like to see this or that?"

This stimulated a new interest and an hour was spent without any real difficulty.

But in subsequent interviews she did not as a rule want to go upstairs at the end of the hour. At first, her play was in general to take things apart, to undress the dolls, to go quickly from one thing to another. But in the second interview she did try to make up the dolls' bed, examining carefully the underlying pad, as perhaps her mother did in the child's own bed to see if the pad had been wet or soiled. Mildred used to unpin the pad in her own bed and soil underneath it.

In the third interview she set the table, put water in the toy teapot and sand in the kettle, and mashed it with the little potato masher. She put some sand on a little plate for me and seemed much delighted when I pretended to take it.

She was once allowed to take her favorite doll home, and then an animal picture book. In general, she merely amused herself in the hour of play therapy. There was very little that could be looked upon as play analysis, and no attempt was made or really could be made, with this little 5-year-old of retarded mentality, to interpret to her any of her play.

In the fifth period, when asked if the dolly had been bad, she answered: "Not very bad."

And that expressed what had happened. Some real therapy had taken place. The soiling had stopped completely for several weeks, and the bed wetting was very much reduced. There was improvement in various other ways at home. She was more interested in using crayons—scribbling and trying to draw pictures. Formerly, when given a crayon, she would mark up the furniture. Now, if a crayon was given to her, she would ask for a piece of paper. She told the other children when they went off to school that she was going on Monday—the day of her clinic appointment.

What was the reason for the improvement that had taken place in only five periods of play therapy? The child had grown, someone might say. But this can scarcely mean anything more than to say that a change had taken place, and that is a mere restatement of the fact that therapy had taken effect.

Growth in the sense of maturation of powers and function could scarcely have attained significant proportions in so short a time. Perhaps what had taken place was only a change in attitude, which led to at least a temporary cessation of a voluntary piece of behavior which essentially was an act of childish revenge.

The child enjoyed her hour of play very much. She often spoke of her play as going to school, a status that the little 5-year-old looked forward to, so as to be on the plane of the other children in the home. The foster mother brought her to the clinic, and this to the child was a proof of love and interest. The scoldings and whippings had seemed to show a lack of all personal love and interest; they appeared perhaps to the child to express merely meanness and hatred. And so she had reacted toward what she regarded as "being real mean" by her act of revenge, which she saw to be quite successful by observing the exasperation of her foster mother. Further scoldings and whippings would have perpetuated rather than put an end to these acts of revenge, which from the child's point of view were eminently satisfactory.

But the foster mother had done something that showed her to the child in a new light. She had gone to the trouble of taking her "to school" and of giving her a happy hour of "schooling" in the clinic. That of itself eliminated the need for revenge, and the soiling ceased. Some months later there was a temporary relapse in the enuresis, which seemed to be an act of revenge.

If our interpretation is essentially correct, perhaps mothers could correct many disorders of behavior by playing with their children themselves, not as a reward to the children for being good, but just as if they loved the children for their own sakes and wanted to play with them. Mothers know far better how to play with a child than any psychiatrist; but unfortunately they sometimes allow antagonism to develop, and charity, the formal principle of organization in the home, is inhibited, and

hatred gives rise to revenge, and the acts of revenge are the disorders of conduct. Not all disorders of conduct will have this defect of charity as their specific cause; but many can be understood only in this light.

Parents may themselves profit by a study of Mildred's behavior and correct many other disorders of conduct indirectly by changing their own attitude toward their children. By play or in some other fashion they can demonstrate a genuine love for the child which will automatically lead the child without scolding, lecturing, or punishment to see things in a new light and so to correct its fundamentally voluntary and deliberate deviations of conduct.

Chapter XI

MENTAL THERAPY BY FAMILY REORGANIZATION*

The family may be looked upon as a small social unit which provides for the physical, mental, moral, and spiritual welfare of its members. Under normal circumstances the earnings of the father procure adequate food, clothing, and shelter for all the members of the family. These material things are not an end in themselves, but the foundations on which something of true value may be erected.

The necessities of life provided by the father must be administered in an orderly fashion. This household organization (by virtue of which the house is kept neat and in order, meals are well prepared and served with fair promptness at a specified time, and clothing is properly cared for) is ordinarily the function of the mother.

If these things are properly organized, there is a background of physical comfort and mental peace in the home, in which it is possible for the child to develop mentally, physically, morally, and spiritually, and attain to a full share of normal human happiness.

Something else, however, is implied in this family organization. This is the organization of the inner mental life of the parents. They have their ideals in life; they have a purpose, and they are organizing their family so that it may make a contribution to the welfare of society. This inner self-organization gives them an understanding of their children and a warm personal love for each child.

The result is that family organization gives fixation points for the affection of the children, and there is a mutual love between parents and children and between any one child and

* This chapter is taken from "Family Organization and Mental Problems," *Living*, November, 1940, p. 100. It is reprinted here with some modifications and additions, with the permission of the editor.

every other child. And so there develops within the household a self-sufficient social unit surrounded by the cloister of the home. In such a home the normal recreation of each member is found within this family cloister. The home is truly a home, not a sleeping-place from which the members disperse to find their interests in extraclaustral pursuits, satisfying the human craving for companionship to a major extent outside the circle of the family.

This does not mean that the family draws back utterly into its home life and has nothing to do with the outside world, for it is the function of the parents to maintain their own social contacts and to provide proper social relations for the children from a very early age, so that when the time comes for the child to go forth, he goes into a world with which he is already well acquainted and in which he has a number of old friends keenly interested in his welfare and anxious to help him to enter upon and succeed in the career he has chosen.

When the word *career* is used in this connection, one must not think of it as limited to the upper levels of human endeavor. It is a word that will take on different meanings in various social levels of family life. It is the function of parents not only to direct the child to an end that is worth while, but also to select that end wisely so that they will be able to help the child to attain it, and to make home teaching of such a character that the child will not look down upon a career within his capabilities, even though it is not at the peak of certain popular scales of value.

Some years ago a woman of 39 was brought to the clinic because her home was inadequate. Her husband was a hopeless alcoholic and had deserted. Her 17-year-old boy had been in the juvenile court several times on charges of disorderly conduct and taking the property of another; she herself appeared to be a mental patient who should be committed to an asylum. A study of the case revealed another complication, namely, epileptic seizures coming on at night, often follow-

ing acute emotional incidents in the day. Their occurrence was proved by the patient's bitten tongue and the blood found on her pillow in the morning.

The simplest procedure might have been to commit the children to an institution and to send the patient to a mental hospital. This procedure was, in fact, urged by a social agency. A superficial study might have led to diagnosis of the mother as suffering from a depressed type of psychosis, with suicidal tendencies. In the first interview the patient was evidently sad, scarcely smiled at all, and sobbed at times. There was a history of two attempts at suicide by turning on the gas, following an argument with her husband. However, a bit of psychotherapy tided over this acute condition, and several years later the patient again came to the clinic for treatment. This time the chief problem centered in the younger children. Both were retarded, disobedient, unmanageable, and antagonistic in school. The mother could not endure the noise they made in the house when they came home, and the whole situation made her tense and irritable.

It was thought that reorganization of the home life might help in the mental problems of the mother as well as those of the children. The mother and children visited the clinic, and a social worker called at the home. The mother was persuaded to devote the morning to setting the house in order, and to sleep for at least an hour before the children returned from school, so that she would be fully rested and more able to endure the noise of her happy children. The social worker visited the home regularly, attempting to bring peace and order out of discord and chaos. It was arranged, after a bit, that the day in the house should commence quietly with short morning prayer. The children were encouraged to get good reports for behavior and academic work in school. The older boy was given an interesting story book, to stimulate progress in reading. The mother arranged to have an hour of quiet before bedtime in which the children could do their homework, and

she was encouraged to help the younger child with his reading. And the day closed in peace with evening prayer. For seven months the social worker visited the home at regular intervals, and the mother and children came to see the psychiatrist at the clinic from time to time.

Reorganization of the home was followed by disappearance of the behavior problems of the children in school. Except for tears at rare intervals, the symptoms of the mother's depression vanished, and there were no more epileptic seizures. She gained in weight and presented the picture of a normal woman. Reorganization of the home gave the mother an attitude of security and the ability to stand alone and make her own decisions. The children reacted well to a more stable mental environment and commenced to take a personal interest in their own progress in school.

The case just presented might be taken as an example of how external organization of the home—regular times for rising, retiring, meals, play, and study—may be a factor in clearing up the behavior problems of the children and the mental condition of the mother. Epileptic attacks are sometimes precipitated by acute emotional conditions, and anything that leads to general peace and happiness in the home may even overcome a tendency to epileptic seizures.

There is, however, another element, and a more important one, in family organization. This is the very soul of the home, the love that is given and received and passes freely and abundantly from each to each without any exclusion whatsoever. There is no reason in the nature of things why any human being should hate any other human being; it is particularly inexcusable when any parent allows to develop in his or her mind a feeling of hatred toward a child. The following case will illustrate such a situation.

Julia was a pretty little girl of 4. She was taken to a neurologist, who listened to her mother's story, examined the child's eyegrounds, tested her reflexes, and expressed the opinion that

she should be sent to an institution for the feebleminded. She was brought to our clinic so that confirmation of the diagnosis might be made and final steps taken for her commitment.

The mother stated that the child, though 4 years of age, talked little but could pronounce some words, and did not seem to understand what was said to her. The mother complained that the whole family was tense because of the presence of this little 4-year-old in the household. In the preceding six months, a change had come over Julia. She had become aggressive, fought back, and did the very opposite of what she was told. She was very spiteful, and when told to go to the toilet would deliberately go to her father's bed and wet it.

Our first procedure with the child was to put her in a playroom. Her silent interest in toys seemed to indicate a mentality somewhat higher than that suggested by the mother's story. It was decided to investigate the home life before going any further. This led to the discovery of a number of important facts that had much to do with the child's abnormal conduct.

From her earliest years Julia had witnessed quarrels between her mother and father. The father prides himself on being a self-made man. His schooling had not extended beyond the eighth grade, but he had been an assiduous reader since then, and felt that he knew far more than his wife about how children should be cared for. He demanded conformity with his orders, and, if this was not forthcoming, he slapped his wife and on one occasion had given her a good spanking. What was freely administered to the mother was much more frequently given to the child. The father had read in the newspaper Angelo Patri's advice about curing a child's temper tantrums by throwing a few drops of water in its face. "If a little is good, a whole lot is better," is a dubious principle, but it seems to have found its way into the father's mind. Hence from time to time he would throw a whole glass of water in Julia's face. The mother professed great interest in the child's welfare and

wanted to have her placed in an institution for the feeble-minded. However, our investigation disclosed that Julia was not treated as were the other children. The two boys were washed and dressed and brought down to dinner, but Julia was left to care for herself in the back room upstairs. She had formed the habit of standing for hours there in a rather fixed attitude, resting her arms on a table. Once when her father was punishing her, Julia said to him, "I hate you, Daddy."

And the father replied, "I hate you too, Julia."

Our first attempt at a mental examination, if taken at its face value, indicated an I.Q. around 50. But the child did not cooperate well, and one must be careful about the interpretation of the results.

We persuaded the mother to put Julia in a small nursing home where there were a number of children 2 to 3 years of age. Here Julia played with the children all day long. She talked incessantly, and seemed to understand everything that the nurse said to her. She tried to imitiate what the nurse did: for example, she got a cloth and washed the beds, as she saw the nurse doing. She even tried to handle the mop and clean the floors. She would run and get various things she was asked to bring and seemed to behave like a normal child. There were no crying and temper tantrums to be dealt with by such an enthusiastic method as dashing a glass of cold water in her face.

But clinic advice is not always taken, and Julia's father said that he was not going to be separated from his daughter, and took her from the nursing home and returned her to her solitude in the garret. What has been said about Julia makes it abundantly evident that when love, the soul of the home, is lacking, it can work havoc in the mental life of a child.

During the ten days that Julia was in the nursing home she gained 6 pounds, showing that for some reason she was very much undernourished in her attic environment. It was evident that the child could be saved only by removing her from her home into a more wholesome environment, for social work with

the parents had failed to change their attitude toward and treatment of the child. After a year of negotiating we arranged for her reception at St. Gertrude's, a home for retarded girls at Brookland, D.C. No child so young had ever been admitted before, and it was necessary to take in another child of about Julia's age, that she might have a suitable play companion.

What a change from her solitude in the attic to the companionship of other children! Now Julia found an outlet for a child's emotional life. She laughed, she talked, she played. At first she often stumbled and fell in play, but she was soon running about, and even climbed into the swing and "pumped" herself up to what must have been giddy heights for a child of 5.

After 18 months Julia was given another mental test, and her Stanford-Binet I.Q. had climbed from 50 to 65, even though at the time of the second test she had been only about six months out of her attic. She was allowed in the kindergarten class from the first, but soon took to reading. When she sees me in the hall she is likely to run up and say, "Come and hear me read." She soon read first-grade material with ease. A mental test two and a half years from the time she was first measured gave her an I.Q. of 79.

In spite of criticisms in various quarters, I have been profoundly impressed with the recent results of a number of workers showing that removal of a young child from a dull, listless environment into one replete with the joys of childhood may bring the I.Q. from the region of moronity well into the region of normal intelligence. These results indicate that Julia's low I.Q. may have been due more to lack of affection and of the ordinary joys of childhood than to the biological action of faulty heredity. If all this is so, home organization may be a factor not only in peace, happiness, and emotional stability, but also in intellectual development. The intellect of man works through his senses. The proper development of that internal synthetic sense on the basis of which our higher thought processes function, demands appropriate stimulation in the early

years of childhood. This stimulation is not to be found in the solitude of an attic, and normal mental growth is inhibited by years of unkind treatment of a child, whose fundamental craving is a point of fixation for its affections.

We have so far given examples of the importance of the material organization of home life, with its provision of a stable routine, and of the essential necessity of love as the organizing principle in the family. Serious defects in either the material or formal factors in family organization may lead to grave mental disorders in the parents and children. We have also called attention to the intellectual element that is necessary in the organization of the inner mental life of each member of the family. By that I mean the profound importance of a goal concept, or, in other words, the necessity of the family's realizing that it exists for a purpose. This purpose of the family is to enable each one of its members to attain his or her end in life. A full realization of this purpose can only be achieved in the light of eternity, and so religion enters into family organization and becomes a powerful factor in the stability of the home and in the peace, happiness, and wholesome living of parents and children.

Anyone who finds his place in life and realizes that he has a work to do, and that life is barely long enough for its accomplishment, has the necessary basis of a stable mind and, barring accidents and gross neglect of the principles of mental hygiene, is likely to pass through life without any major or minor mental disorders. It is the function of the family to guide each of its members to this happy end. Most often one's everyday work will not be his main end and function in life, but the means by which he attains his end: the organization of his own family, which in turn will give rise to a new progeny of healthy seedlings that will grow into stable family units.

Any psychiatrist will be able to recall a number of patients whose minds are illumined by no concepts of eternal value, whose strivings center in themselves, and who live therefore for

personal satisfaction. If we go back into the life histories of these creatures, whom we often term constitutional psychopaths, we find the spoiled child who from early years was protected from reality rather than introduced to life and who was allowed, like Swinburne, "to live at large and stray at will" and then "to flush with love and hide in flowers."[1]

Considerations such as these, and the examples I have made use of, point out clearly that family organization is a major factor in mental hygiene. The world needs the well organized, stable family. It needs this for the sake of the children of tomorrow. It needs it as an example, so that all other social units may be given a structure that is closely analogous to family organization.

[1] T. V. Moore, "A Study in Sadism: the Life of Algernon Charles Swinburne," *Character & Personality* **6**: 4, 1937.

Chapter XII

EDUCATIONAL THERAPY*

When a child presents a behavior difficulty, we should try to find its source. In doing so, it is natural to investigate the interpersonal relationships in the family. At the present time this source of maladjustment is usually thoroughly investigated in child guidance clinics. Another source of abnormal behavior lies in the child's contacts with playmates or others outside the home. And then there is the neighborhood in which the child lives. This is particularly important in juvenile delinquency. Several studies have shown that certain rather limited areas in large cities contribute, for various reasons, more than their share of delinquents to the juvenile court. But one should never lose sight of the fact that the child himself is a free and responsible agent, that his conduct is not entirely determined by external factors, and that we must try to influence the child as well as to modify his environment.

Finally, we would mention maladjustment in school as a source of abnormal behavior. This maladjustment may arise from emotional tension between teacher and child. The teacher who is easily angered and does not take a kindly personal interest in each pupil is likely to be responsible for the development of many behavior problems in her classes. At times the source of the maladjustment is simply the fact that the child's mentality or educational achievement is not on a level with the grade in which he is placed. The child's intelligence may be a year or more above the level of the grade in which he is working. That which appeals to the children in his grade is too simple to interest him. And so he dawdles away his time, teases those who sit near him, gets tired of school life, becomes irritable through sheer monotony, and then takes

* T. V. Moore, "The Work of the Catholic Clinic for Problem Children," *Nat. Cath. Educ. A. Bull.*, vol. 37, no. 2, 1940.

to truancy and slips into various forms of delinquency. Often the irritability developed in school carries over into home life and he displays tantrums and is generally "incorrigible."

Sometimes, especially where home life is essentially wholesome, merely advancing the child to a grade on a level with his mentality will do away with his abnormal behavior in the classroom. With good adjustment in school, the child's emotionality simmers down and he soon ceases to be a behavior problem at home. Such a procedure will generally require some coaching to make good special deficiencies, but it is the most effective manner of treatment when it is indicated. Sometimes the principal of the school will refuse to advance a supernormal child, maintaining that he is dull or a moron. It may be necessary then to transfer the child to another school.

Some years ago an eminent scientist and his wife, who also had a Ph.D. degree from a well known university, came to me in great distress. Their two children were said by the teacher to be unable to make progress in school, and the boy particularly, because of his violent temper tantrums, was a disciplinary problem at home. On mental examination it was shown that each child was in a grade from two to three years below its mental level. I recommended that each be given a little special coaching and moved up two grades, but the principal refused to carry out the recommendation. The children were then transferred to another school, coached, and put in grades on a level with their mentality. The misconduct in class ceased at once and in a little while there were no more temper tantrums at home.

More often it is the dull or feebleminded child, who cannot appreciate what is going on in class, who becomes a behavior problem. Special schools and special classes for retarded children can cite any number of cases in which the truant suddenly ceased his truancy and became an interested and regular attendant at school when he was given work that he really could do and appreciate.

Quite frequently we come across a child that has a normal or supernormal I.Q., but is afflicted with a special disability in reading. It is easy to see the result. His "arithmetic reasoning" appears to be low simply because he can't read and understand the problems he is given to solve. He cannot learn geography or history because he cannot read the text. It is surprising how at times such children get along by listening and getting others to read for them. I remember a physician who told me how he had been hampered all his life by a reading disability. He could never have gotten through medical college had he not married very young and had a patient wife to read his texts to him in the evening.

Obvious as these disabilities are, even the psychiatrist will at times muddle a case by not looking for them, or even by neglecting them when the test results appear in the history. I remember one case of this nature. The symptom presented to the clinic was lack of attention in school. The psychiatrist seems to have looked upon the case as one in which the child had not yet emerged from the identification of himself with his mother, and proceeded to give the child independence by a series of interviews in which he saw the child, while a social worker saw the mother. Nevertheless, the educational tests showed at the time that the child was reading on a level two years below his grade placement, though his average I.Q. on several tests was about 90. After some months of this treatment, the child was naturally still inattentive at school and uninterested in books he could not read.

It is as much a mistake for a child psychiatrist to neglect to look into and evaluate the data concerning a child's mental level and educational adjustment as for a physician to ignore such things as blood pressure and urinalysis in a general physical examination. While it would be a mistake to give a cathartic in acute appendicitis, it would also be a mistake always to operate for appendicitis, when in some cases the patient needs only a cathartic. On the other hand, as the following case will

show, it is often profitable to give the parents a certain amount of psychotherapy when one decides to advance the child a grade or two in his school work.

James, an 8-year-old boy, was referred to the clinic by an excellent pediatrician, who felt that the boy needed special treatment scarcely to be obtained outside of a children's mental clinic. The main problems that James presented were: (1) poor school work—he was doing "absolutely nothing" in school, getting poor marks in all subjects (the pediatrician urged that he be put in a higher class, but the principal would not consider it because she believed that stupidity was his fundamental difficulty); (2) inability to get along with the other children—he was noisy and restless, hostile toward his parents and his teacher, and there was some evidence of sex play with other children, both boys and girls.

In any such problem, we must study (*a*) the child's mentality, and (*b*) the home situation.

Mental tests showed that James was not a dull child, but one of supernormal mentality. On the Stanford-Binet test he was almost two years above his chronological age, and had an I.Q. of 124. On the Arthur performance scale he had an I.Q. of 113. Hence there was no reason to be found in the child's native mentality for his poor school work. The pediatrician's surmise was correct: the child was in a grade well below his mental level, and therefore the school work was uninteresting. But this was not the only trouble. The home situation was an even greater cause of trouble. It was in studying the home background that the social service department gave a demonstration of its importance in clinical work.

The child came to see the psychiatrist, but there was not much response; and in this particular case the psychiatrist soon dropped out of the picture and the treatment was carried out by the social worker. It was true that the child was hostile toward his parents, but it was equally true that the parents were hostile, in a sense, toward the child. The father thought that

he had a moron for a son, and had had little or nothing to do with his boy, devoting his time to preparing for examinations through which, if he were successful, he might hope to gain a more advanced position. The mother had for some reason disliked the child almost from his birth; the dislike had grown to such an extent that she admitted that she did not want to hear anything good about the boy. Evidently the attitude of the parents toward their son would have to be changed. This was accomplished by the social worker's talking with them from time to time. The mother became quite confidential and in one of her conversations revealed the fact that she had suffered a good deal in her own childhood from the coldness of her mother. This made it possible for the social worker to point out that James suffered now even as she had then. As a matter of fact, this was true and was largely responsible for the child's not getting along with others. One day he said: "Mother hates me; therefore everybody else does, too."

So he often played by himself and gave himself up to idle daydreaming.

Gradually the mother came to take more interest in the child. It was suggested that, when he came home at night, they should stop harping on the duty of doing his homework and play games with the boy "that might involve directions which he could follow." When the father learned that his boy was not a stupid moron but a supernormal child, he became much more interested and the games were started. The ice between parents and child was broken. The child enjoyed his evenings at home. He was promoted two grades in school. His behavior difficulties commenced to disappear, and now his problem had found a solution. He loved his parents and his parents loved him. His school work was suited to his mentality, and so it interested him. He had ceased to be a behavior problem and an educational misfit. In the meantime, his mother had become less neurotic and self-centered, and she had multiplied her social contacts. And the father was

delighted to know that his son was a promising child who could go ahead in school and gave good reason to hope that he would succeed in life.

Special reading disability often terminates a scholastic career prematurely. This early end of the child's school life is likely to lead to delinquency. If, however, the reading disability is corrected, not only the supernormal but even the subnormal child may make wholesome progress in school.

The following case exemplifies this point.

Charles was brought to the clinic by his mother at his teacher's request, because he was unable to read, though he did fairly well in other subjects. His inability to read had led to a general attitude of hopelessness in all school work, and then, perhaps by way of compensation for his disability in class, he teased the little children and got into fights on the playground. When he was given his mental tests, he appeared to be a boy of borderline intelligence, with a Stanford I.Q. of 71 (chronological age, 13.6; mental age, 9.6) and an Arthur performance mental age of 9.8 and I.Q. of 72. In general, we take in our remedial reading class only children of normal intelligence, and Charles was on the verge of being rejected; but his mother pleaded and the boy himself begged to be allowed to come to our clinic school, and so he was accepted. When given his educational analysis at the clinic, it was found that he was reading on a lower-second-grade level, due largely to the small number of words he could recognize by sight, to his inability to analyze a word, and to the resulting lack of confidence.

Charles entered the clinic school in December. The following February he was doing upper-second-grade reading. In March he was reading on the third-grade level and in April he tested fifth-grade. This level was maintained in May. In September he entered the sixth grade, and subsequent reports showed him to be doing well.

In the meantime he had lost his sense of incapacity, and was glad to read aloud in class when called upon, whereas formerly

he did not dare to try. He stopped teasing the little children and fighting on the playground and got himself a Saturday job at which he earned three dollars a week, to the great delight of his father.

It is a very likely surmise that if Charles had not been lifted out of his reading disability, his education would have been terminated prematurely, his behavior problems would have increased, and his whole future would have been marred by what might well have been serious delinquencies and general incapacity.

Two brothers were brought to the clinic because they were unable to make progress in school: Carl, aged 9.5, with a mental age of 11.2 and I.Q. of 119, and Everett, aged 7.7, with a mental age of 8.4 and an I.Q. of 110. Evidently the intellectual endowment of these two boys was not the reason for their backwardness in reading. Further study revealed that Carl had had what appeared to be an unsympathetic teacher when he was in the first grade; and Everett had shown, for some reason, a pronounced disability in reading from the start. Furthermore, the size of the classes made it impossible for the boys to receive special attention from their regular teachers. The problem was complicated by a mother who was continually getting after the boys at home and nagging them to get good marks. This made the children tense in the schoolroom and afraid to make mistakes in class. This fear, coupled perhaps with that special disability in reading which seems to afflict boys about ten times as frequently as girls, created a serious situation which was in danger of wrecking the educational careers of two boys of supernormal intelligence.

It was evident that the boys needed remedial teaching. It was clear also that the mother needed some enlightenment as to her manner of dealing with the children. The boys therefore came to the remedial class and a social worker interviewed the mother.

Gradually the mother became less anxious, and their teacher

reported that the mother was not pestering the children as she had previously done. Furthermore, the remedial teaching was completely successful, and in about six months the children were returned to a full-time schedule in their own school. Having learned to read, they had no difficulty in making further progress in school work.

Truancy will often yield to the new interest in school which is awakened by overcoming a reading disability.[1] The following case is illustrative.

Elmer was a boy of 12 years and 7 months, small for his age, and thoroughly dissatisfied with school. At the close of the scholastic year he had failed in all the subjects for his grade, 5A, in spite of the fact that he had been in the class for two semesters, and by various tests had been shown to be a boy whose mentality was slightly above normal. In spite of his good mentality, he was woefully deficient in reading and thoroughly disliked books of all kinds. At the suggestion of the school authorities, his mother brought him to the clinic to see what could be done for him. Disliking school work, he had become a confirmed truant, and would even wander away at times, being absent from home for ten to fifteen days. In one of these episodes of wandering he reached New York, and by climbing the fences got into the World's Fair. Life of this kind was much more appealing than school, where, in the opinion of his teacher, he was a very "irritating boy" who did things just to annoy her. So at least it seemed on the surface. But when Elmer came later to talk over his problems with the remedial teacher at the clinic, it appeared that his wanderings were prompted not so much by a desire to fly from an unhappy situation as by mere curiosity to see the outside world.

In our treatment of this case, the social worker had to "sell" Elmer the idea of going to the Catholic University Summer School for Children, and his teacher had to interest him in the

[1] Others have also noted this fact: e.g., E. H. Stullken, "Retardation in Reading and the Problem Boy in School," *El. Engl. R.* **14:** 179, 1937.

summer school work, so that he would come to class and not play truant as he had done during the regular term. Both ends were successfully attained. One idea that helped was that if he passed his sixth-grade test, he would not have to go back again to the fifth-grade teacher. Arithmetic was made more interesting by being based on geography and the costs of travel. The result was that he did not miss a day of his class in the summer school, and in September he passed his sixth-grade examination, and so escaped from the teacher who had said that he was just a hopeless, bad, annoying boy.

Some time after school opened, Elmer met his remedial teacher of the previous summer. He greeted her with: "Hi! How are you? You know something? I've settled down now. I have got a new afternoon job delivering groceries and I'm saving my money."

He then asked if he might come over to the clinic and borrow some more "good" books to read.

And every now and then we pick up a case such as the one that precipitated the first mental clinic for children in the United States. This first clinic had its origin in the attempt of a school teacher to find out why a boy could not learn to read. She took him to Professor Lightner Witmer at the University of Pennsylvania. This was a brand-new type of problem for a Wundtian psychologist. But he attacked it bravely, and after spending some time in an attempt to solve it, he finally tested the boy's eyesight and found out that he could not see. When fitted with a pair of eyeglasses, the child promptly learned how to read. The following case illustrates this primal incident in the history of child psychiatry in the United States.

John was a boy of 12 with an I.Q. of 98. He was referred to the clinic by his teacher because of his inability to learn to read well. He was doing third-grade work. His ability in arithmetic fundamentals was described by the teacher as good, but his reading and spelling as very poor. During the course of the psychometric examination the examiner noticed that John ap-

parently had poor vision. He was immediately referred to the eye clinic. The doctor there found that his vision was very defective and, upon quizzing, learned that John could see the blackboard only imperfectly, even when he was in the front row in the classroom. It was also learned that he came from a bilingual home, his mother being barely able to understand English. Glasses were immediately procured, the boy attended a summer school, and somewhat later he was reported by the teacher to be making great progress in his reading and doing satisfactory work generally in the fourth grade.

It is to be hoped that every child guidance center will function in close association with a remedial school and that child psychiatrists will learn to value highly the services such a school can offer. Not all disabilities are really rooted in the pathology of the home. Many have their origin in the school and can be adequately treated by remedial teaching.

Chapter XIII

BIBLIOTHERAPY

THOUGH the term bibliotherapy is of rather recent origin, the use of reading for therapeutic purposes antedates the printing press and goes back to the early period of manuscripts and scrolls. Over the library at Thebes was placed the inscription Ψυχῆς ἰατρεῖον.[1]

Alice Bryan, consulting psychologist at the School of Library Service at Columbia University, says that "the term 'bibliotherapy' has been used by Karl Menninger to designate the use of carefully selected books on mental hygiene for therapeutic purposes."[2] In a recent article she points out that Dr. Gordon R. Kamman defined bibliotherapy as a form of psychological dietetics[3] and holds that reading that helps in emotional adjustment may even influence physical disorders.[4]

William C. Menninger[5] has given an account of his experiences with bibliotherapy as a subsidiary method of treatment for adult mental patients. In his technique, the physician works in conjunction with the librarian to select a book that will meet the therapeutic needs of the patient. These needs are regarded as educational, recreational, and a certain necessity of the patient for help in identifying himself with the social group. Menninger feels that a specific value of bibliotherapy arises from the patient's identifying himself with some particular character and abreacting thereby his own emotional difficulties.

[1] "Next comes the sacred library, which bears the inscription 'Healing place of the soul' ": Diodorus of Sicily i. 49. 3; Loeb Classical Libr., vol. 1, p. 173.

[2] Alice I. Bryan, "The Psychology of the Reader," *Library J.* **64:** 11, 1939.

[3] "Can There Be a Science of Bibliotherapy?" *Ibid.*, p. 775.

[4] Cf. also Esther B. Pomeranz, "Aims of Bibliotherapy in Tuberculosis Sanatoria," *Library J.* **65:** 687, 1940.

[5] "Bibliotherapy," *Bull. Menninger Clin.* **1:** 263, 1937. The article gives a helpful list of references on bibliotherapy in hospital use, particularly in relation to mental patients.

We may look on every hospital library as an attempt at bibliotherapy, and every time a mother selects an appropriate book for a child she is attempting a kind of homemade bibliotherapy. I remember a visit to a large English country estate. I picked up some books on a table, noticing that the binding had a paper cover on which was written, "Servants' library." I glanced through the books and noticed that they formed a sequence of stories in which the heroine was a servant girl who got into no end of trouble by stealing butter and pilfering various articles from the home in which she worked. The incident points out a type of bibliotherapeutic endeavor to be avoided.

Hospital librarians have naturally been interested in the application of bibliotherapy to the patient in the hospital. Dorothy Coachman feels that light fiction relieves the monotony of hospital routine.[6]

Elizabeth Creglow enumerates the following benefits of bibliotherapy.[7] (1) It keeps the patient contented during his stay in the hospital. (2) It changes the patient's attitude toward life by replacing "destructive emotions by constructive ones." (3) The patient learns how to take care of himself physically and mentally. (4) The mild physical exercise in reading is itself helpful. She points out that books should be chosen for content in the light of the patient's problems.

A special type of bibliotherapy has been developed by the Delaware State Society for Mental Hygiene. It grew out of an attempt to introduce mental hygiene in the seventh and eighth grades,[8] in the hope of teaching children wholesome reactions to emotional crises, with the ultimate intention of preventing mental breakdowns later on in life. A number of film excerpts were selected and shown to the children. It was

[6] Dorothy F. Coachman, "The Therapeutic Value of Light Fiction in Hospital Libraries," *M. Bull. Vet. Admin.* **9**: 99, 1932–33.

[7] Elizabeth R. Creglow, "Therapeutic Value of Properly Selected Reading Matter," *M. Bull. Vet. Admin.* **7**: 1086, 1931.

[8] M. A. Tarumianz, "How the Human Relations Classes Were Started," *Understanding the Child* **10**: 3, 1941.

felt that "shy and recessive children were inclined to project themselves realistically into the situations presented in these short edited films, for they quickly overcame their normal reticence and participated eagerly in the general discussions."[9] The children were stimulated to discuss the situation presented, to pass judgment on the conduct of the characters, and to illustrate the problems further by recounting similar situations in their own experience. After a while the talking moving pictures were dispensed with and the children were told exciting stories or given the script of a little play, which was acted out by some of the members of the class, and then the problem presented by the playlet was discussed by the children. Here we have really a modification of simple bibliotherapy, which seems to have led to the children's airing their views on various problems and perhaps gaining valuable ideals and principles from the discussion.

The following[10] is a list of topics which came up for discussion in these groups of seventh- and eighth-grade children:

The importance of friends
Personality traits of a "regular fellow"
Our inner human drives: self-preservation (security); recognition (desire for approval); interest in the opposite sex; adventure
The value of facing up frankly to personal and social problems—overcoming personal handicaps
Relationships with younger brothers and sisters
The necessity of self-discipline—learning to lose gracefully
Wholesome school relationships—problems of a new pupil in school
Problems of having older relatives or outsiders living in the family
First impressions—how we look, talk, and act
The advantages and disadvantages of being timid and shy
How various types of punishment affect us
Personality qualifications for various types of vocations
Emotional problems of children in wartime
Use and abuse of comic books

[9] H. Edmund Bullis, "How the Human Relations Class Works," *Understanding the Child* **10**: 5, 1941.
[10] *Ibid.*, p. 8.

Emotions and their effect on behavior
The influence of continued failure on personality development
Sharing our emotional problems with others

One boy, for instance, spoke of the trouble caused by his grandfather's being in the house, and that led to the voicing of a number of complaints about having old people living in a home with children. Whereupon a little girl rose to the defense of her grandmother, and told how the latter helped her in washing the dishes and minded her little sister so that she could go out and play. "Why," she added, "my home wouldn't be at all the same without my grandmother: she's swell to us all."[11]

And so a type of discussion which might have accentuated home difficulties due to the presence of a grandparent, was given a turn that showed the possible value of the grandparent to the child.

The possibilities of group therapy of a prophylactic character deriving from this type of procedure seem very promising. It is easily seen, however, that the teacher who presides over the discussion must have sound moral principles as well as great tact and psychiatric insight.

The attempt at bibliotherapy I am about to describe is based upon the fact that the mind stores ideals and principles of conduct which in due season *may* have a great deal to do with conduct. I say "*may* have a great deal to do with conduct," because the mind may harbor principles the truth and validity of which are recognized, but which are nevertheless not accepted as determinants of conduct. Thus a study in progress under the direction of my colleague, J. Edward Rauth, shows that most boys in an institution for juvenile delinquents have a stock of sound principles, but they have not always acted in accordance with their principles.

In the case we are about to present, we shall have an interesting example of how a principle of conduct was formulated

[11] Emily O'Malley, "A Typical Human Relations Class Session," *Understanding the Child* 10: 13, 1941.

in general terms and accepted as true and worth while, but promptly underwent a psychological restriction when applied to personal conduct. Furthermore, there are such things as false ideals and wrong principles, which also have an influence on conduct. Thus, a boy who was studied in a juvenile corrective institution some years ago pointed to Dillinger as his greatest hero. This false ideal had something to do with his being in a home for juvenile delinquents.

Furthermore, Dr. Rauth has found that many boys who have been in the courts for stealing distinguish very clearly between stealing from the poor, from friends, and from relatives, and stealing from some large concern like Montgomery Ward and Company. They may steal from the poor, or from friends or relatives, and recognize that it is wrong, but see nothing at all wrong in stealing from a railroad company or a large commercial firm.[12]

Principles, therefore, while not necessarily determining conduct, do at times have something to do with conduct. Sound moral principles are a *conditio sine qua non* of good conduct, but, though necessary, they do not suffice to determine conduct.

The problem arises: Can reading be used as a therapeutic procedure in dealing with the problem child? *Ex esse ad posse valet illatio.* The following case shows that it can, and illustrates a technique of procedure.

Charles was a boy of about 11½ years of age, whose difficulty was a certain inability to put up with correction administered by a woman (Mrs. X) who shared an apartment with his mother. Charles's father had died, leaving his wife with two children to support: Charles himself, who at the time he came to the Child Center was 11 years and 5 months of age, and Joe, aged 6½. The woman with whom his mother shared her apartment was an old friend of hers who was also married and had an

[12] For a discussion of abnormalities of reasoning based on pathological major premises, see T. V. Moore, *Cognitive Psychology*, Philadelphia, 1939, pp. 392 ff.

adopted son, Jim. This woman's husband was seldom at home; but, when he was, he caused a great deal of trouble because of his drunken behavior.

The symbiotic relationships of the two families made it possible for Charles's mother to keep her children and go out to work in order to support them. But at the time that Charles was brought to the clinic the symbiosis was threatened with dissolution. Mrs. X said that Charles was rude and unreasonable and Charles's mother sided with Mrs. X, but did not know what to do or where to go if Mrs. X could no longer tolerate them.

When either Mrs. X or Charles's own mother or his school teacher corrected him, he thought he was being persecuted and unfairly treated. The other children seemed to the two women to take correction in a normal way, but Charles was hypersensitive. His mother thought that it was a hereditary trait derived from the boy's father, and feared that unless it were corrected it might make him miserable and unhappy in the future. Furthermore, she had heard that such children sometimes developed dementia praecox, and so thought it a matter of supreme importance to have psychiatric help.

Besides being sensitive to correction, Charles was continuously having trouble with his younger brother, refusing him the innocent pleasure of playing with his toys, and was very selfish, keeping his own things to himself. Furthermore, his teacher reported that in spite of being apparently bright, he was lazy and managed just to pass, though if he had wanted to he could have been at the top of his class. The teacher was entirely correct in her impression that Charles was a bright boy, for by the result in the form L of the Terman-Merrill intelligence test his I.Q. was 118, and by the Arthur performance scale it was 116.

When one sees a problem child, one is quite likely to seek the origin of his difficulties in parental attitudes and training. The question was raised whether or not Charles had ever been

accepted by his father and also whether or not he had been rejected by his mother.

A whole complex mixture of family difficulties group themselves about the two ends of the axis whose extremes are rejection and overprotection. Anyone who is not sensitive to the existence of these disorders of family life will often fail to understand many family problems. But sensitiveness to one type of difficulty need not make us blind to the existence of other types. There is a tendency at the present day to lay the problems of the child squarely on the shoulders of the parents, and to attribute the abnormal behavior of children exclusively to defects in parental care and training. But there are problem children who are in some measure themselves responsible for their maladjustment, and others who, while not personally responsible for the difficulties that give rise to their abnormal conduct, can do a great deal to correct their faulty behavior.

Conduct disorders such as Charles presented are likely to arise when two families attempt to live together and the children of one mother must be left to the guidance and control of another. The problem is *situational* rather than due to the fundamental family mechanism of rejection. Charles's mother seemed to be most affectionate toward him and had gone to considerable trouble and expense to bring him from another city to the Child Center in order to receive help in his behavior difficulty.

On the other hand, had Charles's mother and Mrs. X been perfect characters, there would have been no difficulty calling forth abnormal reactions from Charles. It was Mrs. X who was responsible for the reactions of Charles. Let us turn for a moment to the history to find out why.

As the mother expressed the problem in one interview, "Well, here I am about Charles. It seems he can't get along with Mrs. X."

"Why?" we may ask.

Mrs. X demanded that Charles should obey her implicitly, and when he did not she would become very angry and punish him more severely than she did her own boy. Mrs. X would tell her son to go off with Charles's bicycle without even asking Charles about it. Mrs. X demanded that Charles apologize to her son, but while he admitted that he was wrong, he would not go further and make a humble apology. Mrs. X when angry might slam a door in the face of Charles, or tell him, "If you don't like it here, you and your mother can move out." Or again she would preach him a sermon and tell him that she was sacrificing her life to help him and his mother.

Under such circumstances no one will be surprised to find a boy manifesting a few behavior difficulties. Nor do we need to go beyond the situation to a parental attitude of rejection in order to understand his behavior. What are we going to do about the matter? To dissolve the symbiotic home relationship would be the simplest procedure. But that should not be attempted at once. Psychiatric help may possibly be able to cope with the situation. Charles would not go through life successfully without having to deal with many more or less unreasonable individuals in positions of authority.

It was felt that an attempt should be made to adjust Charles to the awkwardness of his situation. The child was seen eight times. The visits were usually a week apart, but were interrupted for some weeks by an attack of pneumonia. While I interviewed the boy, a social worker spoke with the mother, who had brought him to the center. Mrs. X came also for several visits. But the major element in the therapy seems to have been a change in the attitude of the child.

The treatment of the child started with several periods of play therapy. It would seem that in this case the major result of the play therapy was the establishment of rapport between the child and the psychiatrist. The second stage consisted in lending the boy a book to read. An interesting type of book was chosen, just to stimulate interest in reading. He took

home at first *Men without Fear*, by John J. Floherty. He read the book for interest only, and remembered only a number of exciting incidents. When asked what he got out of the book, he recalled only certain very lively events, but formulated no concepts, ideals, or principles which might in any way have to do with the control of conduct in general or his personal problems in particular. The next book was *Lonnie's Landing*, by C. M. Simon, which shared the same fate. I did not want to suggest that I was trying to change his conduct by getting him to read moralizing stories. He made his own choice from among a number of books on the shelf.

I thought it was time to "sell" him the idea of reading a book from which useful principles might be derived more easily. And so, offering him a book of short biographies, *More than Conquerors*, by Ariadne Gilbert, I suggested that he would find the life of Pasteur very interesting. He took the book willingly. When he returned the next week he said that he had found the life of Pasteur a bully story and wanted to take the book home again and read the other biographies. He said that his mother also wanted to read it. I asked him what he had got out of it.

He replied: "Never to give up, no matter what happens." The answer was prompt and spontaneous.

The boy had crystallized a very important principle, though it had little apparent relation to his own fundamental personal problem. To what extent would it influence future conduct? This we did not know. However, the relation of the principle to his personal conduct, though not at once apparent, was probably very real. Charles had an ambition to enter West Point and follow the career of an army officer. He had been meeting with difficulties in school and had been giving up. If he wanted to get to West Point, he would have to be like Pasteur and never give up.

The next book given him was *Hill Doctor*, by Hubert Skidmore. Whether because of the special character of this book, or because the patient had been sensitized to the perception of

principles of conduct in literature, or both things together, Charles commenced at this point to gather ideals of conduct which, though not all accepted at once, soon commenced to dominate behavior, and the difficulties of the home situation started to clear with remarkable rapidity.

When he came in for the next interview, I recalled to his mind how he had told me that in reading the biography of Pasteur he had perceived the principle, *Never give up; keep on trying.* So I asked him whether or not he had gotten anything out of *Hill Doctor.* He told me that the hill folk among whom the doctor worked always shared what they had with anyone else who came along, no matter how poor they were. Furthermore, they were always nice and kind to everyone. When the "hill doctor" was called out to see a sick man, he never gave up looking till he found him. He would find a way to cross a river and get to some house hidden away in the country.

I asked Charles what else he had gotten out of the book. He said that when the doctor was a student in school someone would stand over him to make sure that he was performing an operation properly. When he was corrected he never got angry. (I might have tried to make capital here by referring to Charles's own sensitiveness to correction, but allowed the matter to pass without comment.) The boy continued to tell me that when the doctor was in the hill country, there was no one to watch him, and he had to be careful and watch himself.

I again asked: "What else did you get out of the book?"

He replied: "Never make yourself the main attraction."

The principle was not very clearly expressed, but further questioning indicated that it meant that the hill doctor never charged the poor very much—his fee was far less than would ordinarily be asked for a similar operation.

"What else?" I again asked.

And he told me that the hill doctor got angry with himself because he went to sleep, in spite of trying to keep awake, when he had to watch over a sick child for several hours in the night.

I asked once more: "What else?"

And he said: "That's all."

I then asked whether or not he had ever thought of putting any of these things into practice himself. He said that when he went to bed at night he kept on thinking of how the hill doctor kept on trying and trying until he got there. And that made him think of working and working until he got to West Point.

We talked then about examinations and what he would have to learn before he could get into West Point. He granted that he had not been working hard, and told me that he got his best marks in mathematics (decimals) and his worst marks in spelling. The mention of poor marks suggested the question: "Do you ever get scolded?"

He said: "Yes, my aunt and uncle [Mrs. X and her husband] often scold me."

I asked: "For what?"

"For teasing my little brother and taking his toys without asking him and not allowing him to play with mine."

I thought it a good opportunity to recall to his mind the principle by which the hill folk lived: sharing whatever they had with anybody whom they could help. And so I asked if the story of the hill folk didn't suggest to him that he should share his things with his little brother. And he promptly answered: "Not a bit of it."

"Why?"

"If I ever let him have anything I will never get it back."

I let the matter drop.

This is a very interesting example of a principle which the subject himself acquired by reading, and formulated in general terms; but as soon as the application of the principle ran counter to the subject's prevailing emotional trends, its logical universality suffered at once a psychological restriction that obviated any interference with egoistic drives.

I went on to ask whether he was scolded in school, and he told me that the teacher often scolded him for sloppy writing and

mistakes in spelling. "It makes me mad," he said, "and I feel like hurting someone and running away."

I recalled the period in the life of the hill doctor when there was someone to point out his mistakes, and argued that it would have been rather foolish for the medical student to get angry at the surgeon for telling him the right way to do his work. He admitted the truth of this and we went on to discuss the idea of correction, and I suggested that the next time he was scolded it might be well to say, "Thank you. I will try to do better." The boy being a Catholic, I reinforced these ethical concepts by discussing the religious values of patience and humble endurance, and so this interview ended.

When he came for his interview the next week, the first thing he mentioned was a tense emotional episode between himself and his aunt; she had scolded him for something he did not deserve and there followed a violent emotional scene. The principles admitted as sound in the previous interview had not as yet become principles of conduct.

In spite of the apparent hopelessness of crystallizing principles to influence conduct, I returned to *Hill Doctor*, which he was still reading. He went on to tell me how a little boy had wanted to take care of the hill doctor's horse because he loved it. The doctor thought he was too small and at first said no. The little fellow begged and so the doctor finally consented, just to make him happy.*

I asked, "Have you applied that principle to yourself?"

He answered, "Yes."

I asked, "How?"

"If my little brother wants to do something and I do not want him to, I should let him do it just to make the little fellow happy." And then without waiting for further questions he blurted out, "I have done this several times already."

"How?"

"He likes to sit on my bike and work the pedals. It makes

* Here and elsewhere our little patient read into Skidmore's tale more than is to be found in the text.

him think he's driving. I used to make him get off, but now I let him work the pedals just because it makes him happy. I also let him play with lots of other things."

I ventured to remark, "That's a whole lot better than being mean."

He told me of other principles he had gotten from reading *Hill Doctor*, and we went on to talk about the quarrel with his aunt. I asked him if he had ever heard the expression, "A soft answer turneth away wrath." I explained it, and he said he was going to put it into practice in dealing with his aunt.

He then told me how he had suffered a keen disappointment the previous week. He had taken a scholarship examination for a military school and to his consternation the first element in the examination was spelling and he did miserably. We recalled how Pasteur never gave up and agreed that in life we had to be good all along the line, and so he would have to learn spelling. So he was given the name of a series of work books in spelling and of a simplified dictionary for schools, so that he could start in promptly and make up his deficiency.

After my interview with Charles, his mother came in and told me that the last quarrel with Mrs. X had almost severed diplomatic relations. So we all had a chat and Charles agreed to try to make up with Mrs. X, and I took the occasion to point out to Charles's mother that in future it would be better to sit down and talk things over with Charles rather than to scold him.

When Charles came in for the next interview, I started by asking whether he had found any more principles in *Hill Doctor*, and he enunciated the following:

"Don't get anyone else in trouble by getting them to do what you would not dare to do yourself.

"Have patience and courage and trust in God and never give up.

"Don't get mad at somebody because he doesn't know what you are talking about."

I asked how he was getting along with his aunt and he told me that on coming home the week before he apologized to her

and she gave him a speech about how she was sacrificing her life to take care of him. So I remarked, "You could swallow that, couldn't you?"

He laughed and said, "Yes."

I asked about school and he said that he had a new teacher who liked to teach arithmetic. He always got a grade of 100 and helped her to correct the papers for the class. He told me that he had finished the second book in the spelling series and was learning how to spell. (As a matter of fact there had been a marked improvement all along the line in his monthly marks.) Then all of a sudden he said, "Say, you know that trick you taught me the last time?"

I was not conscious of having taught him anything which in my language I would call a trick, and so asked, "What trick?"

"You told me," he said, "that when anybody scolded me I should say, 'Thank you, I'll try to do better.' My aunt scolded me and I tried it out on her. It worked like hot magic. She was so proud. She went out and bought Joe and me Coca-Cola and peanuts and let me stay up till half-past ten."

Toward the end of this interview he said, "Why am I coming here, anyhow?" (His mother had just brought him in without any explanation.)

So I asked, "Did you have trouble with your aunt?"

"Yes."

"Did you have trouble with your brother?"

"Sure."

"You weren't working in school?"

"No, I wasn't."

"You got down in the dumps when you were scolded?"

"Yes."

"Now you are getting along well with your aunt and your brother; you are doing well in school and don't get down in the dumps when you are scolded."

The difficulties in the interpersonal family relationships did not vanish immediately. Some months later we contacted the mother, who was delighted to report that Charles and his aunt

had buried the hatchet for good and the family was living in peace. The improvement, however, was not so complete and lasting that the hatchet was never afterward dug out of its hiding-place. But the family situation was very much improved and the change was due in large measure to bibliotherapy.

A child will not, however, always get sound and wholesome principles even from a good book, or one that we might regard as at least harmless.

Jim was a boy who hated school, played truant when sent to day school, and ran away when placed in a boarding school. We attempted to initiate treatment by a little bibliotherapy and took him to our library shelf. He maintained that the only thing he wanted to read was fairy tales and so he took along *Tales from Grimm.*

He had been placed finally in a military boarding school by his mother, with the proviso that he return from school for weekends. On one of these weekends he came in to see me. He did not want to go back to school. If he did he would surely run away. It was useless to argue the matter, so I asked him what he had gotten out of the book of fairy tales. He told me about the goose boy who started out in life with one goose and traded it for something better and kept on trading till in his last bargain he got the hand of the king's daughter in marriage. This, he said, proved to him that even if you are "dumb" in school you can get through life with "your own brains" and don't have to have any "school brains."

I did not raise the question of the accuracy of his analysis of the story or whether or not real life works out like a fairy tale, but dwelt on the fact that if you have good brains yourself you can get "school brains." And then I said, "You know I am a priest and a doctor; could I have become either one or both without 'school brains'?"

He laughed and said, "No."

Then he confided to me the secret that he himself had often wanted to be a priest. I did not discourage him, for even

though an ideal is practically unattainable, it may help one to get through a difficult period. And so I said, "If that is the case, you will have to have a whole lot of 'school brains.' "

I then tried to show Jim the difference between good principles and bad principles, and to get him to see that the idea of getting through life without "school brains" was after all an unwholesome principle for a bright boy like himself (I.Q. 107). He then told me how he had learned from one story that you should not brag, but should prove yourself worthy by what you do. This suggested the question, "How have *you* proved yourself worthy?"

Jim said, "There you've got me."

And so we concluded that he would have to make good, for as yet he had not made good.

Many other things came out in the course of this interview. We spent an hour in pleasant conversation, made possible by our discussion of the fairy tales. Jim on leaving the clinic persuaded his mother to send him to a day school. At the next visit he asked for a book of true stories about the martyrs or the saints who actually did really good and great things. So we loaned him *Quest of Don Bosco*, by Anna Kuhn.

This seems to have been a factor in bringing Jim's truancy to an end, though the main element in this particular case was remedial teaching. Our chief object in mentioning this case is to illustrate the genesis of a pathological principle: A boy with common sense does not need any "school brains."

Reading is a two-edged sword. It cuts both ways. It is a matter of some importance that a child talk over his reading at times with some older person with whom he is in good rapport. Good reading will have on the whole good results, but it may provide every now and then not only nothing more than amusement, but even pathological principles of conduct.

Many examples could be given of the way in which a child will pick out his own problem, and crystallize principles governing his behavior in that problem, from a book which one might think of merely to awaken interest in reading. Thus, for

instance, Richard's problem was that he would not study and would not save any part of the six dollars he made by working on Saturdays. In the course of his visits to the Child Center, the boy was given *Iron Doctor*, by Agnes Danforth Hewes. It is an account of the work of deep-sea divers. When he came back for the next visit, I asked him what he had gotten out of the book. He said that divers are just like the members of a clan: everybody works together.

"Well," said I, "how does that apply to your life?"

I was not prepared for the answer, which came to me as a great surprise: "Divers work together, and I won't work with my mother when she wants me to save."

Not all reading, however, leads to the crystallization of principles of value to the individual in the conduct of his life. Much of children's literature, perhaps too much, has in the past been written merely to entertain and amuse. But even when a work contains much of potential value to the individual, the child reads in general for interest rather than instruction and does not transform potential values into actual gain. Furthermore, it takes a bit of therapeutic questioning to draw out the principles and stimulate interest in finding them. When found, they become a part of the logical stock of the mind but do not necessarily have any influence on conduct. One must help the child to relate the principles to his personal problems.

Could one do the same thing just by ordinary instruction in right conduct? Probably not, or only with great difficulty. When one reads a story he identifies himself with the hero or the heroine. The hero's ideals and principles are likely to become for the time being the reader's ideals and principles. They are accepted, by virtue of the mechanism of identification, easily and as it were from within. Instruction imposes them from without and is much more likely to meet with resistance. Bibliotherapy has so far found little or no place in clinical methods of dealing with the problem child, but the data just presented give us a glimpse of a technique of great therapeutic importance.

Chapter XIV

HYSTERICAL MANIFESTATIONS IN CHILDREN

1. Hysterical Disability

A certain number of children manifest hysterical disabling mechanisms that seriously interfere with normal educational development. If one were to attempt to treat these conditions solely by some form of psychoanalytic treatment, it might take so long to secure results that schooling would be seriously interfered with. And so it is at times justifiable to attack the disabling symptom at once and directly, in order to put an end to the disability and return the child to school. The technique by means of which this is most easily accomplished is suggestive therapy. This type of therapy gave brilliant results in the last world war in the treatment of the so-called conditions of shell shock, known in medical literature as "war neuroses." The same technique, however, can be applied to conditions that make their appearance in civil life.[1]

When one brings about a sudden disappearance of the symptoms, one should not without any more ado look upon the child as cured and terminate the treatment. When such symptoms arise, it is evident that there is something seriously wrong with the background of the child's life—with both the internal mental complexity of attitudes and principles and the external environment of child-parent and perhaps teacher-child relationships.

Some physicians with a dominantly anatomical-pharmacological attitude, when confronted with a little patient of this type, are utterly baffled and may treat the child for months in an attempt to overcome a symptom that will vanish in a few

[1] For a full description of the technique and its application to war neuroses and in hysterical conditions in civil life, see T. V. Moore, *Dynamic Psychology*, pt. 5, chap. v.

minutes with appropriate suggestive therapy. The following case will illustrate what is meant by a hysterical symptom and its sudden cure by suggestive therapy.

One April, a mother brought her 12-year-old daughter to the Child Center with the following note from the physician:

> I was first called to see Jane on January 31, at which time she was suffering from an angioneurotic edema, involving the left eyelid and supra-orbital region, the right upper lip, and the cheek. She complained of a sharp stinging sensation in the involved areas. There were general weakness, bizarre transient pains throughout the body, and general malaise. The child seemed to be extremely weak and was highly nervous. The hemogram and urinalysis were absolutely normal. The reflexes were slightly exaggerated but the physical examination was otherwise essentially negative. The course of the patient has continued with transient pains throughout the body, although the angioneurotic edema has cleared. The patient now complains of weakness and transitory fleeting pains throughout the body. She refuses to walk, saying that she is too weak and cannot stand, and prefers to remain in bed. I believe the case is mental instead of physical. No indication has been found for any physical basis.

From the mother I learned that Jane was born a full-term child with a normal delivery. She had had mumps and measles and, at 2 years of age, whooping cough followed by convulsions. Her tonsils had been removed the previous August. A few carious first teeth had been extracted. She had started to school at the age of 5, and was in the sixth grade when the present trouble appeared. She had done well in school and had never repeated a grade, but now was intensely worried lest she should suffer the disgrace of dropping behind her class.

When the present trouble started the patient had been worrying for about a week over the coming midyear examinations. During this week a rash had appeared, and on the day before her examination she had an itching on the right side of her face. On the day of the examination she became very tense and her face started to swell. Her eyes were swollen and closed. In about a week the swelling went down, but the whole abdomen was tender. She was in bed almost continually for a month.

Then, when urged to get up, she went about the house holding on to a chair, a practice that she still found necessary up to the time of her first visit to the Child Center. She would not leave the house for fear of falling. Her former playmates often came into the house to see her, but she could not be induced to go out with them.

In her psychological examination some months later, Jane obtained an I.Q. rating of 91 on the Terman-Merrill form L, but one of only 76 on the Arthur performance tests. She was intensely apprehensive during the tests and had to be continually urged to make a fresh start, so that the level she attained did not indicate the upper reaches of her ability. She had a marked feeling of inadequacy and a lack of self-confidence. This arose from her dominant attitude of fear lest any one else do better than she, or lest she be found inferior to other girls. When I told her later that the tests showed that she had as good a mind as other girls of her age, and that there was no reason why she should not do very well in school, she seemed much relieved.

Such then was the patient and her problem when she was brought to the Child Center by her mother. With the latter's assistance she limped and stumbled into the office.

In the child's presence I obtained the general history of her previous illnesses and present trouble by questioning the mother. I then asked the mother to withdraw while I chatted with the child. It was in this interview alone with the child that I learned about the anxiety which had preceded the examination. After this chat I recalled the mother and said to the child: "Now let's see how strong your muscles are." Then, pretending that I was playing a game, I said: "Make a fist, and do not let me open your fingers."

The child took great pleasure in showing that I could not force her fingers open. Of course, in none of these tests did I apply enough strength really to overcome the muscular efforts of the child. Then I said: "Bend your arm and don't let me straighten it; hold your arm stiff and don't let me bend it; bend your knee

and don't let me straighten it"—and so on until most of the muscles were tested.

The child was very much pleased with her performance. The basis for suggestion therapy had been laid. I then said: "My child, your muscles are fine. Do you know that you can really stand? Stand up!"

I pulled her hand and she stood. She tried to wobble.

"You don't have to do that; you can really walk. Come, let us go over to the gymnasium. Follow me."

And so, without assistance from her mother, she walked hesitatingly, then went down the steps, holding on to the railing, and over to the gymnasium, about two hundred feet from the back door of the Child Center, but with a few more steps to be negotiated without a railing.

In the gymnasium, I had the child stand on a white line beside her mother, but unsupported, and then I went about fifty feet away, and, taking out my watch, said: "I am going to time you and see how long it will take you to run over to me. Run!"

The child ran, but a bit slowly and with hesitation. I left her where she was and went over and stood by the mother. "You did fine, but let us see if you can't run back even quicker." Looking again at my watch, I said: "Run!"

She ran back and I said: "You beat your first record by three seconds."

The child looked up at her mother a bit ashamed and said plaintively: "I could not do it before, Mother, really I couldn't."

"Yes," I said, "that is perfectly true, but now you can both run and walk."

We returned to the Child Center, and seeing her father reading in a corner, I said to her: "Run over to your father and give him a kiss and tell him that you can walk now."

The command was promptly carried out. After telling her to go out walking every day with her mother and run on the grass, we closed the first interview.

The following progress notes may be interesting:

April 26: Child walked in unaided. We talked about going to school and she thought she would like to start in, but when I called in the mother, she commenced to cry a little about the prospect and stipulated that the teacher was not to ask her any questions. She left with the instruction to go to school if she were feeling well. Evidently the child wanted to go and did not want to go, and I thought it well that she should go on her own initiative rather than that she should be told that she had to go.

May 3: Went to school yesterday afternoon. Played on the campus and painted in class. Enjoyed it very much.

May 17: Has been going to school regularly. Says she gave up jumping rope because it made her muscles stiff. I explained to her that that was merely because she had not used her muscles for some time and that she should keep on jumping until the muscles no longer got stiff. Mother reports she is out running and racing with the children "either full of energy or down in a hump." She tells her mother: "I have my pains but don't tell you about them any more."

"She is the talk of the neighborhood," her mother said, "acting more and more normal every day."

June 14: Has been going to school regularly except for an attack of the measles. Took two examinations in spelling and writing. I tried to start treatments for the excessive fear of having someone do better than herself, and we had a talk about the ideal of a good sport, and how when one is beaten by another the noble way of acting is to congratulate one's rival on his excellent performance. She thought this would be "real nice."

I suggested to the mother that the child should go to the summer school at St. Gertrude's. The idea back of this suggestion was that she should enter the seventh grade in the autumn with nothing to make up and a certain amount of confidence that she could do as well as any girl in the class. She had an intense fear of being left behind and at the same time of being unable to keep up with the others in the seventh grade. The mother came back with the story that the father was altogether against her going to summer school and that they were going to send her to the country for the summer.

I argued for the summer school, pointing out that it would be over by the end of July and Jane could have the whole month of August in the country. The argument prevailed and Jane

went to St. Gertrude's for the summer school. She spent the first few days quite happily, but the parents insisted on having her home for the weekend. That Sunday evening Jane was crying and pleading not to be sent back to St. Gertrude's. It was finally agreed that she should go as a day student. She then complained that her parents only wanted to get rid of her. In the meantime, her little sister was pleading to go also to St. Gertrude's. The result was that both children went as day students. The little sister was intensely delighted with it from the start and Jane soon commenced to like it as much as the younger child.

At the beginning and at the end of the summer school all the children were given the Stanford educational achievement test (two different forms). The results for Jane are shown in the test grades below:

	June 16	*July 23*	*Amount of Progress*
Paragraph meaning	6.7	7.4	0.7
Word meaning	5.7	7.4	1.4
Dictation	6.2	6.8	0.6
Language	9.5	10.1	0.6
Literature	5.4	7.9	2.5
History and civics	5.1	5.3	0.2
Geography	4.9	7.1	2.2
Hygiene	4.6	5.9	1.3
Arithmetic reasoning	3.6	6.8	3.2
Arithmetic computation	5.5	9.8	4.3

It would be rash to assume that the marked improvement in performance was entirely due to increase in knowledge and power. In all probability the child approached the first test with a hopeless sense of inferiority and dragged along in her work and accomplished relatively little. The fine performance in the second test, while due in part to educational progress, is also to be accounted for by the disappearance of a feeling of inferiority and the presence of a certain amount of enthusiasm flowing from the conviction "I can, if I will." It was this sense of self-sufficiency that we hoped the summer school would

supply. Jane made the seventh grade in September and did well in her work in the following academic year. A couple of years later she spontaneously called at the Child Center, just to let us know how well she was doing.

2. Psychogenic Stupor

Very much akin to the therapy made use of in the preceding case was the technique employed with a child in a psychogenic stupor.

One morning about half-past ten I received a phone message that one of the children at St. Gertrude's School of Arts and Crafts had been in a kind of coma the whole morning. All attempts to awaken her had failed. The sister in charge, who was a trained nurse, feared the possibility of a diabetic coma, but the characteristic odor of the breath was lacking. They had been unable to locate the regular house physician and asked me to come over at once. I confess that when I learned the name of the child I approached the problem with a certain amount of assurance that no organic condition was present. Perhaps the general attitude that comes from a firm conviction that a patient's symptoms are purely mental is of considerable importance in suggestive psychotherapy.

Arriving at the bedside, I found a young girl about 12 years of age lying quietly on one side, inclining to a face-downward position. An attempt to roll her over on her back met with moderate resistance, which could not have occurred had the condition been coma. She did not answer when her name was spoken, even though at the same time she was vigorously shaken. With thumb and forefinger I attempted to open both her eyelids at once. This too met with resistance. I then forced the lids open, pressing down somewhat on the eyeballs and saying: "Father Moore is here to see you."

The eyes rolled about in various directions. Then, hoping to elicit some minor voluntary movement, I said: "Open your mouth."

The mouth gradually opened.

"Put out your tongue."

Slowly the tongue was protruded.

"Sit up."

The child sat up.

"Stand up."

The child stood. The sister was told to give her a cold shower, dress her, and bring her down to the office.

Before we go further, let us ask the question: Was this behavior merely the malingering of a naughty girl, or something that bears a kinship with hysteria, or some kind of psychotic manifestation? The question cannot be answered with apodictic certainty. I can only say that I have seen pretenders and hysterical patients, and the child's behavior did not appear to me like pure pretense. She was a kindly, obedient little thing who had never before caused any trouble, and could scarcely have resisted hours of effort on the part of the sisters to rouse her from her stupor, had the whole thing been a matter of mere pretense. At the same time she had a psychotic trend. She had told me on previous occasions of how her own thoughts expressed themselves with auditory clearness approaching the nature of hallucinations. But the content had always been perfectly normal. Beyond these imagined auditory expressions of her own thoughts, there had not been anything of a schizophrenic trend, unless the stupor in question be looked upon as schizophrenic rather than as a hysterical manifestation. The child had something of a schizophrenic facies and general build. Furthermore, in the last few years there had been a drop in her intelligence quotient.

When she came into the office I said to her: "What troubled you yesterday?"

At that the tears came to her eyes and she said: "At the May procession Sunday every other child had a mother or someone to see her and there wasn't a single soul out to see me. And last night I cried and cried and cried and could not go to sleep for a long time."

And so the whole mechanism was clear: she was so sad that she wanted to go to sleep and never wake up any more. She was a very devout child and so I explained to her how God sometimes allows us to suffer and be alone, and we must learn to make a prayer out of our sorrow, that good things may come to those in need.

But it would have been a mistake to allow the therapy to stop with pious advice, however good in itself and helpful if it could be appreciated. The therapy would have been still more inadequate had nothing more been done when the child was out of bed. My first thought after the talk in the office was to get the child playing with the other children, and so I said, "Run out now and play with the others."

When I went by the playgrounds a few minutes later she was happy and taking part with the others in their games.

Only then did it occur to me that I had omitted something of considerable importance: the child had had no breakfast. And so I stopped and said: "Come on now, let us go in and get some breakfast."

This invitation was cheerfully complied with. As an adjunct to the therapy and in an attempt to make good the parental neglect of the previous day, I sat down with the child and had coffee and cookies, which I enjoyed myself as she was eating her breakfast. And then along came little 5-year-old Patsy Ann and wanted a cookie, and another girl discovered us and wanted a cookie, and so the hysterical or schizophrenic episode terminated in a children's party. Later the parents were instructed about the situation, and on the evening when the children gave their circus for their admiring parents, there was no reason why our little patient should cry herself to sleep and shrink from this harsh and terrible world by entering into a psychogenic stupor.

3. Psychogenic Nausea

The patient, a 15-year-old girl, appears like and has the manners of a young lady of 20. Her chief complaint was that she

became nauseated when she thought about going out. If she went out in spite of this feeling of nausea, e.g., to school, she might begin to shake and feel so ill that someone would have to phone and have her mother come and take her home in the family auto. She had been sent to an excellent gastro-enterologist, who had found no organic cause for the nausea and said that she should see a psychiatrist.

As we have said, the patient was a girl of about 15 years of age who had never suffered from any serious illness. She had had chickenpox, measles, and mumps, but no scarlet fever, diphtheria, nor typhoid. Up to the onset of her present illness, she had been in excellent health, and she was now in the second year of high school. Her marks had been good, ranging around 90. She ranked seventh in a class of forty-two. The family history was negative, with the exception of the fact that the father confessed to a phobia that he had been unable to overcome: he had an unreasonable fear of being alone.

According to the patient's first statement and that of her father, the present illness had started about three months prior to her visit to the clinic. At the time she was in bed for a few days, complaining of soreness in the abdomen. There was no fever. She had improved under the care of the family physician and when she was feeling better asked to go to the movies with a girl friend. She went, but a little later her father received a phone message to come down and get his daughter, for she was sick and shaking like a leaf. From that time on she had had great difficulty in going to school. If it was decided that she was to go to school the next day, she would feel nauseated on awakening. Only once or twice was she able to remain the whole day. Sometimes her mother had to go for her before the morning was over and bring her home in the car. Finally the attempt to go to school was given up, and when she first came to the clinic she had not been to school for eight weeks. In the meantime she had been under the care of the gastro-enterologist who referred her for psychiatric treatment. Be-

sides the difficulty in going to school, she became nauseated at the movies, at the bowling alley, in the choir of the church where she sang, and several times when riding in a car with her boy friend. Besides, there was a general fear of going out alone and also a fear of crowded streetcars, lest she should become sick on the car.

Here we have a specific organic reaction of a hysterical character, which seems to be associated in some way with "going out." A number of cases have been reported in the literature in which a violent emotional experience gave rise to a physiological reaction, and some time later the physiological reaction would reappear when the patient was confronted with a situation which bore some resemblance to that of the original violent emotional experience. One has but to recall the cases labeled "disordered heart action" in the first world war. A soldier would experience palpitation, and at times nausea, coming on when he got into a crowd, the original emotional experience having been in the thick of battle in which he had barely escaped death.

It was thought that this patient might be helped by a thorough understanding of herself and her difficulties. The condition was an acute suddenly appearing phobia associated with nausea. As the father said, "This has been a sudden turn of events, for she has always had the utmost confidence in herself."

It was not, therefore, a chronic emotionalism dating back to childhood, and consequently seemed to offer hope for successful psychotherapy.

An attempt was made to trace back her associations with nausea. In this way we came to an emotionally toned incident which placed the origin of the present disorder at a time some five or six months prior to the first difficulty about going to school.

She had gone to a dance with her boy friend. During an intermission he asked her to take a drive in his auto. He drove recklessly and in a wild turn around a curve almost upset the

car; and all of a sudden there came over her an intense nausea and she felt that she was going to vomit. This passed away, and for some months she had apparently not been troubled by nausea when "going out."

However, a little before the acute onset of gastro-intestinal symptoms, she had had a quarrel with her boy friend. They had known each other for about two years and she was very fond of him. But this night he said things about other girls that made her jealous and she said something to him, and then he walked out and the little 15-year-old girl felt that her heart was broken. When the gastro-intestinal condition cleared and she was no longer going to school, she spent much time day-dreaming about the boy she had lost. Just after her acute illness, her mother forbade the boy to come to the house any more, though she afterward relented. The patient said that when he came around she would feel hot and cold and somewhat nauseated.

We have here telescoped into a brief account a sequence of events very characteristic of the development of certain emotional disorders: (*a*) the original violently toned emotional incident; (*b*) a period of quiescence; (*c*) the advent of a period of chronic emotional strain; (*d*) the appearance of a phobia.

Many phobias can be traced to an early incident of acute emotional stress in childhood. This incident is forgotten, and then follows a period of emotional quiescence which may last for years. Then there comes on, acutely or insidiously, a chronic condition of maladjustment, and a phobia arises which has some resemblance to elements of the forgotten emotional incident.

In our patient we have the nausea associated with fright when the automobile in which she was being recklessly driven about by her boy friend almost turned over; then a period of quiescence; and finally an acute emotional episode leading to a period of hopelessless because of the loss of her boy friend.

Then there came a gastro-intestinal attack in which the family physician found some apparent abdominal tenderness but no fever, and after this the series of attacks of nausea on attempting to go out which finally kept the patient at home and away from school.

An attempt was made to get deeper information about the patient's difficulties by dream analysis, but she brought in no dreams. Free association gave little information, and our efforts were reduced to an attempt to break up the association between the idea of "going out" and nausea, by suggestion and persuasion, and by urging her to take herself in hand and go to the store and to church alone or with others, as the case might be.

After a few weeks, during which the patient was seen once a week, some progress had been made. She had been going downtown, and to church, where she sang in the choir, all without nausea. Usually she had to be accompanied by others. She did not, however, go to school at this stage, but got up late in the morning and spent the afternoon reclining in the sun and reading. Evidently her disability had dwindled down to a defense reaction against going to school. So I asked her to ennumerate the pleasures she was able to enjoy by not going to school, and obtained the following list:

1. Sleeping—I do not have to get up as early as I do if I go to school.
2. Lunch at home—I did not like the cafeteria at school.
3. The movies—I can now go to the movies about noon and go downtown shopping in the afternoon.
4. Loafing—reading fiction and fairy tales.
5. Baseball and sometimes tennis.

I then asked her to ennumerate the unpleasant things at school and she produced the following:

1. Most of the girls I go with are not in school with me. [The patient goes with a group of girls older than herself.]

2. If I did not have my homework complete I was afraid to enter the classroom. That scared me a good deal, though they did not scold us.
3. One teacher screams and bangs on the desk. That frightened me.

We then talked of her plans, and marriage was the uppermost thing in her mind. But she wanted an educated man—a doctor or a lawyer. I asked her if she thought an uneducated woman would be happy with an educated man, and she answered, "No."

I then asked: "What is your own opinion as to the reason why you stay away from school?"

She answered: "Because I wanted to quit school and marry."

I did not see the patient after this for about two months when she came in saying: "I am all well now. For the past month I have been going anywhere at all without nausea. I just took myself in hand and conquered. At first I was afraid I would get sick and then I found I didn't."

We must not, however, attribute the cure entirely to having shown the patient her true motives in the previous interview. Certain social factors intervened. Her girl companions and also her older brother were entering the university. They wanted her to get ready and come along with them. But it would be necessary first for her to finish high school. And so she determined to return to high school and get ready for college. In the meantime she had also broken off with her boy friend because he did not keep his promises.

The case is interesting because it illustrates the origin of a phobia accompanied by hysterical nausea. It shows also how the hysteria was maintained because it had a value to the patient.* This is a general characteristic of hysterical disorders. It shows also how a cure was brought about by enabling the patient to understand herself and by attempting to develop a new system of values. The development of this new system

* This is another example of the final cause in the etiology of the phobia. See above, pp. 109, 142.

of values was greatly accelerated by accidental social influences. The case also suggests that much could be done in home life to ward off hysterical disorders, by paying considerable attention to developing a system of values in the child's mind and not leaving this development to whim and fancy.

In the autumn our patient did in fact return to school, and a later report gave us the information that she attended regularly and received excellent marks.

PART IV

ORGANIC EMOTIONAL DISORDERS

CHAPTER XV

THE PHYSIOLOGY OF THE EMOTIONS

WHEN C. LANGE published his little study of the emotions in 1885,[1] he stimulated a long series of researches on the physiology of the emotions. The essential feature in Lange's theory was that the emotion consists in the perception of the bodily resonance which takes place in every affective experience. He denied the existence of a specific type of conscious experience, ordinarily termed an emotion, which follows a perception and causes a disturbance of various organic functions in the body.[2]

This concept was made popular in this country by William James, who wrote:

> Our natural way of thinking about these coarser emotions is that the mental perception of some fact excites mental affection called the emotion, and that this latter state of mind gives rise to the bodily expression. My theory, on the contrary, is that the *bodily changes follow directly the perception of the exciting fact, and that our feeling of the same changes as they occur is the emotion.*[3]

The primary difficulty with this concept of emotional experience is that there is only a fraction of a second between the cognitive act and its emotional resultant, but more than a second usually elapses between the cognition and the subsequent cardiovascular, visceral, and respiratory phenomena.[4]

[1] C. Lange, *Om Sindsbevaegelser et psykofysiologisk Studie*, Copenhagen, 1885, p. 91; German trans. by H. Kurella, *Über Gemüthsbewegungen*, Leipzig, 1887.

[2] Ibid., trans., pp. 50 ff.

[3] William James, *Psychology (Briefer Course)*, 1907, p. 375.

[4] For an extensive discussion of the relationship, see T. V. Moore, *Dynamic Psychology*, pp. 116 ff.

Thus, experiments with the plethysmograph show the changes in the blood volume and the heart coming several pulsations after the awareness of the affective experience. Furthermore, in pathological cases there is a strange independence between emotional experience and emotional expression. Ordinarily, as we have just pointed out, the emotional experience follows promptly on a cognitive insight into the meaning of a situation, and then there arises the bodily resonance, as an apparent resultant of the emotional experience. But it is possible to have the emotional resonance without the affective experience and the experience without the resonance. If emotion consisted essentially in our perception of the bodily resonance, this could not be the case.

Laughing and crying are ordinarily interpreted as expressing joy and sorrow. But in certain patients, particularly those suffering from disseminated sclerosis, the laughing and crying are forced. Reports have appeared in the literature of a number of cases of forced laughing and crying in which the patient's inner mood did not conform to the spasmodic emotional expression.[5] Thus, I remember an old sea captain who had a lesion in the thalamic region and who in conversation would suddently break out into peals of laughter and then in a moment would be sobbing as if his heart would break. However, he was not unhappy when he sobbed nor happy when he laughed, but merely ashamed of himself for being such a fool. Again, an individual may laugh by compulsion when inwardly he feels deep sorrow; another may have his moods of joy and sorrow but be incapable of laughter or tears.

Dott mentions a patient subject to alternations of mood between mild euphoria and depression in whom "the physical

[5] Cf. Maurice-Pierre-Louis Caillet, *Le rire et le pleurer spasmodiques*, Bordeaux, 1934. Observation 10 (p. 32) was made on a man who was neither gay nor sad in his spasmodic laughter and tears, but thoroughly ashamed of himself. Observation 45 concerned a woman who was forced to laugh even when she felt like crying.

ability to laugh or to weep was absent, though the corresponding emotions were present."[6] Dott feels that the thalamus "plays a part in conditioning moods of elation and depression, and their expression in laughter or weeping."[7]

The concept suggested by such pathological conditions is that there are in the brain anatomical centers and pathways which have to do with emotional expression and also perhaps with emotional experience. Toxic stimulation of such centers, or irritation by a sclerotic plaque or electric or other stimulation, might lead not only to violent emotional expression but also to intensified affective experience. If stimulation, whatever its nature, leads only to various forms of bodily emotional resonance, then these centers are loci for the control of emotional *expression* only; but if at times the irritation of nerve centers leads to intensified affective *experience*, then there are regions of the nervous system whose stimulation can call forth emotions or profoundly affect the patient's mood.

An interesting series of observations was made by Head in a study of patients in whom the findings suggested that the optic thalamus was cut off from its cerebral connections. In these patients he found an excessive response to affective stimuli. If the observations concerned only a condition of hyperalgesia, they might be explained as pseudo-affective reactions due to intensification of sensory stimuli coming from the pain spots in the skin. But since there are no pleasure spots, it is a matter of some importance to cite cases in which a hyperhedonic reaction was manifested. Several of these were found. Thus of one case Head writes:

> When large tubes containing water at 40° C., or slightly above, are applied to the affected parts of the body, he says, "That's nice, it's much more pleasant than on the other side." Even when warm hands are placed on his hands or on his feet, he says that the sensation is different on the two sides;

[6] LeGros Clark, John Beattie, George Riddock, and Norman M. Dott, *The Hypothalamus*, Edinburgh, 1938, p. 165.

[7] *Ibid.*, p. 167.

on the affected half of the body "it is more comfortable; it is a real pleasure; it soothes me; it gives me the feeling that it must do me good."[8]

Other patients with thalamic lesions gave similar reports.

Being anxious to learn more about these patients, I called upon Sir Henry on one of my visits to England, and he remarked that he looked upon the observation of a genuine hyperhedonic affective experience as one of great importance in the theory of the emotions. If a lesion which irritates the thalamus or frees it from cortical inhibitions can intensify emotional experience, we have indeed a very important fact to guide us in the understanding of the emotions. This seems to be really the case. Though cases involving the unpleasant may be partially explained by invoking the theory of sensory hyperesthesia, it would seem that some of Head's patients also suffered from an intensification of unpleasant affective experience.

The experiences of some of his patients make us draw the conclusion that there may be various reactions in the body which do not come to focal awareness in our consciousness of emotional experience. Thus, one of his patients said that he craved for sympathy on the right side of his body.

> One of our patients was unable to go to his place of worship because he "could not stand the hymns on his affected side."[9] . . . Another patient went to a memorial service on the death of King Edward VII. As soon as the choir began to sing, a "horrid feeling came on in the affected side, and the leg was screwed up and started to shake." . . . The singing of a so-called comic song left her entirely cold, but *A che la morte* produced so violent an effect upon the abnormal half of the body that she was obliged to leave the room.[10]

A study of the literature extends and develops the work of Head. Störring[11] gives an extensive report of a patient who

[8] Henry Head, *Studies in Neurology*, London, 1920, vol. 2, p. 616.

[9] *Ibid.*, p. 560.

[10] *Ibid.*

[11] Gustav E. Störring, "Zur Psychopathologie des Zwischenhirns (Thalamus und Hypothalamus)," *Arch. f. Psychiat.* **107**: 828, 1938.

after typhoid fever developed a toxic irritation of the hypothalamus. In this patient there was not only a tendency to forced laughing and crying but also a marked emotional lability. Störring feels that not only in pathological conditions but "also in the normal mind the thalamus plays a very essential role in the life of feeling and emotion."

Alpers points out that whether decerebrate animals experience as well as give expression to emotional conditions is highly doubtful; but observations on human beings "indicate clearly that not only is the expression of emotion elicited in hypothalamic disease, but the subjective sensation, commonly spoken of as affect, is also involved in the experience."[12] Gagel, on the basis of data obtained by Foerster's operations, points out that maniacal conditions may be produced in man by stimulation of the anterior region of the hypothalamus, and sleep or loss of consciousness by stimulation of the posterior region. He maintains that the study of tumors bears out this analogy and that the mental symptoms vary in the same way according to the region affected.[13] An interesting confirmation of Gagel's experience that stimulation of the caudal region of the hypothalamus produces lethargy, is found in the work of Ingram and his associates.[14] Catalepsy may be produced in cats by a bilateral injury in the posterior region of the hypothalamus. It is interesting to note that their bizarre fixed positions recall the stereotyped attitudes of catatonic patients.

Among the diseases of the nervous system, disseminated sclerosis is outstanding as affecting emotional expression and

[12] Bernard J. Alpers, "Personality and Emotional Disorders Associated with Hypothalamic Lesions," *Psychosom. Med.* **2:** 299, 1940. "Relation of Hypothalamus to Disorders of Personality," *Arch. Neurol. & Psychiat.* **38:** 291, 1937.

[13] O. Gagel, "Symptome der Erkrankungen des Hypothalamus," *Handb. d. Neurol.* **5:** 485, 1936.

[14] W. R. Ingram, R. W. Barris, and S. W. Ranson, "Catalepsy, an Experimental Study," *Arch. Neurol. & Psychiat.* **35:** 1175, 1936.

also emotional experience. Kinnier Wilson[15] calls attention to the fact that disturbances of emotional expression may be expected in 95 per cent of the cases. Forced smiling and laughing predominated in his series, being found in 71 per cent. What Kinnier Wilson terms *euphoria sclerotica* was found by him in 63 per cent of a group of 100 cases. This euphoria is a genuine emotional experience, distinguished by him from mere emotional expression, such as smiling and laughing. One of his patients gave the following report: "With my first symptoms I noticed, as did others, a gradual oncoming cheerfulness which we all thought very strange, for I had been anything but a happy girl: now I am optimistic, but before my illness I was just the opposite." Sad, depressed moods were found in 10 per cent of Wilson's series and cyclic alternations in 25 per cent.

He speaks also of *eutonia sclerotica*, by which he means a sense of physical well-being which may be present even in the moribund. This he found in 84 per cent of his series. He regards *eutonia*, *euphoria*, and *increased emotional display* as a triad of symptoms characteristic of disseminated sclerosis. In discussing the pathophysiology of the disease, he attributes the emotional disorders to periventricular sclerosis affecting the neothalamus in particular, and involuntary laughing and crying he ascribes to similar lesions.[16]

Thus various pathological studies suggest that there are regions in the brain the stimulation of which leads to exaggerated emotional expression and intensified emotional ex-

[15] S. A. Kinnier Wilson, *Neurology*, London, 1941, vol. 1, p. 166. This account is based on Samuel Smith Cottrell and S. A. Kinnier Wilson, "The Affective Symptomatology of Disseminated Sclerosis," *J. Neurol. & Psychopath.* **7**: 1, 1926. One cannot read the introspections of his patients without realizing that some of them are genuinely but unreasonably chronically happy and gay. The study is of particular value in that it was undertaken specifically to study the problem of emotional expression and experience in these patients.

[16] *Ibid.*, p. 174.

perience. There can be no doubt as to the fact that in animals exaggerated emotional expression can be called forth by stimulation of the hypothalamus. And, if we take Foerster and Gagel's work[17] at its face value, stimulation of the anterior region of the thalamus leads to something akin to manic excitement in man, and of the posterior region to dulness, lethargy, and coma.

It would seem, therefore, that the hypothalamus is a region the stimulation of which leads to both exaggerated emotional expression and intensified affective experience. It does not follow that the thalamus is a compartment in which emotional experience takes place. To say this would be as illogical as to conclude that because visual experience, and not mere optic reflexes, can be called forth by stimulating some region along the optic tract, therefore the center of vision is located in the spot which, when stimulated, gives rise to visual experience. As a matter of fact, we do not know where or how in the last analysis emotional experience takes place. It is a psychic phenomenon that can never be accounted for merely in terms of neurons and their connections.

A number of physiologists find considerable difficulty in allowing that hypothalamic stimulation can lead to emotional experience. They insist very strongly that the emotional expressions obtained in decorticate animals by stimulation of the hypothalamus are pure reflexes and mere sham emotions. This derives from the fact that they look upon the cortex as the seat and locus of all conscious experience. Thus Bard writes: "Cannon and also Dana have proposed the theory that emotion results from the action and reaction of the cere-

[17] O. Foerster and O. Gagel, "Ein Fall von Ependymcyste des III. Ventrikels. Ein Beitrag zur Frage der Beziehungen psychischer Störungen zum Hirnstamm," *Ztschr. f. d. ges. Neurol. u. Psychiat.* **149**: 312, 1934. White, reviewing some of the surgical operations performed in this country, maintains that psychic or sensory changes were detected in the manipulation of the hypothalamus: *The Hypothalamus*, Research Publ., A. Research Nerv. & Ment. Dis. **20**: 854, 1940.

bral cortex and the diencephalon. . . . The cerebral cortex is the immediate site of emotional consciousness."[18] According to Cannon's theory, the diencephalon sends impulses upward to the cortex and these impulses throw into action something which underlies that peculiar type of awareness that we term emotional experience. The diencephalon also sends impulses downward and these impulses give rise to emotional behavior. But as a matter of fact, modern brain pathology has cast a dark shadow of doubt on the orthodox theory of physiology that the cortex is the center of all conscious experience,[19] an assumption that may block our understanding of the many and complex data now available.

Masserman argues at length that the hypothalamus cannot be a locus of emotional experience. But this is beside the point. He also attempts to show that the emotional reactions of animals when the hypothalamus is stimulated are mere reflex actions unaccompanied by affective experience. He points out a difference between the emotional behavior produced by stimulation of the hypothalamus and that produced in a normal animal by the circumstances of life, and argues that because of this difference the emotional behavior produced by hypothalamic excitation is purely reflex in character and unaccompanied by consciousness.[20] But the difference may be that between a "physiological" affective experience and an emotion which is a psychic reaction to a conscious evaluation of the actual predicament in which the animal finds itself. When an animal reacts to perceived danger by emotional behavior and the source of the danger is suddenly removed, the cognitive experience does not disappear at the same time, but remains as a fading memory in consciousness, and so the animal mews and trembles and hides, etc.

[18] Philip Bard, in Carl Murchison, (ed.), *A Handbook of General Experimental Psychology*, Worcester, Mass., 1934, p. 305.

[19] Cf. a critical review of the evidence in T. V. Moore, *Cognitive Psychology*.

[20] Jules H. Masserman, "Is the Hypothalamus a Center of Emotion?" *Psychosom. Med.* **3**: 3, 1941.

However, given no cognitive experience as the cause of the emotion, but only a physiological stimulus, it might well be that a conscious affective mental state would disappear at once and without trace, when there would be neither cognitive experience nor physiological stimulation to maintain it in being. On the other hand, it may be quite possible that sometimes stimulation of the hypothalamus in animals leads to various physiological emotional reactions unaccompanied by any affective experience.

Masserman seems to lose sight of the fact that in a normal situation an animal reacts to a cognitive evaluation of a situation and not to the resultant emotion as such. When a normal cat, lapping up milk, sees a dog coming toward it, it runs away, because it sees the dog—not primarily and in the first instance because it experiences fear. The fear reaction is one of a number of responses and reflexes, such as running, trembling, hiding, acceleration of heartbeat, hair standing on end, etc. If the running is due to a perception which locates danger, horrification and various reflexes might accompany a purely physiological emotional experience without the appearance of such a response as running.

Masserman was unable to condition the appearance of emotional resonance by hypothalamic stimulation following sensory stimulation.[21] If conditioned reactions are obtained by arousing an expectation of something pleasant or unpleasant through perception of a stimulus which leads again and again to the pleasant or unpleasant experience, and if the conditioned reflex is really a reaction dependent on the arousal of expectancy by the perception of the stimulus and not on the affective reaction, it is not surprising that Masserman was unable to develop a conditioned reflex when he produced no expectancy but only an affective reaction. Such an experiment could never settle the problem of whether or not stimulation of the hypothalamus leads to a conscious affective experience or only to physiological reflexes.

[21] *Op. cit.*, pp. 7 ff.

Much light is thrown upon the problem of emotional experience and cerebral centers by a study of the emotional effects of various drugs. Various pharmacologicals affect the nervous centers. Do they call forth only emotional resonance or do they sometimes produce genuine emotional states?

Marañon in 1924 studied the effects of the injection of adrenalin in man. He described two stages in which the effects were manifested. The first is the *vegetative stage*, in which physiological effects of the emotion are manifested, but the patient is cold and has no emotional experience. He is aware of (1) an internal trembling; (2) a sense of precardial pressure; (3) shivering in the back; (4) coldness of the hands; (5) dryness of the mouth; (6) palpitation of the heart; (7) tears flowing from the eyes. Though the patient experiences all these things, he says: "I feel as if I were afraid, as if I were expecting a joyful surprise, as if I were going to cry but did not know why; as if I had a great fright, but I am tranquil."[22]

Most patients experience only the vegetative stage, but some go on to a second state, (2) the *emotional stage*. The patient not only perceives the above named forms of bodily resonance, but also gradually or suddenly a true psychic emotion dominates his mind. This usually takes the form of anxiety. At times the patient refers his anxiety or sorrow to events in his life; again he says he is sad, but does not know why. Marañon's work has several times been confirmed by others.

Cantril and Hunt undertook to repeat Marañon's work and found that while in general normal subjects experienced only the physical symptoms that follow the intramuscular injection of 1.5 cc. of adrenalin chloride (Parke-Davis undiluted solution no. 88), some subjects did report a genuine emotional experience. Thus one subject reported:

> I seem oppressed with a vague fear of something—feeling much the same as when I've lain awake at night, frightened that Bill might die. In spite of knowing the cause of his illness, the fear was not specific and neither is this.

[22] G. Marañon, "Contribution a l'étude de l'action émotive de l'adrénaline," *Rev. franç. d'endocrinol.* **2**: 306, 1924.

I am oppressed with a nameless fear. I want to get away from it, just as the night of Bill's illness I wanted to relax and sleep and tried to rationalize my fears. But that was impossible then and it is impossible now. It is decidedly unpleasant.[23]

Introspections of this kind indicate that the fear is not always secondary to the concept that the injection is having serious effects and may possibly result in death. Such a fear would not be nameless but would have a definite point of reference.

In a later experiment Cantril found that injection of adrenalin prior to placing a subject in situations calculated to produce fear gave a more intense fear reaction than the experience of such situations without the injection of adrenalin.[24] Dynes and Tod[25] found no difficulty in producing anxiety in normal subjects by the injection of adrenalin, but schizophrenic patients gave only a somatic reaction. Lindeman and Finesinger[26] experimented with adrenalin, a sympathetic stimulant, and mecholyl, a parasympathetic stimulant. After receiving adrenalin, 12 out of 40 psychoneurotic patients made 47 references to worry, depression, and anger. After taking mecholyl, 24 out of 40 patients said that they felt happy, silly, or not depressed, and only 2 patients made reference to depression and worry.

A result similar to that obtained by the injection of certain pharmacologicals follows electric stimulation of the hypothalamus. Grinker and Serota[27] devised a method of stimulating

[23] Hadley Cantril and William A. Hunt, "Emotional Effects Produced by the Injection of Adrenalin," *Am. J. Psychol.* **44:** 304, 1932.

[24] H. Cantril, "The Roles of the Situation and Adrenalin in the Induction of Emotion," *ibid.* **46:** 568, 1934.

[25] J. B. Dynes and H. Tod, "The Emotional and Somatic Responses of Schizophrenic Patients and Normal Controls to Adrenalin and Doryl," *J. Neurol. & Psychiat.* **3:** 1, 1940.

[26] Erich Lindeman and Jacob E. Finesinger, "The Subjective Response of Psychoneurotic Patients to Adrenalin and Mecholyl (Acetyl-B-Methyl-Choline)," *Psychosom. Med.* **2:** 231, 1940.

[27] Roy R. Grinker and Herman Serota, "Studies on the Corticohypothalamic Relations in the Cat and Man," *J. Neurophysiol.* **1:** 573, 1938.

the hypothalamus in human beings by passing an electrode through one of the nasal passages and pushing it "through the mucous membrane, submucosa, and periosteum into the sphenoid bone." As they point out, only a stimulation of the hypothalamus as a whole may be obtained by this method. In their human subjects they sometimes obtained during stimulation states of anxiety, which lasted for some minutes, accompanied by sobbing and expressions of fear.

The electro-encephalogram of the hypothalamus showed characteristic differences as against simultaneous electro-encephalograms of the cerebral cortex. An actual emotion (produced by telling the subject that a sex habit about which he was anxious had probably produced irreparable damage) gave the same type of encephalogram as that obtained merely by electric stimulation of the hypothalamus as a whole.

Looking back over the data just reviewed, it seems natural to conclude that we must admit a double origin of emotional conditions: (*a*) cognitive experiences by interpretation of situations which are matters of great moment for the welfare of the individual; (*b*) physiological stimulation of cerebral centers which give rise to a genuine emotional experience that has no primary and justifiable relation to anything perceived.

We cannot say with certainty that the stimulation which gives rise to these physiological emotional states affects only the hypothalamus, or the thalamic region and the cortex as well, or some other region of the encephalon. From what we now know of the mental life of man and animals deprived of large areas of cerebral cortex, it would seem that the cortex itself may not after all be necessary for conscious experience. But for the practical purposes of psychiatry, it is important to realize that emotional conditions have a double origin: (*a*) mental experience, and (*b*) physiological conditions.

This concept is not new. Oppenheim as early as 1909 pointed to the existence of two types of anxiety:

> There is to be found in anxiety a mental and a physical element. There are pathological anxiety states which play their role out only in the first

domain. More frequent are those forms in which the essential basis of the phobia is to be looked for in a pathologically increased irritability of the vasomotor-secretory visceral nerve centers.[28]

Freud's distinction between hysteria and neurasthenia implies one class of emotions due to a mental complex and another to a toxic disorder produced by sexual excess.

Papez has tried to picture the cerebral mechanism at the basis of emotional experience:

> The central emotive process of cortical origin may then be conceived as being built up in the hippocampal formation and as being transferred to the mamillary body and thence through the anterior thalamic nuclei to the cortex of the gyrus cinguli. The cortex of the cingular gyrus may be looked on as the receptive region for the experiencing of emotion as the result of impulses coming from the hypothalamic region, in the same way as the area striata is considered the receptive cortex for photic excitations coming from the retina. Radiation of the emotive process from the gyrus cinguli to other regions in the cerebral cortex would add emotional coloring to psychic processes occurring elsewhere. This circuit would explain how emotions may arise in two ways: as a result of psychic activity and as a consequence of hypothalamic activity.[29]

Papez points out in conclusion that the connections he indicates would meet the requirements of Cannon's and Bard's diencephalic-cortical theory of emotion and also be in agreement with Dandy's idea that the seat of consciousness is located somewhere near the midline, between the limits set by the corpus callosum and the basal structure of the brain.[30]

Sooner or later physiology must take into consideration the individual himself as the center of experience and of the many psychic reflexes that are initiated by conscious acts. This center is no mere aggregate of cells or electrons but a living

[28] Herman Oppenheim, "Pathologie und Therapie der nervösen Angstzustände," *Deutsche Ztschr. f. Nervenh.* **41:** 187, 1911. See also *Idem*, "Zur Psychopathologie der Angstzustände," *Berl. klin. Wchnschr.* **46:** 2, 1293, 1909.

[29] James W. Papez, "A Proposed Mechanism of Emotion," *Arch. Neurol. & Psychiat.* **38:** 728, 1937.

[30] Referring to W. E. Dandy, "Seat of Consciousness," in Dean Lewis, *Practice of Surgery*, Hagerstown, Md., 1931, vol. 12, p. 57.

being in whom there are a psyche and a soma coexisting, not as two substances, but as one; and hence mental conditions can give rise to organic reflexes.

The corollary to be drawn from the existence of physiological emotional conditions capable of being produced by thalamic stimulation is that, over and above a psychotherapy of emotional disorders, we may reasonably expect to develop some form of pharmacological treatment. Evidently the pharmacologicals should be drugs that act on the autonomic nervous system.

Chapter XVI

PHARMACOLOGICAL TREATMENT OF MENTAL DISORDERS

When one speaks of a pharmacological treatment of mental disorders, one naturally thinks of the modern types of shock therapy by means of insulin, metrazol, and the alternating current. None of these techniques was developed originally out of a specific study of the nature of the emotions in the normal mind and the application of this concept to an understanding of the nature and treatment of mental disorders.

The first of these treatments in the field was that with insulin. Sakel, its originator, tells us that the idea of treating schizophrenic patients with insulin had its origin in an attempt to treat morphine addicts with this substance. In the course of these treatments he produced deeper hypoglycemic reactions than he had intended and noticed a profound personality change for the better in his addicts.[1] His attempts at this kind of therapy date back to 1928.

The next method centers in the production of epileptiform seizure by means of convulsant drugs. Meduna tells us that the idea of treating schizophrenics with convulsive drugs came to him after he had noticed in the literature various references to a fundamental antagonism between epilepsy and schizophrenia, and even a report of a sudden recovery in a catatonic patient who spontaneously developed an epileptic convulsion.[2] Cerletti was studying epilepsy by producing

[1] Manfred Sakel, *Neue Behandlungsmethode der Schizophrenie*, Vienna and Leipzig, 1935, p. 7; also, Proc. 89th Meet. Swiss Psychiat. A., Münsingen, Bern, May 29–31, 1937 (*Schweiz. Arch. f. Neurol. u. Psychiat.*, vol. 39, supp.), trans. by Solomon Katzenelbogen, *Am. J. Psychiat.*, 1938, supp., pp. 24 ff.

[2] Ladislaus von Meduna, *Die Convulsionstherapie der Schizophrenie*, Halle, 1937, pp. 6 ff.

convulsions in dogs with electricity. During these experiments he became acquainted with the work of Meduna, who had been treating schizophrenics by the induction of convulsions first with intramuscular injections of camphor oil and later on with cardiazol.* It naturally occurred to him to treat mental patients by means of electrically induced convulsions.[3]

Though the effects of these types of treatment on the vegetative nervous system were not originally thought of, they were soon investigated. Thus Pfister pointed out that "schizophrenia is a disease of the autonomic nervous system . . . and should respond to autonomic drugs."[4]

Gellhorn showed that hypoglycemia and anoxia lead to an effective stimulation of the sympathetic nervous system. Both cause a depression of oxidative processes in the brain cells. Asphyxia of the medullary centers stimulates the sympathetic centers, leading among other things to a rise in blood pressure. After a study of the various types of clinical evidence, he came to the conclusion "that schizophrenia involves hypofunction of the sympathetic system and that improvement or cure may be brought about by sufficient stimulation of the sympathetic centers."[5]

If a convulsion stops or markedly hinders respiration, and if severe anoxia leads to a powerful stimulation of the sympathetic centers, one would expect that epileptiform seizures

* The trade name for cardiazol in the United States is metrazol.

[3] David J. Impastato and Renato Almansi, "Electrically Induced Convulsions in the Treatment of Functional Mental Disease," *M. Ann. District of Columbia* **10**: 163, 1941. One interested in the technique of the shock treatment of mental disorder (insulin, metrazol, and electric convulsive therapy) may consult the very practical work of Lucie Jessner and V. Gerard Ryan, *Shock Treatment in Psychiatry*, New York: Grune & Stratton, 1941 (extensive bibliographic references).

[4] Hans Oscar Pfister, "Disturbances of the Autonomic Nervous System in Schizophrenia and Their Relations to the Insulin, Cardiazol and Sleep Treatments," *Am. J. Psychiat.* **94** (supp.): 117, 1938.

[5] Ernst Gellhorn, "Effects of Hypoglycemia and Anoxia on the Central Nervous System," *Arch. Neurol. & Psychiat.* **40**: 144, 1938.

produced by metrazol or electric stimulation would for that reason alone give the same picture of sympathetic stimulation that is found in hypoglycemia due to insulin shock. Thus in metrazol convulsions Katzenelbogen[6] found a marked lowering of the *p*H, an increase of the lactic acid and of the total white count, as has been found also in hypoglycemia due to insulin. Maurer[7] and his co-workers found in metrazol convulsions a marked drop in the *p*H, followed by a rise after the convulsion; a rise in blood sugar followed usually by a marked fall; a slight rise in the serum calcium, followed by a return to normal when the *p*H attains its first levels. Sogliani found[8] that in convulsive attacks due to electric shock there was an increase in the red cells, the hemoglobin, the white cells, and the blood sugar.

The summary given by Beiglböck of the clinical picture of hypoglycemia after the injection of insulin is that of a preliminary parasympathetic stimulation followed by a more prolonged or more dominating sympathetic stimulation.[9] Perhaps some kind of sine curve could be fitted to the ups and downs of the heart rate, the blood pressure, the temperature, the respiration, the blood count, and other symptoms of autonomic stimulation. This is in line with the somewhat more recent work of Gellhorn and his collaborators. They demonstrate that, after elimination of the sympathetico-adrenal system, anoxia and metrazol lead to a hypoglycemia, instead

[6] S. Katzenelbogen *et al.*, "Metrazol convulsions in Man," *Am. J. Psychiat.* **95:** 1343, 1939.

[7] S. Maurer *et al.*, "Blood Chemical Changes Occurring in the Treatment of Psychogenic Mental Disorders by Metrazol Convulsions," *Am. J. Psychiat.* **94:** 1355, 1938.

[8] Giorgio Sogliani, "Reperti clinici ed ematologici in ammalati trattati con l'accesso convulsivo e con quello cardiazolico," *Note e riv. di psichiat.* **68:** 323, 1939. The author gives only the averages for combined data secured for metrazol and electric shock therapy, maintaining that no essential difference between the two methods was found.

[9] Wilhelm Beiglböck, "Der hypoglykämische ‚Schock,'" *Wien. klin. Wchnschr.* **51:** 497, 1938.

of to the rise in blood sugar that occurs with an intact sympathetico-adrenal apparatus. Stimulation of the hypothalamus faradically before and after elimination of the sympathetico-adrenal system leads to the same results. Emotional excitement in a cat (due to a barking dog) has the same result, which may be eliminated by sectioning the vagi below the diaphragm. "From these experiments it is concluded that the normal emotional process as well as the sham rage reaction is characterized by a simultaneous discharge over the vago-insulin and sympathetico-adrenal system. The latter predominates in the normal animal and masks the effects of the former."[10]

Prior to the use of insulin, some success was attained in the treatment of various mental disorders by the use of artificial fever therapy. It has been shown that artifical fever produced by intravenous injection of triple typhoid vaccine is followed first by a transitory parasympathetic and later on by a prolonged sympathetic stimulation.

Thus the analysis of the physiology of the emotions and the pharmacological treatment of emotional disorders suggests that endocrine preparations affecting the parasympathetic and the sympathic systems might be of value in the therapy of certain psychotic disorders and borderline mental conditions.

Another relevant contribution in the literature is the work of Moffat,[11] who found that follutein, a pituitary-like substance produced in pregnancy urine, causes a prolonged rise in the leucocyte count. This may be regarded as a prolonged sympathetic stimulation. Loehner[12] found adrenal cortex

[10] E. Gellhorn, R. Cortell, and J. Feldman, "The Autonomic Basis of Emotion," *Science* **92**: 289, 1940.

[11] W. M. Moffat, "The Effect of Anterior Pituitary-like Sex Hormones on the Blood Picture in Man," *Endocrinology* **26**: 595, 1940.

[12] Conrad A. Loehner, "Further Observations on the Use of Adrenal Cortical Extract in the Psychotic and Non-psychotic Patient," *Endocrinology* **27**: 379, 1940. See also his interesting study, "The Therapeutic Effect of Adrenal Cortex Extract on the Psychotic Patient," *ibid.* **23**: 507, 1938. Loehner ad-

extract of value in the treatment of a number of mental conditions.

Regarding the adrenal cortex as supplying a hormone in some manner antagonistic to the adrenalin of the medulla, we decided to try out the effects of adrenal cortex extract (eschatin) on manic-depressive patients and follutein on schizophrenic patients. The results were most encouraging. The following abbreviated case histories are very suggestive.

Clinical Abstract 1

The patient was a woman of 59 whose life had been very unhappy for over thirty years. The unhappiness was caused by an alcoholic husband. Their family life had been marred by a long series of drunken episodes and chronic states of irritability with only a few oases of sober good humor. The drunken irritability was used by the husband to force his wife to sign checks until her personal resources had dwindled to nothing. There had been periods when the husband lost his position and the family was threatened with the loss of their home and everything else. Even when her husband was working, the patient had great difficulty in getting him to turn in any money for the support of the household. In spite of his alcoholism, he managed to hold the office of deputy sheriff, and carried a loaded revolver with which he often threatened and terrified the family when he came home, though outside the home he was polite to everybody, even though he had been drinking for weeks.

Finally the patient left her husband and went to live with a daughter. But then she was stricken with qualms of conscience. She commenced to talk incessantly to everyone, strangers as well as members of the family, mourning and complaining about her many sorrows. After about six months with her sister, she went as a voluntary patient to a mental hospital. She left unimproved in a few weeks and about four months later came to the mental clinic at the Catholic University of America.

At this time she manifested no delusions nor hallucinations but suffered from intense sadness. Her facial expression was one of deep sorrow tinged

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ministered, along with eschatin, sodium chloride and calcium lactate in 10-gr. doses t.i.d. by mouth. Cf. also Harry J. Haynes and Chester L. Carlisle, "The Treatment of Schizophrenia with Desoxycorticosterone Acetate," *M. Bull. Vet. Admin.* **19**: 402, 1943, and Edward H. Williams, "Some Clinical Observations of Nervous Disorders with Adrenal Involvement," *Dis. Nerv. System* **4**: 185, 1943.

with anxiety. In the first interview she talked almost continually about having lost her home and the great crime she had committed in deserting her husband. The sad facial expression was never brightened by a faint smile. She said that she could not free her mind of the thought of the wrong she had committed in leaving her husband. Sleep was difficult and broken, and as soon as she woke, she said, "It bursts on my mind like fire: may be I should not have left him."

The onset of her illness could not be set at any definite point in the past. She maintained that she had been particularly sad and worried for two or three years.

The physical examination was negative except for a blood pressure of 160/100 and an accentuated second aortic sound. The urinalysis was negative. The general impression was that of involutional melancholia associated with early generalized arteriosclerosis.

The patient affords a good example of a depression which is in part a reaction to serious mental stress and strain, but which may also well have an organic factor involving the physiological action of the hypothalamus. The prolonged intense affective reaction to her situation was not warranted by the circumstances. If emotional reactions have a physiological basis as well as a psychological cause, it may be that the parataxic depression has its origin to a considerable extent in hypothalamic irritation. At all events such cases do not lend themselves to psychotherapy.

The patient was therefore given 1 cc. of eschatin* three times a week; this was supplemented by ascorbic acid (100 mg. three times a day before meals) and thiamine chloride (3 mg. three times a day before meals). For the first two or three weeks there was no marked change, but the facial expression seemed to be softening and the patient seemed less active.

After about three months she came in smiling and laughing, but maintained that she was still miserable. Two weeks later she seemed perfectly normal, the blood pressure was 120/80, but she expressed some regret at having left her husband. Her

* A Parke-Davis preparation of adrenal cortex extract. For the rationale of supplementing eschatin with ascorbic acid, see T. V. Moore, "Physiological Factors in the Treatment of Mental Disorders," *Psychiat. Quart.* **16**: 768, 1942.

daughter said that she was still a bit talkative. The treatment was dropped. Three months later the patient visited the dispensary and seemed perfectly happy and well, perhaps even a trifle hypomanic. A month later she seemed very happy and normal and the case was closed.

Clinical Abstract 2

The patient was a 21-year-old boy who had an unhappy family history. His mother had a violent temper and the family was described as always in some kind of a turmoil. A rather elderly woman became interested in the patient when he was about 16 years of age and took him to live with her.

When he was about 21 he commenced to develop mental trouble. He became tense and silent, would sit in fixed positions and stare into space, and occasionally would jump up in an excited fashion and speak some words that could not be understood.

When he came to the Child Center he was very slow in answering questions but eventually an answer would come. In this way it was found that he was oriented as to time, place, and person. But he would lapse into a fixed position, staring vacantly at the wall.

On September 9 a series of injections of follutein was started and the patient was given first 125 units, then 250 units, three times a week. Nine days later he seemed more ready to answer questions. He expressed the idea that we were giving him dope. A few days later his guardian phoned that he was worse and could not be gotten out of bed. The next day when he did come to the center he was too fearful to be given an injection. He was trembling and had developed a manneristic gait; the staring and grimacing were more marked than formerly; he seemed to be having hallucinations and would answer no questions.

The next day a dosage of 300 units of follutein was given. The patient talked freely but quietly and in low tones. He was confused, attempting to explain his fears of the past week. "How," he said, "could I have been so crazy?"

He laughed heartily on hearing a funny story.

Two days later he was given 300 units of follutein. He talked more freely but quietly. He expressed a desire to go to work. He laughed and said: "I had silly and fantastic ideas. I thought you were going to put a wire into my spine up to my brain. I saw pictures of people all cut up in a magazine in the front hall. I thought you were going to do that to me. Then I began to trust you and realized you were helping me."

Questions were answered promptly and relevantly.

Eight days later the patient had a position handling lumber and was very proud of the fact that he could hold a job. His blood pressure was 120/70; on the first physical examination it had been 100/65. Otherwise the physical examination was negative.

The case was followed for some months. The patient kept on working as a helper in a lumber yard.

But suggestive case histories do not produce scientific evidence. An attempt was made to evaluate statistically the treatment undertaken.* It was found that, taking the complete series of schizophrenic and manic-depressive patients as a whole, the treatment was certainly of value. This applied evidently in the case of manic-depressive more than of schizophrenic patients. The work so far done is only a beginning, but it does indicate that the pharmacologicals which affect the neurological centers of emotional resonance and affective experience are of distinct value in the therapy of mental disorders.†

The pharmacological treatment of mental disorders must at times be associated with some form of psychotherapy. It is indeed true that emotions may be produced at times by physiological conditions, and, in so far as they are so produced, they may be relieved by drug therapy. But emotions normally and ordinarily have their origin in mental experiences that arise from the conflict between the individual and his environment. Whenever this is the case, an attempt to treat the patient by drug therapy alone is bound to result in merely transitory improvement. Any therapy leading to permanent recovery must deal with the mental conflict. Drug therapy may, however, be a valuable adjunct to psychotherapy in these situations.

Let us consider the following case. I was asked to see a woman who had developed ideas of reference. She felt that

* A report of this work has been published in *Psychiat. Quart.* **16:** 768, 1942.

† A study is now being made of the use of desoxycorticosterone acetate in place of eschatin. It is perhaps somewhat more effective.

people in the streetcar made remarks about her whenever she boarded a car; they were afraid of her and seemed to move away when she went to sit down. She knew that they felt an electrification proceding from her body and making them uncomfortable. Her presence, she said, made them nervous and caused their muscles to twitch and made them move about in their seats.

When I asked her to describe what happened when she got on a car, she said: "The passengers look at each other and laugh."

Thus, for example, a man and woman in the seat in front of her seemed to be disturbed. The man said to the woman: "There she is now. Are you afraid on my account?" Then he turned and looked at the patient, and turning again to his companion said: "Shall we stay on the car or had we best get off?"

She complained also that the passengers talked about her and that she was ridiculed wherever she went. To avoid people who rode on streetcars she started to ride on the bus, but to her horror she found that the people in the bus knew as much about her affairs as those in the streetcars. When asked what they said about her, she replied that she was not sure, but they seemed to accuse her of incorrect living. Then she remarked with some emphasis: "I have never been man-crazy."

The prognosis of a mental condition such as this is not good. In general, it is very difficult to shake such delusions by any analysis, and one would not hope for much help from pharmacologicals, whose main effect is on emotional tone. The case was accepted not with the hope of accomplishing anything, but rather in the spirit of at least making an attempt to save the mental life of a human being, even though there seemed little or no hope of success.

The patient was an unmarried woman about 50 years of age. She had resigned her position and was living on her scanty

savings. She said that she spent a good deal of the day alone with herself, tormented by her train of thoughts and unable to rise above it. She did not go anywhere if she could avoid it.

She was given follutein, 250 units three times a week, and thiamine hydrochloride (3 mg. three times a day before meals). The reason for the follutein was our previous experience with administration of it to shut-in patients who seemed after a course of treatment to awaken to new interest in social contacts. Follutein may bring this about because it is a sympathetic stimulant or because of its influence on gonadal activity. Interest in social activities may in some measure depend on gonadal activity.

It was felt, however, that the psychological origin of the condition should be explored. Such patients do not understand the workings of their own minds. They must change their mental attitude, and to do this they must obtain a deep knowledge of their own mental life.

When asked how long she had been troubled with her suspicions, the patient replied that she had been aware of them for about two years. At the time they originated, she was working in an office where, according to her, the morals of the workers were below sound standards. She could, however, give no actual evidence of any immorality. As she remarked, "When you don't know, you have to guess."

At this office she fell in love with a married man, but she could give no evidence of anything that indicated that the married man was deeply interested in her; she however, was very fond of him. She often dreamed of him and when she woke in the morning he was her first thought. In spare moments of the day she daydreamed of him. Occasionally they went out from the office and had lunch together. Once only she accepted an invitation from him for dinner in the evening. But their conversation that evening was about trivialities and platitudes. He said nothing to indicate the least interest in her or her affairs. This she explained by

thinking that his secretary had followed them and watched them, so that he did not dare to say all that he felt. Nevertheless, she did not see the secretary anywhere the whole evening, nor did she have any evidence that the secretary was anywhere in the vicinity. It was another case of "if you don't know, you have to guess."

When the dinner was over she made up her mind that she would have nothing more to do with the man. It seems that as a matter of fact she realized that he was not interested in her and, what was more, he never would be. But she did not want to admit her defeat, and so the delusion about the secretary came to her mind; it was more comfortable to think that he dared not tell her how much he loved her than to admit he did not love her at all.

When she arrived at the office the next morning, she was conscious of a change. She felt that something was in the air: everybody was worried*; everybody was talking about what went on between her and the married man.

"How do you know that?" I asked.

"You can tell from the way people look."

"Was anything said?"

"No, but if people don't talk you can guess."

She tried to put this man out of her mind from that time on and never again went out to lunch with him. After about six months, feeling she had given the lie to all the talk that was going on about her, she resigned and took another position. Here, however, she fell in love with another man, and for some reason felt that he was in love with her. Just as in the former episode, she developed an unreasonable conviction that this man was in love with her, though she never had a date with him; he had never shown her any sign of affection,

* One might take this as an example of how at times a patient projects his or her worries or emotional condition on others. This seems likely to take place when one does not want to admit a given emotional condition as existing in oneself.

but apparently was only officially kind. It was about this time that she became conscious of a vibration in her personality that caused people in the buses and streetcars to move about and twitch. Once she was standing in a streetcar reading a little Bible and heard a man say: "The book is just for effect."

Finally, feeling that there was altogether too much talk going on about her at the office, and that the moral standards of the place were too low, she resigned her position and spent a good deal of time alone with herself and her thoughts.

The psychological treatment in this case consisted in an attempt to explain to the patient some of the mechanisms of her delusions and to deepen her knowledge of these mechanisms by dream analysis. Thus, when she told about hearing someone say, "The book is just for effect," opportunity was taken to explain to her the concept of the splitting of the personality and how something like this had taken place in her own case. Within her own self there was one personality, an angelic kind of being that wanted to be on a pedestal, and also an animal that wanted a good time. That animal personality did not like the idea of reading the Bible, and what she heard was perhaps an assimilation of words of some kind actually spoken by a man standing near her, to the thoughts of the animal personality which was mocking the angelic creature on the pedestal.

The concept of auditory illusions was also explained, that is, how vowels have their characteristic pitch and even a pure tone from a tuning fork may give rise to a hallucinatory impression of a word having a vowel whose characteristic pitch is the note of the tuning fork.[13]

One day she brought in the following dream:

I went to a wedding. The groom was Mr. X [the man who interested her in the office from which she had just resigned]. And the bride, even though I did not know her—I noticed she was tall with light hair and eyes. What

[13] Cf. T. V. Moore, *Cognitive Psychology*, p. 279.

impressed me most was that they were both so happy. Crowds seemed to come from everywhere prior thereto.

Her associations with the phrase "I went to a wedding" brought up the second of the above mentioned men, Mr. X. She went on to tell how she kept thinking he was about to ask her to marry him; but another girl in the office kept on breaking in and blocking their wedding. Yet Mr. X never showed any positive sign of interest and the intrusion of the other girl seemed to have been an invention of the patient's to explain away the lack of charm in her own personality. The realization that the man was fundamentally unstable, and could never be faithful to any woman, prompted her resignation, to the surprise and regret of everyone, she said, particularly Mr. X.

In her associations with the phrase "the groom was Mr. X" she went on to tell how Mr. X tried in a secret manner to exert his charm over her and tried to make her stop her work and go over and talk to him. She refused to do this because, in the court of her own mind, she stood on her dignity and demanded that he should first come to her. She accused him of feeling in his mind that he need but walk past her to exert a charm to which she must finally yield. And yet, she complained, he was a very poor Romeo and never did anything to show a special interest, to say nothing of ardent love.

In her association with "the bride who was tall, with light hair and eyes," she went back to memories of herself when she was young. At that time her hair had been golden; much to her disappointment, it had darkened as the years rolled by and now was an uninteresting dull greyish auburn. The tallness of the bride seems to have been a character introduced to exclude the short little girl in the office whom the patient had fixed upon as her rival, and, who, she thought, exerted a malign influence on Mr. X and prevented any manifestation of his interest in herself.

The dream, therefore, has a simple wish fulfillment motif; but in the analysis of it, the patient was helped to see that her idea that Mr. X was deeply interested in her was nothing more than a dream of what she would like to be but in reality was not. About three weeks after the first interview, the patient had acquired considerable insight into her wish fulfillment mechanisms. She had a sense of humor and could laugh at herself. No attempt was made fully to interpret everything, but her mind cleared without such an attempt being made—enough to allow her to come forth from her solitude and take another position.

The delusional concepts apparently did not disappear completely; they continued as part of the ordinary flow of thought, but came up in her mind only sporadically; when they did come they caused very little emotional tension.

A well known psychiatrist once told me that he and a friend of his kept records of the various items of content in the flow of thought. They were rather surprised at the things that flashed at times before their minds. Had these thoughts caused emotional tension and held their place on the level of consciousness, they would have provided a delusional basis for affective abnormalities.

And so in our present patient the wish fulfillment mechanism led to delusions; and the conflict between her two selves, to hallucinatory phenomena. However, similar phenomena are present in some degree in the flow of thought of the ordinary man. But they do not attract attention. They do not lead to emotional reactions. It is quite possible that the follutein, acting as a sympathetic or as a gonadal stimulant, gave the patient more interest in reality, and external interests make it less possible to give attention to internal mental phenomena. But after two or three weeks of treatment she volunteered the information that "transportation" was easier. She did not get upset if she had to go on a streetcar, and on the car she did not give as much attention as formerly to what people were thinking

or saying. Nevertheless, she seemed to have a sneaking idea that they were still talking about her, but it didn't bother her. However, she returned to work and carried on in spite of the high pressure of a busy office.

The case we have just abstracted illustrates the value of psychotherapeutic and pharmacological treatment of a mental condition. There are some mental disorders of a serious nature which will yield to such a combination of treatments when either psychological or physiological methods, if attempted alone, would end in failure.

Our study of the nature and treatment of mental disorders has been a sincere attempt to make use of whatever is available in psychology or physiology to clarify the concept of mental disorder or ameliorate any abnormal condition of the human mind. Successful psychiatry can neglect neither the psychic nor the somatic. The developments in each field are bringing to a close that period in the history of psychiatry in which a psychiatrist could afford to adopt an organic-neurological or an exclusively psychogenic theory and neglect the work in all schools but his own.

The scientific spirit impartially reviews all available evidence and organizes into a unit system whatever is good and true. The growth and development of research in many fields of psychiatry and its allied sciences still awaits an impartial scientific synthesis.

APPENDIX

CLASSIFICATION AND DEFINITION OF THE CLINICAL ENTITIES OF PSYCHIATRY

The main headings in the following classification of mental disorders were derived from the *Standard Nomenclature of Disease and Standard Nomenclature of Operations*, edited by Edwin P. Jordan, M.D., and published by the American Medical Association (Chicago, 1942).

The headings were supplemented by explanatory notes and definitions by Dr. Clarence O. Cheney and published by the National Committee for Mental Hygiene, in its *Statistical Manual for the Use of Hospitals for Mental Diseases* (Utica, N. Y., 1942).

It is of great importance that psychiatrists should refer to a given disorder by the same name in all statistical reports, and that students should become familiar with standard nomenclature. To contribute toward this desirable end, and also to give the student some idea of the variety of the disorders of the mind, it was thought well to add as an appendix to this work the standard classification and the definitions and explanatory notes prepared by the Committee on Statistics of the American Psychiatric Association in collaboration with the National Committee for Mental Hygiene. Pages 23 to 43 of the above mentioned *Statistical Manual* are reprinted here with the permission of Dr. Edwin P. Jordan, editor of *Standard Nomenclature of Disease*, Dr. Neil A. Dayton, chairman of the Committee on Statistics of the American Psychiatric Association, and Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene.

*00-1 PSYCHOSES DUE TO, OR ASSOCIATED WITH, INFECTION

0y0-147 Psychoses with syphilis of the central nervous system

It is expected that cases shall be classified as far as possible under the subgroups (002, 003, 004, 00y). A classification under this general heading is to be made only after failure of every reasonable effort to determine the predominating pathological process.

002-147 Meningo-encephalitic type (general paresis)

The earlier clinically descriptive term, general paralysis, has been discarded in the present classification for the term indicating the fundamental pathological process. Under

this heading are to be classified cases showing rapidly or slowly progressive organic intellectual and emotional defects with physical signs and symptoms of parenchymatous syphilis of the nervous system and completely positive serology, including the paretic gold curve. Cases showing symptoms suggestive of manic-depressive, dementia praecox, or of other constitutional psychotic reactions, but showing also physical signs and symptoms of syphilis of the nervous system and positive serology, particularly the paretic gold curve, are to be listed here rather than under other headings. It is to be remembered that with the modern methods of treatment a number of paretics may be found with negative serology. Here the history, particularly that of the length and nature of treatment, must be taken into consideration in making the final classification.

003-147 Meningovascular type (cerebral syphilis)

Under this heading are to be classified cases in which the history, signs, and symptoms, including serology, point to a primary and predominating involvement of the meninges and blood vessels rather than of the parenchyma of the nervous system. Indicating cerebral syphilis rather than paresis are: comparatively early onset after infection, sudden onset with confusion or delirium, focal signs, particularly cranial nerve palsies, apoplectiform seizures, very high spinal fluid cell count, positive blood Wassermann and negative spinal fluid Wassermann and the luetic type of gold curve, often prompt response to systemic antisyphilitic treatment. Under this heading are also to be classified those cases of chronic syphilitic meningitis which may show mild or severe deterioration in emotional and intellectual reactions, but which usually nevertheless show a clinical picture distinguishable from the paretic. Cases showing psychotic reactions on a basis of cerebral

lesions from vascular disease determined to be of a syphilitic nature should be classified here rather than under the heading of "Psychoses due to disturbances of the circulation." The determination of the syphilitic nature of the vascular disease may be difficult in these old "burned out" cases of syphilis as the serology may be entirely negative. A history of syphilis, of its treatment, of vascular attacks earlier in life, and signs of old systemic syphilis help in the differentiation.

004-147 Psychoses with intracranial gumma

Under this heading are to be classified those comparatively rare cases in which the predominating pathological process is gummatous formation, either single or multiple. In most cases gummata are a part of a diffuse meningovascular process under which they should be classified. Occasionally solitary gummata of large size occur, giving symptoms of intracranial pressure with or without focal signs. Serological examination helps to differentiate these from other intracranial growths. It is to be remembered that persons with systemic syphilis may have brain tumors, and that a positive blood Wassermann in the presence of signs of intracranial growth does not necessarily indicate a gumma. Spinal fluid examination is necessary. Response to antisyphilitic treatment may help in the classification.

0y0-147 Other types. *Specify*

Here should be classified the comparatively infrequent cases of psychoses with syphilis of the central nervous system not covered in the above mentioned groups, including psychoses with tabes dorsalis, providing it is determined that such cases do not belong in the paretic group or the group of cerebral syphilis, as they frequently do. Psychoses ascribed to, or associated with, syphilitic

meningomyelitis may be placed here, with the same reservations.

008-123 Psychoses with tuberculous meningitis

Psychoses developing during the course of a demonstrated tuberculous meningitis should be reported here. Cases developing a tuberculous meningitis during the course of a psychosis should not be reported under this heading but under the primary psychoses.

008-190 Psychoses with meningitis (unspecified)

Here are to be classified those cases developing meningitis, the type of which cannot be specified. Psychoses associated with other forms of meningitis which can be specifically determined are to be listed elsewhere under their proper headings.

003-163 Psychoses with epidemic encephalitis

Here are to be listed those mental disturbances associated with acute phases of epidemic encephalitis, such as delirium or stupor, and those chronic cases with demonstrable residual defects of the intellectual processes and emotions; these defects show themselves in a diminution of voluntary attention, of spontaneous interest, and of initiative; memory impairment is often slight. Apathy, depression, euphoria, anxiety, or emotional instability may be found from case to case.

004-196 Psychoses with acute chorea (Sydenham's)

Here are to be classified patients showing acute and chronic mental disturbances associated with Sydenham's chorea, which may be associated with a more or less marked encephalopathy. Care should be taken to distinguish this type of chorea from the hysterical type; in differentiating, a history of rheumatism and repeated

attacks of tonsillitis, presence of cardiac disease, and fever, help in the establishment of the diagnosis of Sydenham's chorea.

009-1y0 Psychoses with other infectious disease. *Specify*

Here are to be classified those psychoses which are primarily and predominantly to be ascribed to, or associated with, infectious disease particularly during the febrile period. The most common clinical picture met is that of delirium with or without motor excitement or hallucinations. There are frequent shifts in the levels of consciousness; attacks may be followed by amnesia for the period. These infectious psychoses are particularly apt to arise in association with influenza, pneumonia, typhoid fever, and acute articular rheumatism. In the classification, care should be taken to distinguish between these infectious psychoses and other psychoses, particularly the manic-depressive and dementia praecox reactions, which may be made manifest by even a mild attack of infectious disease. Delirious reactions occurring in connection with childbirth are not to be looked upon as infectious psychoses unless there is clear-cut evidence of infection with toxemia, so that the infection appears to be the main etiological factor.

009-1xx Postinfectious psychoses. *Specify organism when known (p. 62 of Nomenclature)*

Here are to be classified those mental disturbances arising during the postfebrile period or the period of convalescence from infectious disease, frequently showing themselves as mild forms of confusion, or depressive, irritable, suspicious reactions. Here also are to be classified the occasionally occurring states of mental enfeeblement following acute infectious disease, especially typhoid fever, acute articular rheumatism, and meningitis. Ab-

normal mental states arising as part of the asthenia or exhaustion following infectious disease are to be classified here rather than under the heading of exhaustion delirium.

00-3 PSYCHOSES DUE TO INTOXICATION

001-332 Psychoses due to alcohol

Under this heading are to be grouped only those cases that have abnormal mental reactions which can reasonably be concluded to have alcohol as the main etiological factor. Excessive alcoholism may be a symptom of some other psychosis or psychopathological condition or, on the other hand, it may aggravate and bring to notice an already existing psychosis of a nonalcoholic nature. Such cases are to be carefully distinguished by the previous history, by the symptomatology and course, and should be grouped elsewhere under their proper categories.

002-332 Pathological intoxication

Under this heading belong those cases which show as a result of small or large amounts of alcohol sudden excitation or twilight states, often with a mistaking of the situation and also with illusions and hallucinations and marked emotional reactions, particularly of anxiety or rage. Such an attack may last a few minutes or a number of hours and usually there is complete amnesia for the attack. In making such a classification, epileptic conditions precipitated by small amounts of alcohol, or catatonic excitation in dementia praecox, or manic-depressive reactions or general paresis or arteriosclerotic episodes are to be ruled out.

003-332 Delirium tremens

Little difficulty is usually experienced in reaching a classification in a case of delirium tremens; the delirium,

often of sudden onset but frequently showing premonitory signs of nervousness and "jumpiness," with predominantly visual hallucinations and distinct clouding of the sensorium, defects of attention, and physical prostration, with marked tremors, point to this classification. Cases which do not recover within two weeks may require careful consideration for differentiation from Korsakoff's psychosis.

004-332 Korsakoff's psychosis

This reaction is sometimes referred to as chronic alcoholic delirium in contrast to the acute delirium of delirium tremens. The onset of the two types of reactions may be similar, although in the Korsakoff reaction there is noticed at times a more marked interference with the intellectual functions than in delirium tremens. The course is a protracted one, however. After the acute stages are recovered from, there is usually a striking defect of retention, with confabulation. Perhaps the majority of these patients are left with a permanent defect of memory and retention, but occasionally patients are seen who completely recover. Polyneuritis is frequently a part of the total reaction; it may be severe, leaving physical defects of a permanent nature; in other cases it is slight and is recovered from, and in still other cases polyneuritis is not demonstrable and is not considered necessarily a criterion of the Korsakoff reaction. The Korsakoff syndrome appearing in connection with other toxic conditions, i.e., toxemia in pregnancy, should not be classified under this heading.

007-332 Acute hallucinosis

Under this heading should be grouped those cases that as a result of the excessive use of alcohol develop suddenly or gradually hallucinations, particularly of the auditory type, with a characteristic fear or anxiety reaction but with

retention of clearness of the sensorium. Physical prostration and other toxic physical signs are not as outstanding as they are in delirium tremens. These cases, particularly those which do not recover within a few weeks but continue in a chronic hallucinatory state, often require careful differentiation from dementia praecox reactions, and consideration has to be given to the possibility that in certain potential or actual cases of dementia praecox alcohol has precipitated a psychotic reaction which should be classified as one fundamentally of dementia praecox.

0y0-332 Other types. *Specify*

Under this heading are to be grouped psychotic reactions on an alcoholic basis not already specified in the above subgroups. In the present subgroup there may be placed, under the designation "Deterioration," those chronic alcoholics who appear to show deterioration not only in the moral and ethical senses and in their emotional blunting, but also evidence of an organic memory defect. Other chronic alcoholics who seem to develop paranoid ideas, particularly delusions of infidelity in connection with chronic drinking, may best be placed in this subgroup with the designation "Paranoid type."

002-300 PSYCHOSES DUE TO A DRUG OR OTHER EXOGENOUS POISON

002-310 Psychoses due to a metal. *Specify* (*p. 70 of Nomenclature*)

Here are to be grouped those psychotic cases due usually to prolonged exposure to metallic poisoning, particularly lead, arsenic, and mercury. Persons so exposed, often showing earlier gastro-intestinal and peripheral nerve toxic symptoms, may develop deliria with marked prostration from which they may recover, or they may be left with intellectual or emotional defects apparently based

on encephalopathy associated with these toxic conditions. The clinical picture at times resembles the Korsakoff syndrome.

002-350 Psychoses due to a gas. *Specify (p. 72 of Nomenclature)*

Under this heading should be placed the cases that develop mental disturbance from exposure to poisonous gases, particularly carbon monoxide gas in illuminating gas and automobile exhaust. The preliminary period of unconsciousness may be followed by a more or less protracted delirium after which the patients may be left with increased fatigability and difficulty in concentration. It should be recalled that persons who have suffered from carbon monoxide poisoning may appear to clear up entirely from the initial disturbance and have a free interval lasting over weeks, to be followed by the appearance of symptoms of defect which may not be recovered from. These patients remain in a chronic state of mild or severe mental enfeeblement.

002-370 Psychoses due to opium or a derivative

Here should be grouped those comparatively infrequent psychotic reactions appearing in habitual users of opium and particularly its derivative morphine. Such effects appear to show themselves in mental deterioration with demonstrable memory defect as well as an ethical and social deterioration. Paranoid states may also develop. Difficulty may be experienced in differentiating the actual effects of the morphine intoxication from the underlying personality defects which seem frequently to be present and which would place these individuals for statistical purposes rather in the group of psychopathic personalities. Drug addicts who do not show definite psychotic manifestations sufficiently to justify their hospitalization or

their special treatment because of their mental condition should be classified not under this subgroup but under the heading "Drug addiction" (000-3xx).

002-3.. Psychoses due to another drug. *Specify* (*p. 70 of Nomenclature*)

Here should be classified those cases which develop abnormal mental states in association with long-continued or brief excessive use of other drugs such as cocaine, bromides, chloral, acetanilid, phenacetin, sulfonal, trional, and proprietary combinations. Following the use of these drugs certain individuals become dull or apathetic, these conditions sometimes being followed by toxic delirium with confusion, hallucinations of sight and hearing, flight of ideas, confabulation, misidentification, and paraphasia. Cases developing a toxic reaction from the use of drugs in the treatment of another form of psychosis should be reported according to the primary psychosis and not as drug psychoses.

00-4 PSYCHOSES DUE TO TRAUMA

Under this heading should be classified only those cases of fairly characteristic psychotic reactions which it is reasonable to conclude were brought about by head or brain injury as a result of force directly or indirectly applied to the head. Psychoses following injuries to other parts of the body are not to be classified here. Manic-depressive psychoses, general paresis, dementia praecox, and psychoneuroses in which trauma may act as a contributing or precipitating cause should not be included in this group.

009-42x Delirium due to trauma

Here belong those cases of acute (concussion) delirium developing immediately following head injury and also

those which show, following such injury, a protracted or chronic delirium which often resembles the Korsakoff syndrome, with superficial alertness but marked disorientation, memory defect, and confabulations.

009-4x9 Personality disorders due to trauma

This term is used in place of the former designation of post-traumatic constitution and is intended to apply to those cases showing post-traumatic changes in disposition, with vasomotor instability, headache, fatigability, and explosive emotional reactions, intolerance to alcohol, and sometimes convulsive seizures. A complete history of the previous personality reactions and a careful evaluation of the present reaction are often necessary to rule out psychoneuroses.

003-4xx Mental deterioration due to trauma

Here are to be classified those cases which, following severe or apparently slight head injury with or without an acute or protracted delirium, develop a gradually increasing mental enfeeblement or dementia. Symptoms mentioned under post-traumatic personality disorders may also be present. Psychoses to be ascribed to arteriosclerosis, complicated by head injury, may be difficult to differentiate. If the case history shows symptoms of arteriosclerosis before the injury and the mental and physical examination bears this out, the case should be classified under that heading instead of under the present one. It is to be remembered that the confusion of an arteriosclerotic or a cerebral attack may have brought about the head injury.

003-4y0 Other types. *Specify*

It appears that only occasionally will other traumatic reaction types be found to be classified under this heading.

00-5.0 Psychoses Due to Disturbance of Circulation

003-512 Psychoses with cerebral embolism

Emboli interfering with the cerebral circulation, causing cerebral softening and neurological or psychotic symptoms, may arise from the pulmonary circulation, from vegetations on the heart valves, or from thrombosis of the arteries of the neck and head. The incidence of such occurrences is comparatively rare, however.

003-516 Psychoses with cerebral arteriosclerosis

Here are classified the comparatively large group of middle-aged and old persons who show evidence of interference with the cerebral circulation in such symptoms as difficulty in sustained mental operations, confusion, loss of memory, and general impairment of the intellectual functions in varying degrees. Preservation of the personality and insight into the defects may be present in early or mild cases, but in severe circulatory disturbance, with cerebral destruction, mental enfeeblement may be advanced to a high degree. In elderly persons hypertension may or may not be found in the presence of severe vascular disease. Cases with essential hypertension or with arteriosclerosis without demonstrable degenerative changes in the larger vessels, but showing psychotic symptoms of the arteriosclerotic type, should be classified here. Differentiation from the senile psychoses is sometimes difficult; the pathological changes lying at the basis of the two psychotic reaction types may be associated. The age, history, and careful survey of the symptoms often assist one in determining which is the predominant type of reaction, but where such a determination is not clearly possible, preference should continue to be given, for statistical purposes, to the arteriosclerotic classification.

009-5xx Psychoses with cardiorenal disease

Here are to be classified those psychotic disturbances, particularly deliria or temporary periods of confusion, often worse at night, shown by persons with cardiac disease, especially in stages of decompensation. Fearful hallucinations sometimes occur. There is difficulty in concentration and memory may be impaired. Marked fluctuations in the degree of mental clearness may be striking. Also to be classified here are the psychotic changes associated with acute and chronic kidney disease, including uremia.

003-5y0 Other types. *Specify*

Rarely will there be psychoses developing because of disturbance of circulation that may not be properly classified under the headings already mentioned, but if such cases arise they should be classified under this present heading.

00-5.5 Psychoses Due to Convulsive Disorder (Epilepsy)

Under this heading will be classified only cases that show psychotic disturbances in connection with epilepsy which appears to be primary, essential, or idiopathic. Cases showing convulsive manifestations symptomatic of other diseases are to be classified under the headings for these diseases rather than under the present heading.

003-550 Epileptic deterioration

Under this heading are to be classified those epileptics who show a gradual development of mental dulness, slowness of association and thinking, impairment of memory, irritability, or apathy. Various accessory symptoms, paranoid delusions, and hallucinations may be added to this fundamental deterioration.

003-560 Epileptic clouded states

Here are to be classified those epileptics who develop, preceding or following convulsive attacks or as equivalents of attacks, dazed reactions with deep confusion, bewilderment, and anxiety or excitement, with hallucinations, fears, and violent outbreaks; instead of fear there may be ecstatic moods with religious exaltation.

003-5y5 Other epileptic types. *Specify*

Here are to be classified the occasional epileptics who without obvious deterioration or clouded states may develop psychotic manifestations such as paranoid trends or hallucinatory states, depressions, or elations.

00-7 PSYCHOSES DUE TO DISTURBANCES OF METABOLISM, GROWTH, NUTRITION, OR ENDOCRINE FUNCTION

001-79x Senile psychoses

Some feebleness of mind is characteristic of, and normal for, old age. It may be designated as senility or dotage. It is characterized by self-centering of interests, reminiscence, and difficulty in assimilation of new experiences so that there is forgetfulness of recent occurrences; childish emotional reactions are prominent, with irritability aroused on slight provocation. Such mental states may best be classified under a heading "Senility" in the group "Without psychoses," rather than with the senile psychoses.

002-79x Simple deterioration

Under this heading should be classified as psychotic those persons who show definite exaggeration of the normal senile mental change, in loss of memory for recent events particularly, defects of attention and concentration, misidentification of persons and of places, and lack of appreciation of time. Such persons may require special

hospital care because of restless wandering, marked irritability or assaultiveness, erotic excitement, or because of delusions which may be fleeting or persistent. Deterioration of the mental processes may progress to a state of vegetative existence.

003-79x Presbyophrenic type

Under this heading are to be classified those cases of senile psychosis showing severe memory and retention defects, with complete disorientation but at the same time preservation of mental alertness and attentiveness, with ability to grasp immediate impressions and conversation quite well. Forgetfulness leads to marked contradictions and repetitions; suggestibility and free fabrication are prominent symptoms. The general picture resembles the Korsakoff mental complex.

004-79x Delirious and confused types

Here are to be classified those cases in which the outstanding picture is one of deep confusion or of a delirious condition. This type of reaction is often precipitated by acute illness.

005-79x Depressed and agitated types

In certain cases of senile psychoses the outstanding picture may be one of pronounced depression and persistent agitation. Such patients are to be distinguished from cases of involution melancholia by the presence of fundamental defects of the memory and grasp of recent occurrences.

006-79x Paranoid types

In certain cases well marked delusional trends, chiefly of a persecutory or expansive nature, may accompany the deterioration; in the early stages the diagnosis may be

difficult, particularly if the defect symptoms are mild or absent on superficial examination.

930-796 Alzheimer's disease (presenile sclerosis)

This condition is characterized in its pathological manifestations by a very marked brain atrophy with microscopic focal necroses and neurofibral alteration. Clinically these cases present at a comparatively early age period, sometimes in the forties, a high degree of dementia, often with aphasic or apractic symptoms. In the absence of other causes for an organic dementia, Alzheimer's disease is to be considered, although few cases may be classified clinically as belonging to this group.

001-796 Involutional psychoses

002-796 Melancholia

Here are to be classified the depressions occurring in middle life and later years without evidence of organic intellectual defects, characterized mainly by agitation, uneasiness, and insomnia, often with self-condemnatory trends and hypochondriasis. For statistical purposes, cases showing such symptoms but with a history of previous attacks of depression or excitement before the involution period should be classified with the manic-depressive group.

003-796 Paranoid types

Here should be classified those cases that during the involutional period, and without previous indication of paranoid reactions, show transitory or prolonged paranoid reactions with delusions of persecution, suspiciousness, and misinterpretation.

0y0-796 Other types. *Specify*

Other types of psychotic reactions occurring during the involutional period and from which organic brain

disease can be excluded, may be classified under this heading.

00x-770 Psychoses with glandular disorder. *Specify glandular disorder (p. 427 of Nomenclature)*

This classification is provided for those cases which show psychoses obviously to be ascribed to diseases of the endocrine glands, separating them off for statistical purposes from psychoses occurring with other somatic diseases. Outstanding among the cases classified here are psychoses associated with disorders of the function of the thyroid gland, more specifically the hallucinatory deliria of thyrotoxicosis, and the apathy of myxedema, the latter often accompanied by paranoid trends. Psychoses to be ascribed to diabetes, disorders of the pituitary, Addison's disease, and multiglandular disorders should be classified under this heading.

009-712 Exhaustion delirium

Under this heading should be classified only those cases which do not have infectious disease or other organic disease as a basis for the delirium. Care should be taken to rule out manic-depressive and dementia praecox reactions of a delirious nature, before classifying cases as due to exhaustion. With proper elimination of cases belonging to the other categories, it appears that cases with true exhaustion delirium are rare.

009-7623 Psychoses with pellagra

Under this heading should be classified only those psychoses developing during the course of pellagra and apparently caused by this disease. The mental disturbances occurring in connection with pellagra are deliria or confused states similar to other toxic-organic reactions. Cases developing pellagra during the course of some other psychosis should not be classified under this heading but rather under the primary psychosis.

009-yxx Psychoses with other somatic disease. *Specify disease*

Here should be classified only those psychoses developing in connection with other somatic disease not already specified in the classification, ruling out psychoses with infectious diseases and postinfectious psychoses which are provided for elsewhere in the classification.

00-8 PSYCHOSES DUE TO NEW GROWTH

003-8.. Psychoses with intracranial neoplasm. *Specify (p. 87 of Nomenclature)*

Psychoses developing during the course of intracranial neoplasms (brain tumor) should be classified here whether the brain tumor is primary or secondary.

009-8.. Psychoses with other neoplasm. *Specify (p. 87 of Nomenclature)*

Here should be classified those psychoses developing in connection with new growths elsewhere in the body, these growths being instrumental in bringing about psychotic reactions either by their general toxic effects or by their psychological effects on the patient. Toxic delirious conditions may be seen, or depressions with hopelessness, with or without agitation.

00-9 PSYCHOSES DUE TO UNKNOWN OR HEREDITARY CAUSES, BUT ASSOCIATED WITH ORGANIC CHANGE

Under this heading, which takes the place of the former classification designation of "Psychoses with other brain and nervous diseases," are to be classified those psychoses developing with, and as a part of, certain diseases of the nervous system not classified under foregoing headings, specifically multiple sclerosis, Pick's disease, paralysis agitans, and Huntington's chorea. These psychoses are

essentially of the organic brain disease type, with defects in the intellectual functions and emotional deterioration, sometimes with accessory symptoms of hallucinations and delusions. Cases showing psychoses of a constitutional or functional nature prior to the development of symptoms of the organic nervous disease, and in which therefore the latter disease seems incidental, should be grouped under the heading of the primary psychosis rather than under the present heading.

00-x Disorders of Psychogenic Origin or without Clearly Defined Tangible Cause or Structural Change

This heading is so worded in the present nomenclature to imply that the disorders classified under it may or may not be of psychogenic origin, but that there is no *clearly defined tangible* cause or structural change. Reference to heredity and "constitutional psychoses" made in the previous nomenclature is eliminated, although it would seem that the latter term served a useful purpose.

001-x10 Manic-depressive psychoses

This group comprises the essentially benign, affective psychoses, mental disorders which fundamentally are marked by emotional oscillations and a tendency to recurrence. Various accessory symptoms such as illusions and hallucinations may be added in individual cases to the fundamental affective alterations. To be distinguished are:

001-x11 Manic type, with elevation of spirits (elation) or irritability, with overtalkativeness or flight of ideas and increased motor activity. Transitory, often momentary swings to depression may occur but should not change the classification from the predominantly manic type of reaction.

001-x12 Depressive type, with outstanding depression of spirits and mental and motor retardation and inhibition; in some cases the mood is one of uneasiness and anxiety.

001-x13 Circular type. Here should be classified cases which show a change without a free or recovered interval of one phase to the opposite, i.e., when a manic reaction passes over into a depressive reaction or vice versa.

001-x14 Mixed type. This term is not meant to apply to those cases that show transitory changes from depressive to elated moods or the reverse but is for those cases that show a combination of the cardinal symptoms of manic and depressive states. Perhaps the most frequent of these is the agitated depression, i.e., a depression of mood but with increased motor activity and at times pressure of thought. Occasionally also are seen cases of a so-called manic stupor in which there is elation and flight of ideas but with retarded motor activity amounting at times to complete immobility. Still other cases show elevation of mood and increased motor activity but without evident pressure of thought or flight of ideas, a so-called "unproductive mania."

001-x15 Perplexed type. In this type of reaction perplexity is an outstanding symptom in a depressive setting. Patients are apparently unable to understand their surroundings or they misinterpret them. Apparently as a result of this, they may show strange symptoms and bizarre behavior. The prognosis in general is good but the attacks may run a long course. Such patients are sometimes mistaken for cases of dementia praecox. The perplexity and general depressive reaction are differentiating features.

001-x16 Stuporous type. This reaction is characterized by a marked reduction in activity, at times leading to

immobility. The mood is essentially one of depression and mutism may be present, and this with drooling and muscular symptoms at times suggests the catatonic form of dementia praecox. Retrospectively, however, it is found that the sensorium has been clouded and that there may have been ideas of death and dreamlike hallucinations.

001-x10 Other types. *Specify.* The above classification covers the majority of the manic-depressive reactions but occasionally there may be found some other type to be classified under this subgroup.

001-x20 Dementia praecox (schizophrenia)

This general group is divided into the following several subgroups because of the prominence of the various symptoms in individual cases, but it is to be borne in mind that these are only relative distinctions, and transitions from one clinical form to another are common.

001-x21 Simple type. Cases to be classified under this heading show essentially defects of interest with gradual development of an apathetic state but without other strikingly peculiar behavior and without expression of delusions or hallucinations.

001-x22 Hebephrenic type. Cases to be classified under this heading show prominently a tendency to silliness, smiling, laughter which appears inconsistent with the ideas expressed; peculiar, often bizarre, ideas are expressed, neologisms or a coining of words or phrases not infrequently occurs and hallucinations which appear pleasing to these individuals may be prominent.

001-x23 Catatonic type. These cases show prominence of negativistic reactions or various peculiarities of conduct with phases of stupor or excitement, the latter characterized often by impulsive or stereotyped behavior and usually hallucinations. It is found

retrospectively that in the stupor the sensorium has remained clear.

001-x24 Paranoid type. These cases are characterized by prominence of delusions, particularly ideas of persecution or grandeur and frequently with a consistent emotional reaction of aggressiveness due to persecution. There may be hallucinations in various fields to which the patients react at first consistently but later, as deterioration occurs, apathy or indifference may make an appearance. A predominately homosexual component or fixation at this level of development appears prominent in this group of cases whereas the previous groups show evidence frequently of not having reached this level or of having regressed to more infantile levels of psychosexuality.

001-x10 Other types. *Specify.* Occasionally other types of reactions of dementia praecox may be met with, to be classified under this present heading.

001-x30 Paranoia

From this group should be excluded the deteriorating paranoic states (dementia praecox) and paranoid states symptomatic of other mental disorders, included under the organic brain disease, toxic, and other groups. In the present group are to be classified those cases showing fixed suspicions and ideas of persecution logically elaborated for the most part after a false interpretation of an actual occurrence has been made. The emotional reactions are consistent with the ideas held and such persons may become dangerous because of their tendency to take action against their alleged persecutors. Intelligence, which is often of a superior type, is well preserved. In this group belong certain types of reformers, agitators, litigious persons, and prophets. Hallucinations, if present, are not prominent and may consist of visions, particularly in religious ecstasies.

001-x31 Paranoid conditions

Cases in this group lie between the paranoia and paranoid dementia praecox groups in respect to the preservation of their personalities, coherence of their thinking, and abnormalities in behavior. In this group should be classified those cases showing predominantly delusions, usually of a persecutory nature, with an inclination more toward illogical thinking and misinterpretation. Hallucinations may be prominent. Such conditions may exist for many years with little if any deterioration in general interests and with better preservation of the emotional reactions than in the paranoid form of dementia praecox.

001-x40 Psychoses with psychopathic personality

In this group are to be classified those cases that show abnormal reactions essentially of an emotional and volitional nature apparently on the basis of constitutional defect, which are not to be classified under the groups already described. Cases of intellectual defect (feeblemindedness) are not to be included in this group.

Psychopathic personalities are characterized largely by emotional immaturity or childishness, with marked defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes. Special features in individual psychopaths are prominent criminal traits, moral deficiency, vagabondage, and sexual perversions. Intelligence as shown by standard intelligence tests may be normal or superior, but on the other hand, not infrequently, a borderline intelligence may be present.

The abnormal reactions which bring psychopathic personalities into the group of psychoses are varied in form but usually of an episodic character. Most promi-

nent are attacks of irritability, excitement, depression, paranoid episodes, transient confused states, etc. True prison psychoses belong in this group.

A psychopathic personality with a manic-depressive attack should be classed in the manic-depressive group and likewise a psychopathic personality with a schizophrenic psychosis should go in the dementia praecox group. Psychopathic personalities without episodic mental attack or psychotic symptoms should be placed in the group "Without psychosis."

001-x50 Psychoses with mental deficiency

Under this heading should be classified those mental defectives that show psychoses. These are usually of an acute transitory nature and most commonly are episodes of excitement with depression, paranoid trends, or hallucinatory attacks. The degree of mental deficiency should be determined from the history and the use of the standard psychometric tests.

Mentally deficient persons may suffer from manic-depressive attacks or from dementia praecox or from the organic psychoses and they should be classified then under such respective headings instead of under the heading of mental deficiency. Cases of mental deficiency without psychotic disturbances should be placed in the group "Without psychosis."

PSYCHONEUROSES

Hysteria

002-x00 Anxiety hysteria

There is not complete agreement on what should be covered by this designation. According to one viewpoint, anxiety hysteria is conversion hysteria with anxiety added to the clinical picture. From another viewpoint, anxiety hysteria includes those reactions which are indi-

cated in the present classification under "Psychasthenia, phobia" (002-x23). From still another viewpoint, anxiety hysteria is not a desirable designation and all reactions which have been previously designated as anxiety hysteria are, according to this viewpoint, more properly classified as anxiety states (002-x33).

For statistical purposes, patients showing conversion phenomena with recurring attacks of anxiety may be classified under anxiety hysteria. Other patients who present conversion symptoms or phobias but who are relatively free from recurring attacks of anxiety may be grouped under "Conversion hysteria" (002-x10) or "Psychasthenia, phobia" (002-x23). Because of the frequent combination of psychoneurotic symptoms in individual cases the classification "Mixed psychoneurosis" (002-x0x) may be the proper one in many instances.

002-x10 Conversion hysteria

Cases should be classified according to the subgroups under this general heading. The symptoms to be found in these various types are indicated in the classification for guidance in differentiation and are self-explanatory. It is to be recalled, however, that some of these hysterical symptoms may occur in the psychoses, and by themselves are not diagnostic; the whole clinical history and picture must be considered.

Psychasthenia or compulsive states

Under this heading are to be classified those cases showing predominantly obsessions, compulsive tics and spasms, and phobias; examples of frequent symptoms are given in the classification for guidance in differentiation.

002-x30 Neurasthenia

To be designated under this heading are those cases in which organic disease is ruled out, and with complaints of

motor and mental fatigability, diminished power of concentration, and pressure in the head, scalp, neck, or spine. Early dementia praecox or mild depressions of the manic-depressive type not infrequently have to be considered in the differential diagnosis.

002-x31 Hypochondriasis

Under this heading are to be classified those cases that, without other symptoms of a psychosis or psychoneurosis, show essentially an obsessive preoccupation with the state of their health or of various organs, with a variety of somatic complaints which are not relieved by demonstration of a lack of pathology. Occurring frequently in the involutional period, they are to be differentiated from involution melancholia by the absence of marked depression with agitation and self-condemnation. Hypochondriacal complaints may be a symptom of dementia praecox and this reaction type should be eliminated before classifying cases here.

002-x32 Reactive depression

Here are to be classified those cases which show depression in reaction to obvious external causes which might naturally produce sadness, such as bereavement, sickness, and financial and other worries. The reaction, of a more marked degree and of longer duration than normal sadness, may be looked upon as pathological. The deep depression, with motor and mental retardation, shown in the manic-depressive depression is not present, but these reactions may be more closely related in fact to the manic-depressive reactions than to the psychoneuroses.

002-x33 Anxiety state

Cases which show more or less continuous diffuse anxiety and apprehensive expectation, with paroxysmal exacerba-

tions associated with physiological signs of fear, palpitation, dyspnea, nausea, diarrhea, are to be classified here. Emotional tension is apt to be high and irritability and intense self-preoccupation may be prominent, particularly during episodes. The diagnosis should not be made until all other more clearly defined types showing anxiety as a symptom have been excluded.

001-y00 UNDIAGNOSED PSYCHOSES

In this group should be placed the cases in which a satisfactory diagnosis cannot be reasonably made and in which the psychosis must therefore be regarded as an unclassified one. Most frequently this may be due to lack of history, inaccessibility of the patient, or a too short period of observation. On the other hand, the clinical picture may be so obscured and the symptoms so unusual that a reasonably accurate classification cannot be made.

The number of undiagnosed psychoses may reflect the attitude of physicians, indicating either inadequacy of careful collection of facts and insufficient observation or, on the other hand, may indicate a too rigid tendency to absolute accuracy. It may be mentioned that reasonable accuracy and not absolute accuracy is looked for in statistical classification of medical conditions; this does not mean guessing at a classification or forcing one without reasonable facts.

0y0-y00 WITHOUT MENTAL DISORDER

Attention is called to the note in the classification that this heading is to be used only in psychiatric clinics and in psychiatric hospitals. In these as well as in noninstitutional practice the nonpsychotic condition which the patient shows is to be reported according to the designations in the classification. Disorders not named in the

classification are to be specified under "Other nonpsychotic diseases or conditions."

000-163 Disorders of personality due to epidemic encephalitis

Here are to be classified those cases that show comparatively mild changes in personality as a result of epidemic encephalitis. These changes are not severe enough to handicap the individual in his relations with others. Erratic disordered behavior is not shown, intellect is not impaired, and there is no marked emotional instability.

Cases showing character changes which disturb relations with others and that show disordered erratic behavior, intellectual defects, or marked emotional instability should be classified as "Psychosis with epidemic encephalitis" (003-163).

000-x40 Psychopathic personality

The symptoms listed in the classification are included as guides in the differentiation of the various types of psychopathic personality. Cases showing combinations of these traits should be classified under "Mixed types."

Psychopathic personalities showing episodes of excitement, depression, definite paranoid trends, hallucinatory states, and other marked deviations from their usual personality reaction, should be classified as "Psychoses with psychopathic personality."

INDEX OF AUTHORS

Abraham, Karl, 40 f.
Adler, Alfred, 57, 64 ff., 120
Alexander, Franz, 69 ff.
Almansi, Renato, 263
Alpers, Bernard J., 252
Alvarez, Walter C., 73

Barahal, Hyman S., 75
Bard, Philip, 255
Barris, R. W., 252
Barry, Herbert, 84
Baynes, Cary F., 107
Baynes, H. G., 107
Beattie, John, 250
Beaumont, William, 73
Beiglböck, William, 264
Blanton, Smiley, 139
Bleuler, Eugen, 83
Bowers, Anna Mae, 129, 165, 174
Bridges, Katherine B., 45 f.
Brill, A. A., 119
Bronner, Augusta F., 129, 165, 174
Brown, William, 107
Bryan, Alice I., 216
Bühler, Charlotte, 43, 47 f.
Bullis, H. Edmund, 218

Cabot, 72
Cade, A., 73
Caillet, M.-P.-L., 249
Cannon, W. B., 72 f., 254
Cantril, Hadley, 257 f.
Carlisle, Chester L., 266
Cassino, Frank, 181
Cerletti, U., 262
Cheney, Clarence O., 277
Clark, LeGros, 250
Coachman, Dorothy F., 217
Conn, Jacob H., 41, 43
Connolly, C. J., 22
Cortell, R., 265
Cottrell, Samuel S., 253
Creglow, Elizabeth R., 217
Crookshank, F. G., 65

Dalbiez, Roland, 178
Dana, C. L., 254
Dandy, W. E., 260
Dayton, Neil A., 277
Dicks, Henry V., 43, 148
Dott, Norman M., 250
Dunbar, Flanders, 76
Dynes, J. B., 258

Feldman, J., 265
Finesinger, Jacob E., 258
Floherty, John J., 224
Foerster, O., 29, 254
Freud, Sigmund, 1, 26, 33–40, 41, 43 f., 48–55, 57, 63 ff., 70 f., 85 ff., 94, 116, 122, 128, 146 ff., 165, 177 f., 190, 260
Friedjung, Josef K., 52
Frink, H. W., 93

Gagel, O., 29, 252, 254
Gellhorn, Ernst, 263 ff.
Gibbs, E. L., 29
Gibbs, F. A., 29
Gilbert, Ariadne, 224
Glueck, Bernard, 65
Goeckerman, William A., 75
Griesinger, W., 1
Grinker, Roy E., 258

Harrington, Milton, 3
Haynes, Harry J., 266
Head, Henry, 251
Healy, William, 129, 165, 174
Hendrick, Ives, 40, 44, 51
Henry, George W., 7
Hewes, Agnes Danforth, 232
Howard, Frank E., 148
Howe, Eric Graham, 156
Hsü, En Hsi, 10, 13, 15, 20, 23
Huddleson, J. H., 5
Hunt, William A., 257 f.

Impastato, David J., 263
Ingram, W. R., 252

Jacobi, Jolan, 56, f., 64
James, William, 56, 248
Jessner, Lucie, 263
Jones, Ernest, 40, 44, 128
Jones, Mary Cover, 92
Jordan, Edwin P., 277
Jung, C. G., 55–64, 107

Kamman, Gordon C., 216
Kant, Immanuel, 59
Katzenelbogen, S., 262, 264
Kinnier Wilson, S. A., 253
Komora, Paul O., 84
Kraepelin, Emil, 5–10, 25, 28, 78
Krafft-Ebing, R. von, 77 f., 81
Kretschmer, E., 26
Kuhn, Anna, 231

Landauer, Karl, 45
Lange, C., 248
Lashley, K. S., 3
Latarjet, A., 73
Leloir, Henri, 75
Levy, David M., 41 ff.
Lind, John E., 65
Lindeman, Erich, 258
Loehner, Conrad A., 265

McDougall, William, 107
Maeder, A. E., 120 ff.
Malamud, William, 87
Malzberg, Benjamin, 84
Marañon, G., 30, 257
Masserman, Jules H., 255 f.
Maurer, S., 264
Medina, Gonzalez, 75
Meduna, Ladislaus von, 262 f.
Menninger, Karl, 216
Menninger, William C., 216
Meyer, Adolph, 5, 105
Moffat, W. M., 265
Moore, Thomas V., 8 f., 10, 13, 15, 17, 19 f., 22 f., 25 f., 30 f., 54, 63, 87, 167, 205 f., 220, 233, 248, 255, 267, 273
Moulton, Forest Ray, 84
Murchison, Carl, 255

O'Malley, Emily, 219
Oppenheim, H., 259 f.

Palmer, G., 87
Papez, James W., 260
Pasteur, Louis, 225
Patry, Frederick L., 148
Peale, N., 139
Pfister, Hans Oscar, 263
Plato, 59
Pomeranz, Esther B., 216
Pratt, Carl Chapman, 46

Rank, Otto, 103, 126 f., 142
Ranson, S. W., 252
Ratcliff, Arthur J. J., 119
Rauth, J. Edward, 219 f.
Rayner, Rosalie, 93
Riddock, George, 250
Ryan, V. Gerard, 263

Sadger, J., 135
Sakel, Manfred, 262
Sales, Francis de, 167 f.
Sears, Robert R., 55
Serota, Herman, 258
Sharpe, Ella Freeman, 119
Sherman, Mandel, 45
Silberer, H., 120
Simon, C. M., 224
Skidmore, Hubert, 224, 227
Sogliani, Giorgio, 264
Sollier, Paul, 75
Stekel, Wilhelm, 103
Stern, William, 48
Stevenson, George S., 277
Störring, Gustav E., 251
Stratton, G. M., 46
Stullken, E. H., 213
Swinburne, Algernon Charles, 205
Symonds, Percival M., 71

Tarumianz, M. A., 217
Teagarden, Florence, 41

Thurstone, L. L., 25
Tod, H., 258

Wallin, J. E. W., 94 f.
Watson, John B., 93 f.
White, James C., 254
White, William A., 166
Williams, Edward H., 266
Wilson, S. A. Kinnier, 253
Wundt, C., 7

Yule, G. Udney, 9

Ziehen, Theodor, 7
Zilboorg, Gregory, 7

INDEX OF SUBJECTS

Abnormal behavior and reading disabilities, 208
Abreaction, *and* cure of phobia, 105, 129
  Jung's concept of, 107
Adrenalin, injection of, and emotional expression and experience, 257 ff.
Affective experience, *and* mecholyl, 258 ff.
  and thalamic lesions, 250
  See also Emotion
Affective reactions and disseminated sclerosis, 249, 253
Analysis, *by* association, 243
  based on patient's outline of his emotional history, 148
  by free association, 143
Anxiety, childhood, origin of, according to Freud, 53
  neurosis, Freud's concept of, 50
  sexual restraint and, 165
Archetypes, concept of, in Jung, 57 ff.
Association, analysis by, 243
  of symptoms in psychiatry, 8
  Yule's coefficient of, 9

Behavior problems, 6
Benzedrine sulfate as aid in psychotherapy, 151
Bibliotherapy, 216 ff.
Birth control and psychoneurotic conditions, 170 ff.
Birth trauma, 53

Canities and fright, 74
Cardiazol (metrazol), in treatment of schizophrenia, 262
Castration complex, 40 ff., 133
Catalepsy and hypothalamic injury, 252
Catatonia, 22
Catatonic dementia praecox, 22
Cathexis, 36, 174
Cause of phobia, efficient, 109
  final, 109
  formal, 109
  material, 109
Celibacy, *and* insanity, 85
  and psychoneurotic conditions, 55
Center of experience, individual as, 260
Change, resistance to, 189
Character types, according to Jung, 56
Child, unwanted, 178
Children, anxieties of, origin of, according to Freud, 53
  problems of, *and* parental attitudes, 184, 195, 209
  reactions of, to genital differences, 41 ff.
Clinical entities of psychiatry, 25
Complex, castration, 40 ff.
  inferiority, 66
  superiority, 67
Concept, *of* psychoneurosis, 4
  of psychoses, 4
  of the sexual, in Freud, 52
Conduct problems and reading disability, 208
Conflict expressed by pain, 187
Confrontation, therapy by, 245
Conscience and superego, 38
Consciousness, degrees of, according to Jung, 57
Constitutional hereditary depression, 10
Constitutional psychopathic inferiority, 5
Constitutional psychopathic states, 5
Corporal punishment, 183, 190

Definition of general factor, 10 n.

Dementia praecox, catatonic, 22
paranoid, 19
Depression, constitutional hereditary, 10
retarded, 13
Disordered heart action, 73
and neurotic personality, 160
Disorders, truly mental, existence of, 2
Displacement, example of, 174
Disseminated sclerosis and affective reactions, 249, 253
Dream, anagogic interpretation of, 120
analysis, 80, 149, 273 ff.
as indicator of patient's own solution to his problem, 120
two types of, according to Jung, 60

Economic stress and mental disorders, 84
Educational therapy, 206 ff.
Efficient cause of phobia, 141
Ego, differentiation of, from nonego, 69
Freudian concept of, 35
Electra complex, 36
Electrically induced convulsion, treatment of schizophrenia by, 263
Emotion, bodily resonance of, 31
normal roots of, 31
as specific psychic experience, 31
See also Affective experience
Emotional affection and volitional love, 179
Emotional conditions, acute, and insanity, 77 ff.
double origin of, 259
expression and experience of, and injection of adrenalin, 257 ff.
Emotional expression and experience exaggerated by hypothalamic stimulation, 253 ff.
Emotional shock, results of, 82
single, as origin of psychoneuroses and psychoses, 77 ff.
Emotional tension, chronic, and skin eruptions, 75
Emotions, cerebral center of, 29
development of, 45 ff.
Lange-James theory of, 248
physiological and psychological, 29 ff.
physiology of, 248 ff.
unconscious, negated by Freud, 35
Endocrine activity and sexual experience, 49
Entities, psychiatric, 6 ff.
explanation of, 25
Enuresis, 188 ff.
Euphoria sclerotica, 253
Eutonia sclerotica, 253
Excitement, manic, 15
Extroversion, 56

Family, concept of, 197
organization and origin of phobias, 97
problems and their treatment, 177
reorganization as psychotherapy, 197 ff.
romance, 177
social contacts of, 198
Fear, genesis of, in children, 93
of high places, 101
of inflicting injury, 169
of self-injury, 172
Feeblemindedness, functional, 201 ff.
Final cause of phobia, 142
Follutein and treatment of schizophrenic conditions, 265 ff.
Free association, 114 ff.
analysis by, 143
Freud, *on* anxiety neurosis, 50
on ego, 35
on emotions, unconscious, 35
on id, 37
on impulse, 41 ff.
on neurasthenia, 50 ff.
on origin of childhood anxieties, 53
on psychopathology, 33 ff.
on the sexual, 52
Fright and canities, 74

General factor, definition of, 10 n.
Genital differences, children's reactions to, 41 ff.
Graying of hair from fright, 74
Growth, childhood, 195

Homosexuality, false, 157
Hyperhedonic experience and thalamic lesions, 251
Hypoglycemia and anoxia in stimulation of sympathetic nervous system, 263
Hypothalamic stimulation and exaggeration of emotional expression and experience, 253 ff.
Hypothalamus, *and* emotional reactions, 54
injury of, and catalepsy, 252
Hysteria and sexual repression, 39
Hysterical manifestations in children, 233 ff.
Hysterical paralysis, 233 ff.

Id, Freudian concept of, 37
Ideas, existence of, in unconscious, 36
of reference, 269 ff.
Identification, 131
in reading, 232
Impulse, Freudian concept of, 41 ff.
Individual, Adler's concept of, 66
Jung's concept of, 63
Infantile negativism, 189
Infantile sexuality, 40, 44
Inferiority complex, 66
treatment of, 98
Inferiority of organs, 65 ff.
Insanity and celibacy, 85
Insulin shock in treatment of schizophrenia, 262
Introversion, 56
I.Q., rise in, after change in environment, 203

Jung, *on* abreaction, 107
on archetypes, 57 ff.
on character types, 56
on consciousness, degrees of, 57
on dreams, 60
on individual, 63
on psychotherapy, 63
on schizophrenia, 60
on will power, 60

Lange-James theory of emotions, 248
Love, nonsexual, 48

Mania, 15
Manic-depressive psychoses, organic factor in, 83
Manic excitement, 15
Married life, mental difficulties in, 169 ff.
Masturbation and insanity, 87
Mecholyl and affective experience, 258 ff.
Mental disorders, concept of, 1
economic stress and, 84
emotional origin of, 76 ff.
inner mental organization and, 2
neurological concept of, 3
quantitative differences in, 3
secondary to organic conditions, 156
toxic, 49
truly psychic, 3

Nausea, psychogenic, 24
Negativism, infantile, 189
Neurasthenia, Freud's concept of, 50 ff.
Neurological concept of mental disorder, 3
Neurosis, Adler's concept of, 67
Neurotic conditions and preparation for life, 68
Neurotic dependent, 185

Occupational therapy, 146
Oedipus complex, 36, 177
Organ inferiority, 64 ff.
Organic conditions, emotional origin of, 72 ff.
and mental disorders, 156

Organic factor in manic-depressive psychoses, 83

Pain as expression of conflict, 187
Paralysis, hysterical, 233 ff.
Paranoia irritabilis, 17
Paranoid dementia praecox, 19
Parent-child relations and psychotic conditions, 83
Parental anger and origin of phobia, 141
Parental attitudes and children's problems, 184, 195, 209
Parental example and origin of phobias, 95
Passive attitude in psychotherapy, 147
Patient's life history and therapy, 105 ff.
Permanence of symptomatic cures, 163
Personal effort of patient in therapeutic procedure, 126 ff., 155
Personality, prepsychotic, 26, 28
  structure of, according to Jung, 55
Pharmacological treatment of mental disorders, 262 ff.
  in association with psychotherapy, 269 ff.
Phobia, cure of, by abreaction, 105, 129
  efficient cause of, 141
  final cause of, 142
  incidence of, 89
  origin of, *and* course, 89 ff.
    in parent-child relations, 140
    in parental anger, 140
  parental example and, 95
  self-treatment in, 101
  sexual origin of, 93 ff.
  treatment of, 103
  value of, to patient, 103, 113, 125 f., 134
Physiology of emotions, 248 ff.
Play therapy, *and* unruly child, 188
  self-revelation in, 193
Precipitating incident, *in* psychoneuroses, 171
  in psychoses, 79
Prepsychotic personality, 26, 28
Principles of conduct, 219 ff., 226
Projection of personal anxiety, 272
Pseudohomosexuality, 157
Psychiatric entities, 6 ff.
Psychoanalysis, field of, according to Alexander, 70
  task of, 146
Psychogenic nausea, 241
Psychogenic stupor, 239
Psychoneuroses, 4
  concept of, in Adler, 66
  etiology of, according to Freud, 38
  incidence of, in priests and nuns, 55
Psychoneurotic conditions, 170, 173
  and birth control, 170, 173
  and celibacy, 55
  origin of, according to Alexander, 70
    in women, according to Abraham, 40
Psychopathology, type concepts of, 33
Psychoses, concept of, 4
  origin of, according to Alexander, 69
  and parent-child relations, 83
  and widowhood, 84
Psychotherapy, according to Adler, 68
  and benzedrine sulfate, 151 f.
  important adjunct of pharmacological treatment of mental disorders, 269 ff.
  Jung concept of, 63
  passive attitude in, 147
  of schizophrenia in childhood, 80
  social, and cure of phobias, 99
Psychotic conditions, *and* celibacy, 85
  and chronic emotional strain, 83
Punishment, corporal, 183, 190

Quantitative differences in mental disorders, 3

Reading, disability in, *and* abnormal behavior, 208, 214
  and principles of conduct, 230
Religion and psychotherapy, 167
Remedial reading as therapy for conduct disorders, 211 ff.
Retarded depression, 13

Sadism, 150
Schizophrenia, *in* childhood, 79
Jung's concept of, 60
organic factor in, 83
treatment of, *by* cardiazol, 262
by follutein, 265 ff.
by insulin shock, 262
School malajustment and abnormal behavior, 206 ff.
Sexual, concept of, in Freud, 52
Sexual disorders and insanity, 87
Sexual experience and endocrine activity, 49
Sexual origin of phobias, 93
Sexual repression and hysteria, 39
Sexual restraint and conditions of anxiety, 165
Sexuality, infantile, 40, 44
probing of, in psychoanalysis, 119
Situational therapy, 155, 246
Skin eruptions and chronic emotional tension, 75
Social psychotherapy and cure of phobias, 99
Soiling, 188 ff.
Stupor, psychogenic, 239
Suggestive therapy, 235 ff., 239 ff.
Superego, 36
conscience and, 38
Superiority complex, 67
Supernormal children and school maladjustment, 207
Symptomatic cures, permanence of, 163

Temperament, early experiences as determinants of, 33
Tetrachoric correlation, 9
Thalamic lesions, affective experience and, 250
and hyperhedonic experience, 251
Therapist as helping friend, 122
Therapy, *of* conduct disorders by remedial reading, 211 ff.
by confrontation, 245
educational, 206 ff.
by family reorganization, 197 ff.
occupational, 146
and patient's life history, 105 ff.
and personal effort, 155
by psychological analysis, 111 ff.
by religious ideals, 167
by reorganization of patient's life, 164
situational, 155, 246
suggestive, 235 ff., 239 ff.
See also Psychotherapy
Thyroid disorders and neurotic conditions, 156
Thyroid treatment in neurotic condition, 158
Toxic mental disorders, 49
Transference, 175
Trauma of birth, 53
Treatment, *of* inferiority complex, 98
of manic-depressive conditions, 265 ff.
pharmacological, in mental disorders, 262 ff.
of phobias, 103
of schizophrenia by electrically induced convulsions, 263
Truancy, treatment of, by remedial reading, 213
Type concepts of psychopathology, 33

Unconscious, collective, 58, 61
degrees of, according to Jung, 57
ideas and emotions, 35
personal, 58
Unwanted child, 178

Vision and reading disability, 214 f.
Volitional love and emotional affection, 179

Widowhood and insanity, 84
Will power, according to Jung, 60
Rank's concept of, 126
Will to health, Rank's concept of, 126

Yule's coefficient of association, 9