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The Drama of Sex

The Frustrated Martyr

UNDERSTANDING

HUMAN

BEHAVIOR

BY

JAMES L. McCARTNEY, M.D., F.A.C.P.

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Dedicated to

ALL MY PATIENTS

Preface

As a practicing psychiatrist for the past thirty years, the author has seen great advancement in the treatment of the disturbed or maladjusted personality. In the earlier years this specialty was looked upon with such suspicion that any physician entering the field was considered abnormal himself. The findings in World War I proved beyond the possibility of doubt the need for a better understanding of human behavior, and slowly the public has come to accept psychiatry as a legitimate branch of medicine. Unfortunately, there is still too much confusion about this subject in the mind of the layman, and many people still feel that there is a stigma attached to consulting a psychiatrist.

This book is an attempt to bring together what is known about human behavior and what can be done to help maladjusted individuals gain a healthier state of mind.

J. L. McC.

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CHAPTER I

The Integrated Personality

Personality is a complex organization of physical and emotional factors, which has, as its goal, a harmonious adjustment to the environment. It requires constant readjustment and acceptance of these premises when necessary so that the individual may be happy and efficient in this adjustment. The process of living should afford a reasonable degree of contentment and efficiency, and an individual who approximates this ideal is said to be well-adjusted. His capacity to deal successfully with experience is an index of his personality integration.

The extent to which a high degree of personality integration may be achieved is dependent upon the potentialities which have been transmitted from previous generations, and upon whatever enters into the constitution of the individual. To the complexity of these elements is added the stress of the environment, and the person's reaction to these stresses gives us some indication of the personality. This personality consists of the correlation between the mind and the body. The body consists of the brain and the nervous system, tied in with the glands of internal secretion. The mind, on the other hand, is an intangible something which is interpreted by emotions, feelings, habits, dispositions, dreams and purposive activity.

HEREDITY

Personality has to do with both heredity and environment. More emphasis is being placed on environment than

on heredity, as in our present state of society we cannot do much about heredity. In this country of free marriage, people marry with little or no consideration of heredity, and our laws and churches insist that it is free man's right to breed as he pleases. We do not breed people as intelligently as we breed animals. We leave human heredity pretty much to chance, but, fortunately, we have been doing a great deal more about the environment, which is the major molder of personality and human nature.

The effects of heredity are established at the time that the child is conceived, and much can be learned about human nature if the person's heredity is understood. There are factors, such as the size of the individual's body, tall or short, fat or thin, small-boned or big-boned, delicate hands or stubby hands, the shape of the feet, and even of the genitals, which depend a great deal on the hereditary strain, and which may have much to do with later behavior. General appearance, such as the color and distribution of the hair, the color and set of the eyes, the size of the ears and nose, the color and texture of the skin, the arrangement of the teeth, is determined by the combination of germ cells. Later, some of these characteristics can be temporarily changed. Straight hair can be dyed or "permanently" waved, and kinky hair can be straightened. A plastic operation can alter the features, the teeth can be straightened or removed, but this has no effect on the next generation.

CONGENITAL DEFECTS

A person may have characteristics that some people think of as being hereditary or inherited, but which really are not. Short sightedness, far sightedness, sometimes defects in the iris or pupil, defective teeth, deformed extremities, and birth marks are all congenital deformities. Something went wrong in the germ cells before conception or with the process of growth during the nine months before the child was born.

From the beginning the individual is affected by his environment, even during the intra-uterine period. If the mother is living in a turmoil, the few layers of muscle, the little bit of fat, and the clothing that are between the child and the outside world do not protect it from noise. The child hears all the racket, such as a loud radio or a banging dishpan, and may move. Things that the mother eats also affect the child, and defective nourishment may cause a defective child. If the mother's glandular system is not functioning properly, the child does not get the proper hormones. If the mother happens to be injured, or if she falls, the child may suffer an injury. If the mother has a venereal infection, such as syphilis, which is a common disease in civilized life, the child will have syphilis. The child does not get syphilis directly from the father, but may be defective as a result of a defective male cell, which was defective as the result of the father's syphilis. Actually, the syphilitic germ is much larger than the male cell. Therefore, it could not possibly be transmitted through the male sex cell.

Toxins, such as drugs and alcohol, may cause defects in the germ cells of the male and the female. Various food toxins may have bad effects. If the mother has scarlet fever, the chances are the baby within her will have scarlet fever too. If the mother happens to have measles, the child will have measles and may be born with a defective brain. Any toxin which is transmitted through the blood will affect the child. If a woman is anxious, the child will not be anxious, but the anxiety of the mother may cause a disturbance of the baby's metabolism. If the mother does not get proper rest, the child also cannot rest and may be born with an emotionally wrought-up emotional system. The child may thus be nervous because the mother is nervous, but it should be remembered that the child did not inherit nervousness. The child was just not given a chance to properly develop during the period it was in the uterus.

In the first nine months, the individual goes through

the process of complete evolution of the human race, from the lowest cell to the most complex form of human being. In those nine months it has been guarded and protected. It has been put in as nearly an ideal environment as nature could possibly give. True enough, the mother and father may abuse nature's resting place, but in any case, the child goes through the rapid process of development of the whole history of the race, concentrated down to nine months.

THE FIRST CRISIS

The first big crisis in the individual's life is being born. This is a terrible crisis, a crisis which may leave an impression on that individual for the rest of his life if it is not properly handled. The child, going through the process of birth, suffers, to say nothing of the suffering of the mother. The mother may not suffer, or she may, but that is of little consequence to the child, except as he is reminded of the "sacrifice" by the mother in later life. It is of really no consequence in comparison to the crisis that the child goes through. It is a case of forcing the child out from security to insecurity. The eternal struggle of a person for existence. The salvation of self. Such a process does something to the personality. It may cause very serious emotional injury to the child.

BRAIN CAPACITY

Each person is born with a certain brain capacity. The brain may be either small or large, with a limited capacity or with an extensive capacity. By studying the embryo and fetus, the young human being before birth, the steps that the brain goes through in its development can be noted. These steps can be compared with the lower forms of animals who have the same type of brain structure. The brain becomes more and more intricate in its construction until

finally, when the child is born, it has a completely organized brain which is ready to receive nerve impulses.

The brain is a part of our physical being, just as our blue eyes or our brown eyes, red hair or brown hair, light complexion or dark complexion are physical signs, so the person is born with a limited brain capacity, an average capacity, or an extensive brain capacity. This is something that was inherited from the parents. In other words, a child does not have "brains" if the parents do not have "brains." Once in a long while a child may be born to defective parents and have a normal or above average brain capacity, but such is called a "sport," and it is very, very rare. If the child has brains, it indicates that the parents have brains. And vice versa. If a child is considered dumb, then, of course, it usually indicates that the parents must have been dumb. On the other hand, if something injures the brain before birth, or if something interferes with the proper development of the brain, then the child may be subnormal.

BIRTH TRAUMA

As said before, at the time the child is born, there may be an injury to the brain tissue. Birth is one of the first traumatic experiences the individual has to go through. The average individual goes through the first nine months without accident or difficulty. At the end of nine months a great change takes place. The child is now supposed to be able to face life. The mother goes into labor and may have considerable difficulty. The baby is forced out into the world. Although the bones of the head are still loose, sometimes the mother has a small pelvis or a tight cervix, or a forceps delivery may be necessary, and so much pressure is put upon the head that, as a result, there may be a hemorrhage and possibly some brain destruction.

Some children are more prone to bleed than others because of the antagonism of the baby's blood to that of the mother. This is known as the Rh factor, but, fortunately,

the obstetrician or doctor who cares for the pregnant woman can do much to counteract the bad effects. If such bleeding is not prevented, there may be a large hemorrhage on the brain. It may push on the brain sufficiently to destroy it and cause imbecility or paralysis. Such children sometimes are crippled for life with a paraplegia or hemiplegia. Thus, an arm or leg may be paralyzed due to hemorrhage, but this is the result of the environment, and not heredity.

The brain is within the skull. Its size is totally independent of the size of the head. The big-headed individual does not necessarily have a big brain. So-called "pin-heads" may have good-sized brains. Little can be told about the brain capacity of an individual by the size of his head, the height of his forehead, the amount of hair he has on his head, etc. Some of the brainiest individuals have little hair, and others have a great deal of hair.

GRAY MATTER AND WHITE MATTER

Human beings have a great deal of gray matter, and a great deal of brain substance which as yet has not been assigned a function. Their skulls are filled with a lot of material which is not essential to life. In fact, much of the brain can be taken out, and the person will go on living. A person can exist without five-sixths of the brain. This has been found by accident, by experimentation, and by the removal of the brain in the form of treatment known as topectomy. The thinking processes are in the part of the brain known as the cortex. This is made up of the surface layers of the cerebrum. The inside of the brain is composed mostly of white matter, which consists of all the various nerve tracts that lead to and from the spinal cord. The surface of the brain, or cortex, is called gray matter. You have heard people say that So and So hasn't very much gray matter. It simply means that they conclude that the person has a thin layer of gray matter. It is this part of the brain that does the thinking.

The main bulk of the brain is divided into two hemispheres, left and right, which are connected at the base. This base is called the brain stem and medulla oblongata. It is really the important part of the brain as far as life is concerned. All the vital centers of the brain are located in this little area. Therefore, all the nerve tracts, the thousands upon thousands of them, going up to the cortex on the two sides of the brain go through this medulla. This extends down to the spinal cord. A little accident, such as a small hemorrhage, might happen in the medulla, which would have serious consequences, while a large hemorrhage in the upper part of the brain might fill half of the front of the skull with blood, and the person might not be affected very much. He might have loss of memory, but he could go on living. If a little blood vessel, as large as a pin point, happened to break in the medulla, it would be likely to affect some nerve, and, consequently, a paralysis would result. Since the breathing and heart centers are in the medulla, a hemorrhage here may cause death.

BRAIN CENTERS

Personality characteristics are elaborated through the function of the brain. The brain contains the centers for special senses, and sensory and motor control of the muscles. Little is known about the specific function of certain parts of the brain, but some general observations have been well-established. The front part of the brain takes care of the final correlation and synthesis of all impressions sent to the brain, together with the selection and discharge of appropriate action. Its development is co-ordinated with intelligence. On the other hand, the central part of the brain has to do with the discrimination of bodily sensations, including touch, pain and temperature, as well as the postural relations of the body, and the ability to identify objects placed in the hand or under the foot. Unusual stimulation of this part is apt to set off a convulsion. The temporal part of the

brain is associated chiefly with higher elaboration of hearing, while the back part of the brain has to do with sight. At the base of the brain is a group of nerve centers known as the hypothalamus, which in recent years has been found to be of great importance in the activity of the emotions.

SPINAL CORD

All the nerve tracks to the body go down the spinal cord. In the spinal cord the gray matter is in the center, and the white matter is on the surface. This gray matter carries the various tracks from the brain down into the extremities and other parts of the body. The so-called sensory nerves, those that feel, come in the back of the spine, and the motor nerves, those that act, go out the front of the spinal cord to the muscles. When the feeling nerve comes in, it forms a connection with another nerve fiber. This connection is called a synapse. From this synapse there is another nerve pathway that goes on up to the brain stem, and then again it synapses and goes on to the cortex of the brain. As an example, if the centers of feeling in the skin of the hand feel something, the impulse is sent into the spinal cord. If it is something that the nerve center in the cord can interpret right way, then it immediately sends out an impulse to withdraw the hand. For instance, if the hand happens to touch a stove and it is hot, immediately the hand will be taken away before the brain even has a chance to think of it. This is called a simple reflex. The touching of a hot object, the pricking of the finger with a needle, or any painful stimulus, automatically causes the hand to be pulled away before a thought takes place. But at the same time the hand is pulled away, that fraction of a second, an impulse is sent up the gray matter of the spinal cord to the brain, and it interprets the stimulus as being painful. Although the hand was pulled away to protect it, the stimulus was not interpreted. It may have been hot or cold. It may have been freezing or scalding. The spinal cord did not know whether

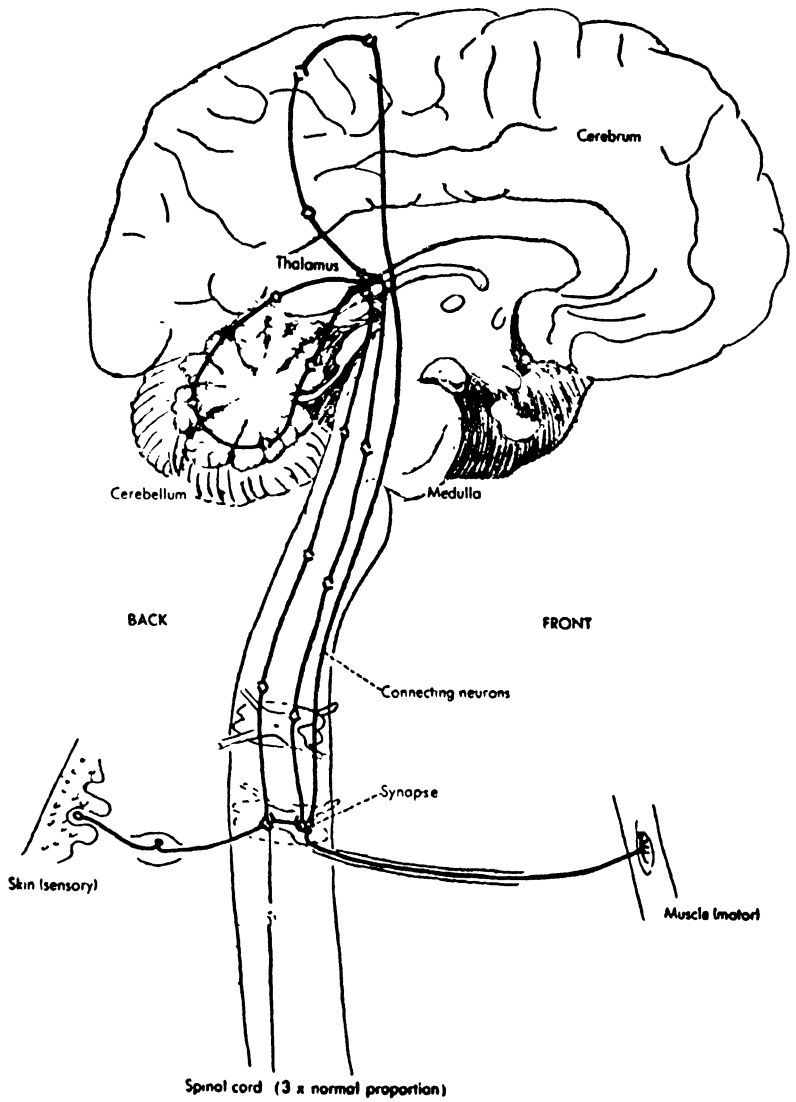


FIGURE 1. ANATOMY OF THE NERVOUS SYSTEM

it was hot or cold. All it knew was that there was danger and said, "Pull it away." When the impulse goes up to the brain, it is interpreted right away if the cortex, or thinking cells, are intact.

At the same time, or about the same time that the simple reflex happened, another synapse was made in the medulla, and an impulse was sent out to the eyes and simultaneously to the neck muscles. The eyes and head turned to look at the object. Likely the impulse was from the cortex, which said it would like to know what kind of object it was. Then there is another stimulus. The retinas of the eyes are stimulated, and the impulse is carried by the optic nerves back to the cortex of the brain. Have I seen an object like that before? If so, what does it look like? If I haven't seen it before, does it look like a stove? A lot of impulses are sent back to the brain. I see that it is nickel, I see that it is porcelain, etc., and, calling on my past experience, I finally reason out the fact that the object is a stove. The original stimulus has gone through many synapses to come to this conclusion.

CENTRAL NERVOUS SYSTEM

The brain, spinal cord, and nerves are called the central nervous system. The brain and medulla are within the skull, and the spinal cord goes down the spinal column within the vertebrae, or backbone. It comes down only to about the middle of the back, and then it ends in a lot of little branches. The lower end is called the *cauda equina,* or horse's tail, because it looks like a horse's tail. All along the way it sends out nerves. Right after these nerves have left the spinal cord and passed out through the vertebrae, they join in one nerve sheath, which carries the nerve fibers on out to the skin and muscles.

Every nerve impulse that is sent to the cortex immediately leaves an impression on the brain. The gray matter is just like a duplicating pad, no matter how light the stimulus, it leaves an indelible mark. In order to understand what is

said later in this book, it should be realized that everything that happens to the individual leaves a permanent memory on the cortex. Even the things that happened during the nine months before birth.

The Chinese figure a person's age from the time that he was conceived. They say he is a year old when born. Actually, a person is nine months old when born, and everything that happened during those nine months made an impression on the brain tissue. Not everything that happened to the mother, but everything that happened to the baby within her. There is no nerve connection between the child and the mother, so the mother cannot send an impulse from her brain to the child's brain. There is no such thing as prenatal influence. The only connection is through the blood. On the other hand, if the mother is physically sick, drinks or smokes too much, takes drugs, is under-nourished, or is not eating the proper food, she might affect the child within her. Of course, the cell from the father might have been defective, or the cell from the mother might have been damaged before conception, resulting in a defective beginning.

INTELLIGENCE

One thing is certain, and that is that the brain cells are all present at birth, and the person's intelligence is fixed at the time of conception. In other words, an individual's I.Q. is an inherited trait. The I.Q. (Intelligence Quotient) is simply a measure of the person's brain capacity, or the ability to reason, as compared to the standard or normal capacity.

If all the people in the world were taken one by one and given an intelligence test, they could be divided into subnormal, normal and superior. A normal intelligence is a 100 I.Q., which is the measure of the learning ability of a normal boy or girl of fourteen years of age. A child of ten who is able to do tests that a fourteen-year-old is supposed

to do has a much higher I.Q., and a person of fourteen who can do only the tests that a normal person of ten can do has a much lower I.Q. At fourteen or fifteen years of age the average individual's brain stops growing. No adult has any more thinking ability than a fourteen-year-old child who starts out with the same I.Q. Of course, each person may start out with a different brain capacity. The amount of information a person acquires may in no way indicate the basic intelligence of the individual.

There are as many people with 70 I.Q. as with 140. Those with 145 and above are considered geniuses, while under 70 is considered subnormal or feeble-minded. State institutions for the mentally deficient will not admit as a patient anyone who has more than a 70 I.Q. Persons with 70 to 80 are borderline, 80 to 90 are dull normal, 90 to 110 are normal, and 110 to 140 are superior.

There are certain individuals who, because of in-breeding, tend to have a higher I.Q. than other types, but in-

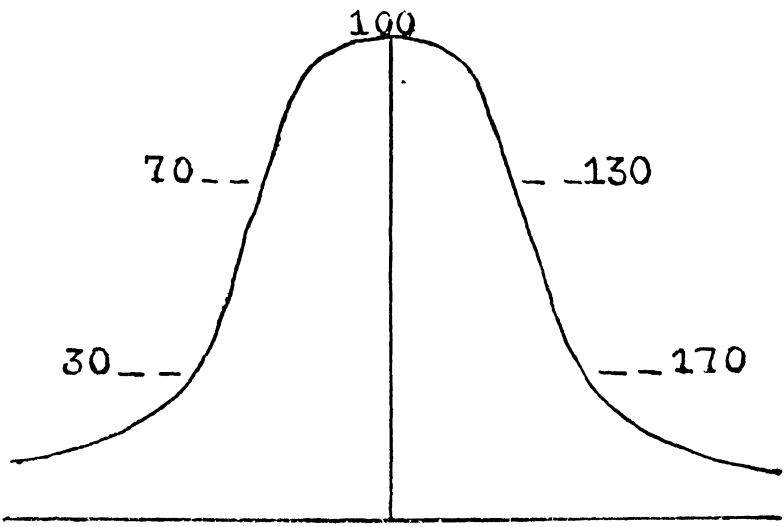


FIGURE 2. I.Q. DISTRIBUTION

breeding may also perpetuate a lower I.Q. Examples of these are the Jews and the Chinese, who are higher than average, while the Negro tends to have a lower than average intelligence. The Anglo-Saxon race has average intelligence. This has nothing to do with training. It is a question of breeding.

If a man and a woman have an I.Q. of 140, their children will have an I.Q. of 140 or better. If a man and a woman have an I.Q. of 70, their children will have an I.Q. of about 70. Feeble-minded breed feeble-minded, and geniuses breed genius. In a country like this, with free marriage, type picks type. It should be realized that schooling does not increase intelligence.

It takes an I.Q. of 105 to go through high school, and an I.Q. of 125 to go through college. If a student has an I.Q. of 100 or less, it is foolish to expect him to successfully complete an academic high school course, even though some schools may push such students on from grade to grade.

Mental stability may depend somewhat on the intelligence. If a person has a conflict with his environment, that individual is usually in a high I.Q. group. He is not content with what he is or what he has. He worries about the future. Planning for the future may give him conflict. A person who has few brains has no conflict. The low I.Q. group is usually content. They may make large salaries but don't save, or they make up the relief rolls. Today is sufficient for them, they don't think of tomorrow.

APTITUDES

Individuals are also born with certain aptitudes. People with musical ability can become musicians if given training, but others with no musical ability can never become musicians, no matter how much training may be given. People with mechanical ability can succeed in mechanical work, while others who have no perception of the mechanics of a

thing are unable to learn how to drive a nail or to thread a needle. To become an artist requires an aptitude for art. These aptitudes can also be tested, and the results of such tests may be helpful in assisting a person to find the proper work.

SPECIAL SENSES

Besides the thinking part of the brain, we have a system of centers which are called the special senses. These are the nerves, known as the olfactory nerves, which go to the tip of the nose to record impressions of smell. The optic nerves go to the background of the eye, the retina, and give the person sight. When a person has a neurological examination, the physician looks through the pupil at the retina. The background is naked nerve tissue. Its condition reflects the condition of the brain tissue. If the patient has arteriosclerosis, or if there is an anemia, it will show on the eye grounds. If the individual has a tumor, which creates a pressure, it will also create a pressure on the optic nerve, known as a choked disk.

Then there are nerves that have to do with hearing. These nerves end in fine hairs that interpret sound waves. Also, in the ears is the special sense of stability which helps a person to learn to walk upright. Humans are built to walk on all fours. Therefore, they have to learn to walk on their hind feet and keep themselves stable. The child starts to crawl as soon as he gains sufficient strength, and he depends on the parent to get him up on two feet. Youngsters of superior intelligence frequently walk on all fours instead of crawling.

Then there is the special sense of feeling, such as touch. Every point on the surface of the body has a nerve that connects with the brain. Certain parts, such as the back of the hands, have fewer nerve endings, while others, like the fingertips, have more.

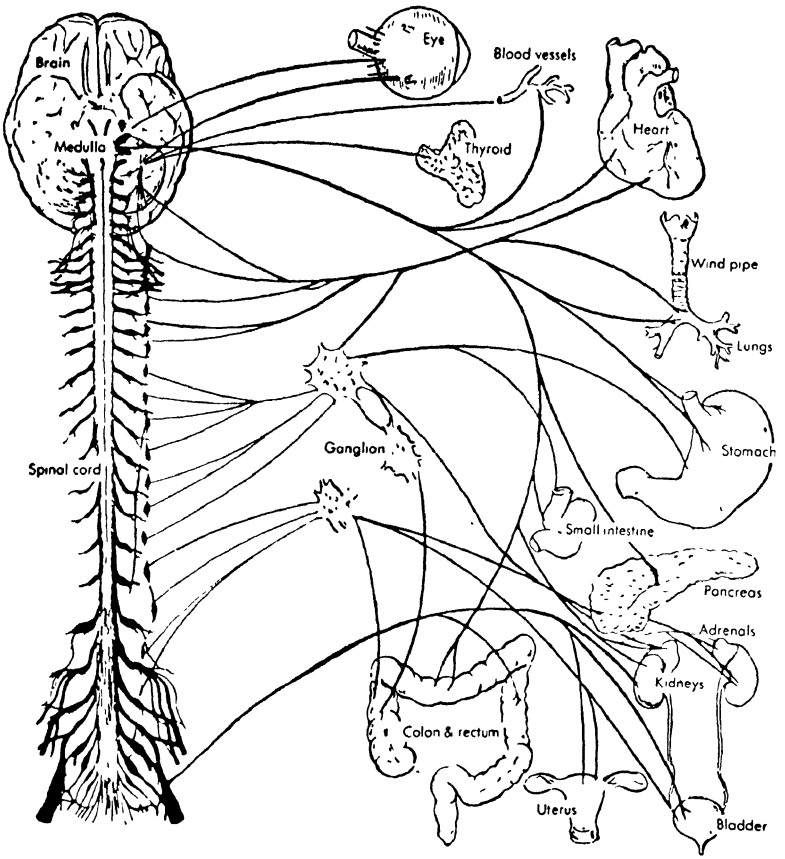


FIGURE 3. AUTONOMIC NERVOUS SYSTEM

AUTONOMIC NERVOUS SYSTEM

Outside the spinal cord, but inside the body cavity, along the bony column of the backbone, is a chain of nerves. They are indirectly connected to the central nervous system and make up the autonomic or vegetative nervous system. The central nervous system is called the voluntary nervous system, primarily because it means that the person

thinks and acts with it. This other nervous system is not under the control of the will, so it is called the involuntary nervous system.

The autonomic or involuntary nervous system is the term applied to the nerves which are concerned with the unstriated muscle and many of the secretory glands. It is divided into two separate pathways, the sympathetic and the parasympathetic, which are mutually antagonistic in function. In the case of both the sympathetic and the parasympathetic nerves, two neurones intervene between the central nervous system and the innervated organ. The nerve centers for this system are situated in the hypothalamus, which is situated in the brain below the thalamus and constitutes the floor of the third ventricle.

Stimulation of the posterior hypothalamus causes an increase of the heart-rate, rise of blood pressure, dilatation of the pupil, erection of the hair, and inhibition of movements of the stomach and intestines, and of the tone of the bladder. This part of the brain is also responsible for the reaction known as "sham rage" which occurs in animals when this region has been released from higher control. Destruction of this area may cause lethargy and sleepiness.

Stimulation of the parasympathetic nerves causes slowing of the heart-rate and increase in the conduction time of the heart. There is also an increase in the peristaltic movements of the stomach and of the tone of the bladder. Injuries of this region may cause hemorrhage in the stomach, or adiposo-genital dystrophy, which is characterized by great obesity and genital atrophy.

The hypothalamus is involved with water metabolism and with the disease known as *diabetes insipidus*. After injury to some of these nuclei or nerve cells, the posterior lobe of the pituitary gland degenerates. The hypothalamus is also concerned with the regulation of the temperature of the body, in which shivering, sweating, and constriction and dilatation of the blood vessels play a part. The role of the hypothalamus in carbohydrate metabolism is not completely

understood, but glycosuria, or sugar in the urine, which is usually transitory, may follow injuries in this region. The hypothalamus is also concerned in sleep regulation.

The emotions affect these nerves, but so also does the blood, which flows to every part of the body. Consequently, what is taken into the system and absorbed into the blood system may have an effect on the involuntary nervous system. Thus, this system can be controlled somewhat by taking certain drugs which may be injected or absorbed into the blood stream.

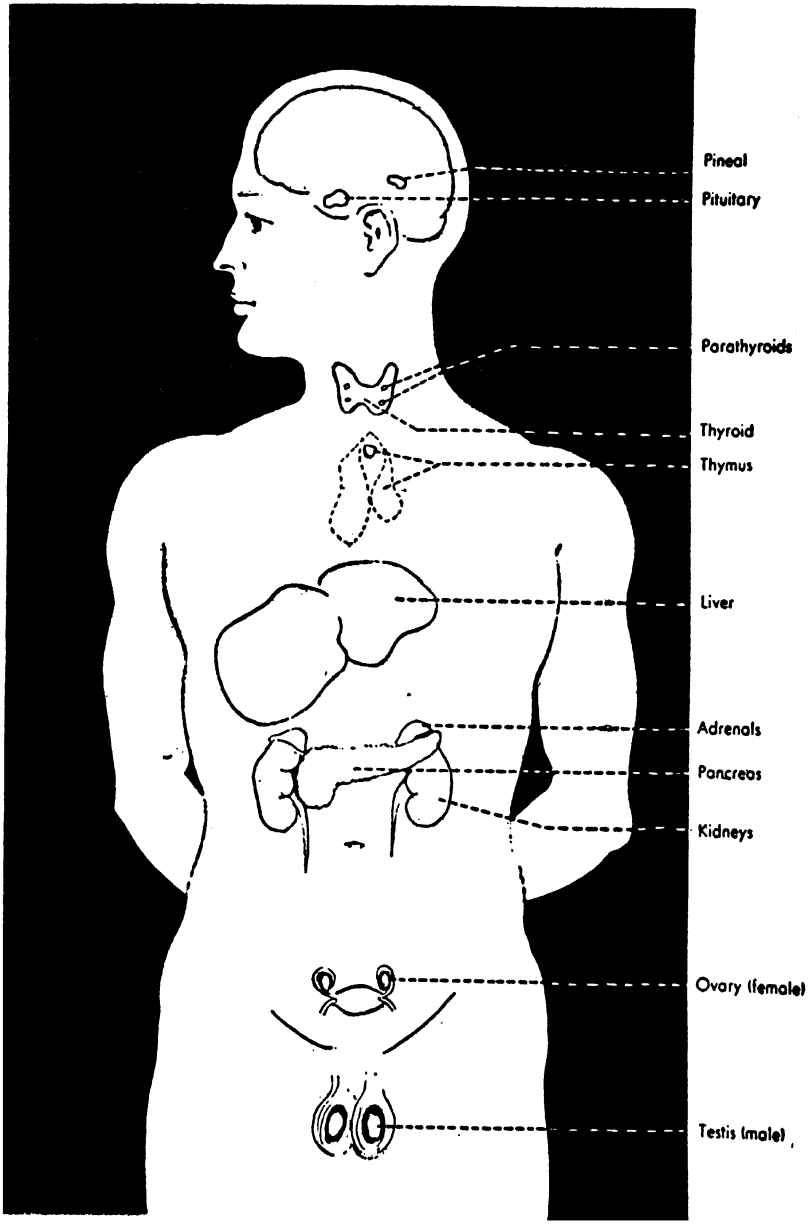
ENDOCRINE SYSTEM

There is a group of organs in the body which is tied up with the involuntary nervous system. These are the endocrine glands, or the glands of internal secretion. They are called this because they do not secrete to the outside of the body as do the kidneys, the tear glands, the salivary glands, and the other externally excreting glands. The endocrine glands secrete, or increte, into the blood stream.

These endocrine glands are important in the development of the individual, both before and after birth. They are the pineal, the pituitary, thyroid, parathyroids, thymus, adrenal glands, pancreas, and the gonads or sex glands

The pineal gland is very tiny. It is inside the brain, is evidently not necessary to life, and very little is known of its function.

Also in the skull is the pituitary gland, a small gland connected with the hypothalamus. In most individuals it ranges from the size of the little-fingernail to that of the thumbnail. It is located at the base of the brain in a pocket of bone. This gland is extremely important, as it has to do with the growth of the individual. If this gland goes wild, the individual may become a giant. If it underfunctions, a dwarf results, or the person may become fat. The pituitary gland is divided into two parts. One part has to do with growth, and the other part with stimulating the smooth


Pineal
Pituitary
Parathyroids
Thyroid
Thymus
Liver
Adrenals
Pancreas
Kidneys
Ovary (female)
Testis (male)

muscles in the body. Pituitrin, an extract of this gland causes the uterus and intestines to contract. This makes it possible for the pregnant woman to deliver her baby at the end of her term. This gland also has to do with the growth of hair and other sexual characteristics. At the time of menstruation, the gland may swell and so fill the bony well in which it rests that it causes an intense headache. After menstruation has started, the secretion is used up, and the headache relaxes. The sex glands do not properly form if the pituitary gland is not working as it should.

The thymus gland is located underneath the chest bone. This gland functions primarily in the nine months before birth. If the thymus gland does not atrophy properly by birth, the child may be slow in developing, have difficulty in breathing, or may develop convulsions. In this case, the physician usually gives the child one exposure to X ray, which atrophies the gland.

Possibly the most important gland in the body is the thyroid, which is located in the front of the neck. The thyroid is the pacemaker of the body. Every gland is dependent on the effect of the thyroid. The thyroid governs brain development and physical development. In order that the other glands may function, the thyroid must function normally. If a child is slow in learning to walk and talk and later is slow in school, it may be due to a lack of thyroid. The thyroid also has to do with the general metabolism. If a basal metabolic test is done, and more oxygen is used than is normal, this is a sign that the thyroid is secreting too much. These people are overactive, are thin, and very nervous. If less oxygen is used, the thyroid is underactive. These people may put on fat, lack ambition and effort, complain of weakness, have no desire, grow hair on the face, have dry skin, coarse hair, and may be dumb-looking. Such lack may prevent the person from reproducing.

Lack of thyroid in the mother during her pregnancy, or illness in later life may cause lack of thyroid function. This can be balanced by giving the individual thyroid by mouth.

may become flushed, then cold, then hot, and at the same time get contractions in the intestines which result in diarrhea, or urinary frequency.

Excessive and continued secretion from the adrenal glands may cause precocious sex development and abnormal interest in sexual behavior. Continuation of a state of emergency may set up chronic fear. Lack of adrenalin may cause a chronic tiredness. Lack of cortisone may be a cause of arthritis or rheumatism, or other changes in the metabolism.

In the tail of the pancreas are located the Islands of Langerhans, which manufacture insulin. Diabetes may be set off by the degeneration of these cells, or by having taken too much sugar throughout life, or by an emotional situation. The proper secretion of insulin makes it possible to store sugar in the liver. Sugar is used by the body as a fuel.

A person may feel very tired during the afternoon. This is frequently due to a lack of sugar in the system. This is called hypoglycemia. This is the reason why people feel like taking a piece of candy for a pickup. Undoubtedly, this is how afternoon tea in England originated. People coming home from work very often buy a candy bar in the railroad station, and by the time they get home they have gotten a lift and can face the family.

In the pelvis are located the gonads, or sex glands, the ovaries in the female, and the testes in the male. Before birth the testes are inside the body, but at birth or just before birth the testes come down outside the body and into the scrotum. These glands are not necessary for life but stimulate the general system.

The ovaries produce the egg, or ovum, which is the female reproductive cell. Beginning at adolescence and continuing until the menopause, at least one egg each month comes to the surface of the ovary and is expelled. In the place where the egg was, *corpus luteum* is formed, which regulates the menstrual flow. Besides the hatching

If the thyroid gland continues to function under normal, the individual may build up a psychological pattern which handicaps him all his life.

Whenever an anxiety situation arises, such as a woman's fear of pregnancy, the thyroid quite frequently will speed up and get out of control. This results in a chronically scared state, with staring eyes, due to exophthalmic goiter, or too much thyroid. To treat this condition, surgeons in the past used to take out about half of the thyroid. Now there is a medicine which can be given to cut down the action of the thyroid. Another approach to the cure of this situation is the realization that it is due to an anxiety state. If the anxiety can be removed, the thyroid will slow down. If this is impossible, some of the thyroid may have to be removed, and then the person should be given psychiatric treatment. The thyroid will enlarge again if the anxiety remains.

Back of the thyroid are some little glands called the parathyroids, which are important in certain disease conditions because they have to do with the building up of calcium in the bones and teeth. Lack of this gland substance may cause excessive contraction of muscles and may actually cause convulsions.

The adrenal glands are located at the top of the kidneys and are important because they are essential to life. Several extracts are made from these glands, such as adrenalin and cortisone. In an emergency, the adrenals get ready for the situation, whether the individual is going to run or fight.

If a sample of a sleeping cat's blood is taken, a certain amount of adrenalin will be found present. If a dog is brought in, the cat will get scared, bristle its fur, arch its back, and push out its claws. If the blood is now sampled, an increase in adrenalin will be found. The same situation exists in people. An emergency causes an increase of adrenalin in the blood. Their pupils dilate, they may get goose pimples and break into a cold sweat. The roots of the hair stand on end. The heart starts to beat faster, and in turn the pulse is faster, and the blood pressure goes up. They

may become flushed, then cold, then hot, and at the same time get contractions in the intestines which result in diarrhea, or urinary frequency.

Excessive and continued secretion from the adrenal glands may cause precocious sex development and abnormal interest in sexual behavior. Continuation of a state of emergency may set up chronic fear. Lack of adrenalin may cause a chronic tiredness. Lack of cortisone may be a cause of arthritis or rheumatism, or other changes in the metabolism.

In the tail of the pancreas are located the Islands of Langerhans, which manufacture insulin. Diabetes may be set off by the degeneration of these cells, or by having taken too much sugar throughout life, or by an emotional situation. The proper secretion of insulin makes it possible to store sugar in the liver. Sugar is used by the body as a fuel.

A person may feel very tired during the afternoon. This is frequently due to a lack of sugar in the system. This is called hypoglycemia. This is the reason why people feel like taking a piece of candy for a pickup. Undoubtedly, this is how afternoon tea in England originated. People coming home from work very often buy a candy bar in the railroad station, and by the time they get home they have gotten a lift and can face the family.

In the pelvis are located the gonads, or sex glands, the ovaries in the female, and the testes in the male. Before birth the testes are inside the body, but at birth or just before birth the testes come down outside the body and into the scrotum. These glands are not necessary for life but stimulate the general system.

The ovaries produce the egg, or ovum, which is the female reproductive cell. Beginning at adolescence and continuing until the menopause, at least one egg each month comes to the surface of the ovary and is expelled. In the place where the egg was, *corpus luteum* is formed, which regulates the menstrual flow. Besides the hatching

of the egg, the ovary sends estrogen into the system. This female hormone causes sexual desire, and the sex characteristics, such as the development of the breasts, hair growth, and menstruation. At the menopause the ovaries go out of function, and the woman has what is known as "the change of life," which is partly physical and partly psychological.

In the male, the testes not only manufacture spermatozoa, the male reproductive cells, but they also manufacture testosterone, or androgen, the male hormone. This causes sex desire and the sex characteristics to develop, such as the beard, change of voice, musculature, and development of the penis. This is what makes the boy a boy, and the man a man.

HORMONES

The gonads are related to the pituitary gland. These glands are important not only for sexual development, but also for their effect on the general personality. It is psychologically obvious that if these glands do not function, there is a lack of substance in the system that makes it impossible for a person to feel normal. If a boy is unable to develop a beard, it obviously makes him feel very self-conscious. If his penis does not develop to normal size and function, there is sure to be a penis envy and a marked feeling of inferiority. If the girl lacks breast development or does not menstruate, or does so irregularly, she is certain to feel abnormal, and her whole emotional life may be affected thereby.

During the first quarter of this century when the Steinach operation and the transplantation of chimpanzee glands to men had a vogue, the more romantic physiologists were certain that the way to restore youth to the aged had been found. But time proved that such transplanted glands did not function in the new body. The initial feeling of well-being was caused by the patient's belief in the method.

Some remarkable results were recorded on the injection of purified sex hormones, but in the end the conservatives decided that sex hormones alone will not bring about rejuvenation. Yet, millions of dollars are spent every year for the administration of purified sex hormones, with the hope that such injections or tablets will delay the progress of old age and bring back the vitality of youth.

Recent work gives evidence that much can be accomplished with a combination of male and female sex hormones. It has been known for years that every man has a little of the woman in him and every woman a little of the man in her. There is a deficiency of both androgens and estrogens in every middle-aged man and woman, and they continue decreasing as the age increases.

Injections of a male-female hormone combination for a year or more give dramatic mental and physical improvement and a new interest in social life. Well-being and vitality increase during the second and third months. This improvement increases steadily until a peak is reached at about the fifth month and is maintained throughout the period of treatment. Psychological tests leave no doubt that the patient's memory and ability to learn are better. This combination of hormones achieves its effect by apparently arresting and partially reversing the aging process, the result of general rejuvenated cellular and organic metabolism.

VITAMINS

Vitamins are not only important in nutrition, but are tied up with the endocrine glands. The glands cannot develop or properly function without adequate nutrition. American youth is the tallest in the world, and each succeeding generation is taller than the last. This is probably due to the administration of vitamins. The present generation is better nourished and has fewer deficiency diseases than past generations.

THE MIND

An intelligent person is one with the ability to apply the knowledge that he has. Such a person has the ability to learn. He may have adequate information, but he may not use his knowledge. He lacks insight. He may not reason the thing out, although he has the ability to do it. Something may prevent him emotionally. He may be upset and therefore unable to use his brain. Intelligence is located in the brain; but the mind, on the other hand, is not necessarily located in the brain. The normal mind is the ability to react, and that includes not only the brain—the ability to think and acquire knowledge—but the ability to respond emotionally as an integrated individual. In the mind is the whole makeup of the individual—the ability of the muscles to contract, the ability of the nerves to feel, the ability of the endocrine glands to respond, and so on. Therefore, when we speak of a disordered mind, we don't necessarily mean a disordered intelligence. We don't necessarily mean a disordered brain. We mean a disordered ability to react.

CHAPTER II

The Origin of Frustration

Throughout the body there are circular muscles known as sphincters, which are stimulated by the autonomic nervous system. They can contract or expand like a rubber band. These muscles surround the sweat glands, the hair follicles, the eyes, the pupils of the eyes, the mouth, the salivary glands, the gullet, the stomach, the gall bladder, the digestive glands, the intestines, the anus; the cardiovascular system—the heart and the blood vessels; the respiratory system—the windpipe and the lungs. They also are present in the genito-urinary tract, the ureters or the tubes from the kidneys to the bladder, the bladder itself, and the exit from the bladder, which is known as the urethra, the seminal vesicles, the penis, the vagina, and the uterus. The contractions of these muscles cause tension, and, if overly contracted, they cause pain. Their relaxation causes a sense of relief and a feeling of pleasure.

Many of the symptoms that are thought of as being signs of nervousness are associated with these sphincter muscles, as stimulated by the involuntary nerves. Emotions may be expressed by a dilation of the pupils, goose pimples, a flow of tears or sweat, or painful contractions of any of the muscles mentioned above. Consequently, in understanding an individual's emotional response, it is important to understand how these muscles were trained or conditioned during the person's childhood.

INSTINCTS AND EMOTIONS

Impressions already in the brain when a child is born are called instincts. Instincts make up a good part of personality, but society tries to mold them from birth by the process of conditioning. When the instincts are not allowed to express themselves, there is frustration, and the emotions come into action. Emotions are important because they determine what the personality is. If there is a personality disorder, there is an emotional disorder.

The instincts and the way they are expressed by the emotions can be classified as follows:

1. EXISTING INSTINCT	EXISTING EMOTION
Breathing	Anxiety
Feeding (Sucking or eating)	Hunger
Wandering (Hunting)	Restiveness
Acquiring	Hoarding
Cleansing	Cleanliness
Excreting	Discomfort
Sleeping	Fatigue
2. SECURITY INSTINCT	DEFENSIVE EMOTION
Flight	Fear
Submission	Disgust (Awe)
Hiding	Timidity
Seeking warmth	Huddling
Avoiding	Embarrassment
Modesty	Shyness
Clothing	Covering
Construction	Home-making
Lying	Shame
3. AGGRESSIVE INSTINCT	AGGRESSIVE EMOTION
Fighting	Anger (Rage)
Resenting	Hatred
Domineering	Envy
Rivalry	Pride
Vanquishing	Exultation
4. HERDING INSTINCT	SOCIAL EMOTION
Family (Parental & filial)	Affection
Tribal (Herding)	Cordiality
Sympathetic (Compassionate)	Pity
Apopathetic (Unemotional)	Scorn
Antipathetic (Contrary)	Detestation

4. HERDING INSTINCT (*Cont.*)	SOCIAL EMOTION (*Cont.*)
Co-operative	Gratitude
Identification	Admiration
Fantasy	Suspicion
Cruelty	Revenge
5. REPRODUCTIVE INSTINCT	REPRODUCTIVE EMOTION
Sexual attraction	Love
Mating (Copulating)	Lust
Courtship	Jealousy
Maternal love	Coyness
Filial love	Tenderness
6. INDIVIDUAL INSTINCTS	EXPRESSIVE EMOTIONS
Curiosity	Surprise (Wonder)
Playfulness (Show-off)	Satisfaction (Elation)
Dextrality	Handedness
Imitativeness	Hope
Communicativeness	Exuberance
Esthetic expression	Ecstasy
Cheerfulness	Mirth
Enthusiasm	Joy
Uncertainty	Regret
Fear	Dread
Despair	Grief
Flight	Shock

THE ORAL PERIOD

When the child is first born, if he has had his full uterine development, the initial instinctive reactions that he shows are the processes of breathing and sucking, which, of course, were given to him in order that he might preserve his life outside of his mother's womb. As is well-known, the thing that the delivering doctor desires to have the child do is to open its mouth and cry, because, in so doing, it necessarily expands its lungs and breathes. Sometimes the doctor has to inflict a painful stimulus, such as to smack the buttocks of the baby, in order to make it breathe. Then, anything that is put between the baby's lips will cause him to suckle, and so he can be fed and find pleasure. Therefore, it can be seen that the sphincter of the mouth is important to the baby's existence and the expression of emotions.

During the first several months of the child's life, the

center of the child's feeling is concentrated in the mouth area. If the child feels uncomfortable and feels pain, it relieves its tension by crying. If the child feels hungry and it cries, something is put into its mouth, on which it suckles automatically and thus gains a pleasurable sensation. Because the child's entire sense of feeling during these first few weeks is centered in the mouth, this is called the oral stage in his process of personality development.

Emotions are dependent on the adjustment of the instincts. This, of course, requires memory. If the memories are pleasant, the emotions are constructive. If the memories are unpleasant, the individual tries to push them out of mind because of the associated pain. All reactions to experiences are dependent on pleasure and pain, love and hate, security and fear. If a person is constantly fearful, he will have difficulty in making a normal adjustment to life and will withdraw from the painful situation.

The attitude of the parents and of the relatives starts to have its effect on the child immediately after birth. Most people think that the baby is just to be admired and played with. Actually, the attitude of adults may terrify the child. Parents think that the child smiles and recognizes the family, but there is no perception except fear during the first few weeks. The child feels pain and is afraid of loud noises. During the early months the child can be conditioned by fear. As an example, if the parents spank the baby or yell at him, the baby becomes terrified because of a sense of fear. This is a traumatic experience, and the more times it is repeated, the deeper becomes the scar, and the baby is conditioned to fear, a painful emotion.

Parents are prone to think that it does not matter how they treat a baby, and they may not realize that everything that happens to the growing youngster leaves a lasting impression. Feeding is one of the earliest experiences, and the nursing may be pleasant or unpleasant. The mother may be so anxious that she makes her milk unfit for her child. He is hungry, but when he feeds, it is followed by pain. Many modern women do not want to breast feed and give

as an alibi that it is too much trouble, it will spoil the form, or that a formula is better for the child. The formula may be a good substitute for mother's milk, but there is no substitute for mother's love, softness and warmth. When the child is left in the crib, with the bottle propped up, he misses loving arms. Such an experience can have a very destructive effect on the child's personality.

Many parents feel guilty about bringing the child into the world. The mother may not want to go through the pregnancy and thus fulfill the main function of womanhood. Or she may have developed a resentment against the father for his inconsiderateness. As a result, she takes it out on the child, who becomes a "whipping boy" for the father. The father may also take out on the child the resentment he feels against the mother. The child is the brunt of all this, is picked on, slapped and spanked, suffers from constant nagging, and grows up with a distorted outlook on life.

Because there is apt to be considerable confusion in the infant's mind during these first weeks of orientation, it is very necessary that the sensations be associated with pleasure rather than with pain. If a baby is given a bottle of milk that is either too hot or too cold, he will be given a confusion of sensations, as the sucking is supposed to be associated with a pleasurable sensation as the stomach is filled with warm milk. Also, there is a definite argument for breast-feeding in the first few weeks of a child's life, because the mother's milk is at the ideal temperature and consistency, which can never be exactly reproduced in the bottle. Also, the mother's nipple is much more pleasant than the rubber substitute. Besides this fact, in feeding the child at the breast, the child is snuggled up against the warmth of the mother, which gives an over-all sensation of comfort and security, which is definitely lacking if the child is allowed to remain in the crib while the bottle is propped up beside it. Should it be found necessary to feed a child by a bottle during the first few weeks of its life, then most certainly it should be snuggled in the mother's arms during the process of feeding.

In the first few weeks, the child of normal intelligence, if given the mother's attention, begins to associate the process of sucking with satisfaction and pleasure, and, if the child is contented after the feeding, he usually falls off to sleep in complete relaxation. Thus, the infant who has a properly satisfied system sleeps at least twenty hours out of the twenty-four during the first few weeks.

Since the child's feelings are centered in the mouth, he orientates himself to his surrounding community by using his lips, and at a very early age he automatically puts things into his mouth in order to find out its feelings. He soon differentiates between the things that have one sensation and those that have two sensations. The nipple of his milk bottle, or his mother's breast, creates only one sensation in his mouth, while by accident if his finger gets into his mouth, he discovers that there are two sensations, one in the mouth, and one in the finger. Thus, he discovers that his finger is part of himself.

As brought out before, the individual is born with a certain potentiality to respond to stimuli. All these stimuli will be followed by either pleasure or pain in various degrees. These responses will continue throughout the individual's life. As a result, the individual conditions his behavior accordingly; he avoids those that cause pain, and repeats those that give pleasure. He goes through processes of trial and error, as is natural for his curiosity instinct.

Conditioning of the person's response is dependent on this pleasure and pain principle. Reflexes are either simple or complex, and some are very complex, but every reaction is either pleasant or unpleasant, with a desire to repeat the pleasant reactions, and to avoid the unpleasant.

The physiologist, Pavlov, experimented with conditioned reflexes in dogs and proved without a doubt that this was an important factor in personality formation. During the feeding periods, a metronome was kept ticking, and after several periods, the metronome was started at the feeding time, but the meat was not given the dog. This was known

as "sham feeding." Even though there was nothing to eat, still the saliva flowed. Reflexes spontaneously repeated form a habit.

Reflexes can be so conditioned in humans that they form habit patterns. Each pattern requires completion. This cycle is called a Gestalt. When the cycle is not completed, the person has a feeling that it must be completed, a sense of tension.

Some reflexes may and some may not be conditioned. The reflex of pupils dilating or contracting, the ability to accommodate the eye, eye-fixation, winking and cross-eyedness, may be conditioned. Withdrawing reflex (pulling hand away from heat, etc.) may sometimes be modified. Digestive reflex of the stomach and intestines is out of the control of the will, but it can be modified. Shuddering, starting, shivering, trembling, rhythmic contractions are seldom controlled. Hiccoughing, laughing, sneezing, dizziness, sea-sickness, yawning and vomiting can all be conditioned. Grimaces, salivation, smell, reaction to tickling, muscle-twitching, fainting, blushing, breathing changes, asthma, sweating, groaning, cramps, crying, squirming, coughing, swallowing, intestinal movements, bowel and bladder control soon become habits. Biting, hunger and thirst can all be easily modified. The grasping reflex, knee-jerk reflex, and stepping reflex may be altered. In learning to stand up, one must condition certain reflexes to keep one's balance.

Always modified by the time the individual becomes an adult:

Sucking
Biting and grinding
Spitting
Hunger and thirst reflexes
Lip and tongue reflexes
Vocal reflexes
Turning the head
Tossing with hand
Grasping (finger reflex)
Tugging
Clasping
Reaching
Kicking
Stepping
Jumping
Sitting up
Bending forward
Rising
Holding head erect
Sitting
Standing
Equilibration

Often modified in adults:

Visceral discharge (excretion)
Generative reflexes (copulation)
Orgasm
Coughing
Swallowing and gulping
Reflexes to colors
Gasping
Weeping
Sobbing
Smiling
Scowling
Stretching
Convulsive contractions

Inhibited or increased by adulthood:

Winking
Accommodation, ciliary reflex
Eye-fixation & convergence
Hiccoughing
Sneezing
Dizziness
Yawning
Vomiting
Facial reflexes (to bitter or sour taste)
Salivation
Tickle reflexes
Hand twitching (dermal pain)
Patellar reflex (knee-jerk)
Plantar reflex
Great toe reflex
Vasomotor changes (blushing, fainting, paling)
Breathing changes
Sudorific reflexes (sweating)
Groaning
Laughing
Cramp movements
Squirming

Seldom modified:

Pupillary or iris reflex
Ear twitching (controlled in some)
Hand withdrawal (heat & cold)
Digestive
Shuddering
Starting (to sudden noise, etc.)
Shivering
Trembling
Rhythmic contractions (paralysis agitans)

Most of these patterns are established during the first six years of the child's life. The parents need insight to guide the growing individual into wholesome maturity. If the child has brothers and sisters, he has a better chance of coming through normally than if he is an only child. The only child may not have the opportunity to learn how to get along with other individuals, and as a result, may be poorly conditioned.

THE ANAL PERIOD

At about six months of age, depending on the meticulousness of the mother, she starts to pay attention to the

controlling of the baby's bowels. She may want to train the baby to control its bowel movements because she wishes to avoid bothering with soiled diapers, or because she may feel that it is necessary to teach the child self-control. It is a very simple matter for the mother to observe that following the feeding, which automatically sets up contraction of the intestines, known as peristalsis, the baby is apt to empty its lower bowel. These contractions of the intestines cause a feeling of tension which is carried down through the lower bowel and creates a sense of uncomfortableness, which is relieved by a relaxation of the anus, thereby allowing the peristaltic waves to force out the content of the rectum. Therefore, if the mother puts the baby on a potty following a feeding, it usually does not take the child many times until he realizes that the feeling of the potty ring is a signal to release his anus and thus empty the bowel. The usual result is that the mother expresses pleasure in her accomplishment, and may hug and cuddle the child for having followed her directions. And he soon gets the happy idea that emptying the bowel not only gives him a sense of pleasure by relieving the tension in the rectum, but also wins him compliments and praise for having fulfilled this act. He is quite apt to discover that he not only earns the pleasure of his mother, but may also receive the attention of everyone else in his environment. He learns, too, that if he does not give up the content of his bowel, he may also receive attention. The mother may sit with him and read to him or talk to him, play with him, or cajole him, and he is somewhat mystified by the fact that so much attention is paid to something which comes out of him.

During these weeks of training the child discovers that instead of getting pleasure primarily in his mouth, he can also get a great deal of pleasure in the process of having a bowel motion, which within itself gives him a comfortable sensation when he releases his anal sphincter and empties the content of the lower bowel. He soon realizes that just as he might use crying as a weapon to control his environment,

he can use his bowel motions as a weapon to get attention, and he at times finds that he gets more pleasure from not giving up the bowel content than from giving it up. Thus, this period of bowel training is called the anal stage. In most normal children the bowel habit usually takes about two years to be firmly established.

THE GENITAL PERIOD

After the mother has established her child in a regular bowel pattern, she then turns her attention to training the child to keep dry. Just as the child is apt to empty its bowel at a definite time following eating, so when the bladder becomes filled with urine, he has a desire to relax the sphincter muscles and empty it. The filling of the bladder to the point of tension depends somewhat on the amount of liquid intake, the rapidity with which the kidneys secrete urine, the irritability of the bladder, and the general emotional tension of the child. As the bladder fills, the tension increases to a degree that there is a desire to release the tension, and, if the child does not make an effort to keep the sphincter closed, the release becomes automatic when sufficient pressure is reached.

The mother may logically try to figure out the time when the tension is apt to be demanding, or she may try to impose her will on the child by insisting that he control the impulse to relieve the tension. Thus, the process of training necessarily takes the attention of the child away from the anus, and he begins to concentrate on the urinary apparatus, which is also in the genital region. Because the child finds that relieving the bladder tension gives pleasure, and that refusal to empty the bladder may also give him a certain amount of attention, so this period of development is called the urethral stage. Sometimes it is spoken of as the genital erotic stage. This period of training usually takes place during the second year of the child's life, and if emotional conflict does not develop, the habit should be well established at least by the third year.

The time of training is often for the infant a time of confusion. If he wets himself, he may get spanked. Because of the attention that is being paid to this area, the child begins to observe himself, and in his attempt at control, he may hold his genitals to keep himself from wetting—and then in many cases he is also spanked for touching himself. Thus, the child becomes confused. The more exasperated the parent becomes, the more confused becomes the child. He is asked to control something—nevertheless, he is not allowed to do anything effective to stop the flow of urine and is given an unmistakable taboo against the touching of this area. At this time the child may also discover that by the handling of the area he gains a certain amount of pleasure, and so he may repeatedly play with himself. Although bladder control may become automatic by the third year, under conditions of excitement, tension or cold, the child may lose control of this sphincter and accidentally wet himself. In such cases he not infrequently is severely punished or given a sense of rejection by the parent.

Although these three stages of so-called psychosexual development are called "erotic," they are not in the usual sense sexual. The term erotic primarily refers to the sense of pleasure.

The prime objective of the personality is toward the attainment of pleasure and self-satisfaction. During the first five or six years of a child's life these personal desires express themselves uncertainly. There is apt to be a change back and forth between these various erotic manifestations. Therefore, these first five or six years of life may be considered as having definite sexual implications, and during this pre-school period the boy is apt to find definite satisfaction in associating with the mother, while the girl finds her satisfaction in associating with the father. The parents, on the other hand, not understanding the potential in such a relationship, may cause the child to become overly attached, or to become confused in this relationship. The parent is very acutely aware that the child is of a certain sex—either boy or girl—and the child, in orientating itself to

its environment, becomes just as acutely aware that it is a boy or a girl. The boy comes to recognize that he is like his father, and if there is an opportunity to observe the parents in the nude, the boy further recognizes that all males have certain sexual likeness, and that females also have a certain sexual likeness. The girl also recognizes that she is like her mother and all females. Thus, the children identify themselves with one parent or the other.

If the parents conduct their lives in a normal manner and demonstrate normal emotional expressions to each other, rather than demonstrating emotional expressions to the child, the child grows up to feel that there is a normal attraction between the sexes. On the other hand, because of the disparity of such expression between the parents, and because of the prudery of some parents in not allowing the children to observe such expressions of attachment, the children may take sides and line themselves up with either parent. Thus, the girl may become overly attached to the father, while the boy becomes overly attached to the mother, and future emotional problems are the result.

Because the child is apt to become attached to the opposite sex during these first five or six years of life, and to find its interests in the opposite sex in its process of orientation, this period is definitely heterosexual. The term also implies that pleasure is found in association with the opposite sex.

Next to birth, the biggest crisis in life is going to school. At five or six years of age the child may be taken to nursery school or kindergarten, where he finds that it is necessary to get along with persons of his same sex and age. Of course, if the child has the good fortune to have siblings, then he has already learned to play with brother or sister, and, if the parents have not taken sides in this process and thereby caused a parental fixation, the child will have no difficulty in adjusting to such school life, but, if the child has been overly protected and has become abnormally fixed in the process of these first five or six years, then he will have considerable difficulty adjusting to other children, especially those of the same sex.

From the age of five or six until adolescence, which on the average is between ten and sixteen, the child normally should identify itself with the same sex. He or she is interested in copying the activity and physical development of the same sex. The little boy is primarily concerned with demonstrating the fact that he is a boy. He plays boys' games, he fantasies himself as being a man, he competes with other boys, and he usually assumes an attitude of disdain for the opposite sex. The girl, on the other hand, is primarily concerned with demonstrating that she is a girl, and she, therefore, has common interests with other girls, plays girls' games, and has no conflict over the fact that she is a female.

In this period of about ten years the child is essentially homosexual, meaning interested in the same sex, and finding pleasure in associating with the same sex. If the parents clearly understand this process and do not try to mold the child into their personal requirements, the child will not be retarded in his psychosexual development. If, on the other hand, the mother has resented the father and has been over-protective of her boy child, then he gets his greatest pleasure in doing what the mother wants and is apt to identify himself with her. Also, the mother may have a resentment against all men and, therefore, raise her son to be genteel, as she would if the child were a daughter. The girl, on the other hand, may be overly attached to the father, and, because the father may have wanted a boy, he tends to raise the girl to act as if she were a son, causing her to identify herself with the father. Or, the father may have a resentment against women and, therefore, wish the girl to grow up to be different from other women. This will, of course, cause a great deal of confusion in the developing child.

THE DISCOVERY OF SEX

This period between six and sixteen is also a period of great curiosity, and it is during this period that the child

starts to discover sex and its implications. Usually at about five or six the child begins to ask questions in his attempt to differentiate rightly between boys and girls, and he asks such questions as where babies come from. If the parents do not satisfy this curiosity, or if there are no other brothers or sisters in the home with whom the child can compare himself, he tries to find out from his classmates what the answers are to the questions. If he is over-protected by his parents, he may not have the opportunity to satisfy this curiosity, and, therefore, later he is stunted in his normal psychological development. Unfortunately, most parents put a taboó on the subject of sex and are evasive in their answers. Consequently, the child is apt to withdraw and to satisfy his curiosity through secret means. He suggests such games as "playing house" or "playing doctor" in order to obtain the information that he desires. Also, older children may make suggestions which whet the curiosity, yet do not entirely satisfy it. If the parents and teachers do not make too much of the situation, the average child will pass through this stage without conflict and will go on to a mature development in his sexual adjustment to life.

As the child gets into his teens and adolescence begins to make itself shown, definite changes take place in the individual which increase the personal anxiety over the whole subject of sex. If the questions have been answered along the way, and the individual's curiosity has been satisfied, then adolescence does not become a crisis. If the child has been given a feeling that sex is something very secret and wrong, then a definite crisis does arise.

Girls and boys growing up in warmer climates, or whose parents are from the warmer climates, are more apt to develop secondary sex characteristics more quickly, while those from the northern European countries are apt to mature more slowly. Adolescence makes its appearance when the sex glands speed up their function. This creates an urge within the individual which cannot be defined, and which increases the general tension.

The girl notices that her body is starting to take on a more mature form, and as her breasts enlarge, she becomes very self-conscious about the fact that she is either ahead or behind the development of the other girls of her age. Consequently, the boys of her age may comment about her development, and she tends to become embarrassed on these occasions. About this time she hears of menstruation, either from her parents, or her girl friends who have perhaps already begun this function. In the temperate climates, most girls begin to menstruate at about fourteen, but it is not uncommon for a girl to begin menstruating as young as ten, or to delay this function until sixteen or seventeen. Either one of these digressions from the considered normal may certainly make her self-conscious and withdrawn.

With the onset of menstruation, many girls are given the impression that they are now handicapped in their general activity, must restrict themselves in their athletic pursuits, and must act like "ladies." It is, therefore, not surprising that one of the commonest terms for menstruation is "the curse," or that the person is "sick." Unfortunately, most girls even today do not realize that menstruation is a normal function which indicates that they have now developed the capacity to reproduce, and that menstruation is an indication of their womanhood, instead of being a sign of inferiority. It is unfortunate when a girl is raised to believe that she does not have what her brother has and, therefore, is inferior to him. When such is the case, the girl most naturally will develop a conscious or unconscious envy of her brother's penis, which is the main sign of his difference from her. If girls were frankly taught that they have something which their brothers do not have, and that they have a counterpart and not a lack, much anxiety could be removed as adolescence develops.

During adolescence, the boy also goes through dramatic changes which will give him much concern. His voice changes, his testicles usually descend into the scrotum, and his penis becomes larger. Also during this period, hair

begins to develop on the body, which in the boy's case is looked on with favor, as it has been used as a sign of masculinity. Although hair also develops on the girl during adolescence, if it is not restricted to the genital area or under the armpits, it is apt to cause a great deal of conflict in the girl's mind, whereas, if hair does not develop about the boy's body, he is apt to feel that he is not keeping up with the standard. Also during this period, the boy's muscles start to develop, and he begins to take on competitive sports in an attempt to compete with his fellows. His voice changes at this time, and he may be embarrassed when it cracks, or if it does not take on a deeper tone. Unfortunately, adults sometimes tease the youth about these changes.

During the period of adolescence, since the major difference in the individual's body is centered in the genital area, it is perfectly natural to center attention in this area. Either by accident or by example of other adolescents, it may be discovered that by the manipulation of the genitals definite pleasure is obtained, and, consequently, the practice of masturbation may be instituted. Although children, both boys and girls, may indulge in genital manipulation before the age of six, it is usually found that the child does not pay much attention to the genital area between the age of six and adolescence, when again there is a desire to obtain pleasure from such manipulation. Along with the enlargement of the penis, the boy at the beginning of adolescence finds that he is troubled with sexual dreams, which may or may not be definitely centered on the opposite sex, but in any case, he finds that his sleep is at times disturbed by the erection of the penis, and in due time there may be a nocturnal emission, known commonly as a "wet dream."

Because his associates are becoming aware of this sex development, there is apt to be a comparison of genitals, and there may be an indulgence in mutual exhibitionism or mutual masturbation. If by any chance the adolescent boy is initiated into such activity by an older man, then

there is grave danger that the adolescent will find that there is an advantage in continuing the practice, and, therefore, he becomes essentially homosexual. Likewise, in the girl, she may discover that there is pleasurable sensation in manipulating the genital area, or she does so by mechanical means such as riding a bicycle or horseback, and, therefore, she may continue the practice for this purpose. It is not uncommon for girls unwittingly during adolescence to develop severe crushes on other girls, and if such association is encouraged by an older person, such as a teacher, then there is also danger that the girl may wish to continue in this homosexual activity.

These changes in the physical development of the individual during adolescence are called secondary sex characteristics. If the child has had his questions answered along the way and is aware of the beginning of these secondary sex characteristics and their indication of mature development, there is little danger that he will develop a homosexual interest. If, however, the parents have put a taboo on such questions, or if the parents have over-emphasized the matter of sexual pleasure in the adolescent, then there is danger that the individual may become so preoccupied with this function that homosexuality may result. This is also a grave danger if the child in adolescence is shut up in a private school where only members of the same sex associate. Most certainly, the most healthy environment for the adolescent is a coeducational type of environment where there is an opportunity for free exchange in social activity between the sexes. Properly supervised play, classroom activity, and social gatherings are the best assurance against abnormal development in personality.

OVER-PROTECTION

If in the pre-adolescent period the parent has overly attached himself or herself to the child and resists the

normal breaking away of the child, then there is danger that severe conflict may develop in the individual's personality. The mother may have been overly protective of her son and may have created a situation in which the son is unable to act independently of the mother. He feels obligated to her and feels that he must at all times do as she wishes. Our society tends to put a premium on such behavior, and to place the mother on a pedestal. Therefore, the boy must always be kind to the mother, affectionate to her, and usually is required to kiss her goodnight. Not infrequently, the mother tucks her boy in bed and takes care of his every want, seeing that his room is cared for, that his clothes are in order, that he has properly washed himself, and may even go so far as to supervise his bath. Unfortunately, she is not aware of the fact that she is surrounding the boy with the shackles of obligation.

As adolescence comes on, the boy unconsciously may be affected by his mother as a woman and not as a mother, and have the perfectly normal response that a boy would have if he were kissed on the lips by someone of the opposite sex. He, therefore, finds that when his mother kisses him, he is sexually aroused and may have an erection. This causes considerable consternation within him because during his training he has been given plenty of evidence to indicate that it is not right for a son to love his mother in a sexual way. Therefore, he becomes conflicted over this situation and develops what is known as the Oedipus complex. Because of his training, the boy may be known as a goody-goody boy, but when he finds that he is aroused by the affections of his mother, he then becomes greatly disturbed and is apt to withdraw within himself, perhaps even developing an emotional breakdown. In such a situation the boy develops a fear of the opposite sex and may, therefore, actually withdraw from any association with girls.

In the case of a girl, where the father has been overly protective of his daughter, there is also a danger that an

Oedipus situation may develop. Sometimes the father wishes for a son and may raise his daughter as a tomboy and spend a great deal of time with her, taking her on hikes or fishing trips, and making a pal of her. On the surface, this situation may appear ideal, but actually it is fraught with a great deal of danger. Even before adolescence, the mother may resent the father's attachment to the daughter, as the daughter thus deprives the mother of the affection that she feels she is entitled to, and the girl, therefore, becomes her rival. Also, the father may have been showing much affection to the girl, holding her on his lap, kissing her goodnight, tucking her in bed, or allowing her to crawl in bed with him on a Saturday or Sunday morning, without realizing that although there was no sexual feeling in the pre-adolescent period, when adolescence arrives, the girl does become sexually conscious of the fact that her father is a person of the opposite sex. He may or may not be sexually aroused by the kissing of his adolescent daughter, but he most certainly is very conscious that her body is becoming mature. There is no reason why he should not be as much aroused by his daughter's breasts as by the breasts of any other woman. He may also discover that as she goes into adolescence there may be a change in the sensation she creates when she kisses him, and he may, therefore, become much disturbed by the fact that such a kiss may cause him to have an erection. Also at this time, the girl herself may be aware of the fact that this person she is very fond of can arouse something within her, and that when he kisses her or puts his arms around her, she becomes moist in the genital area. She then realizes that she is really in love with her father, and, like the boy who has an over-attachment for his mother, so she may develop a conflict over her attachment to her father. This, of course, may be an entirely unconscious process.

Just as normal attachment between a parent and a child is perfectly natural, so sexual arousement by the oppo-

site sex in adolescence is perfectly natural. Nevertheless, when a person who is related is sexually aroused by the individual, then it is considered incest. This is one of the conflicts which is very early developed in the individual, and through society is one of the earliest taboos. Animals do not have taboos. Mankind does. In the case of animals, individuals of opposite sexes can be mated irrespective of their relationship—a practice not infrequently used, of course, in the breeding of certain types. But in the case of human beings, man over the centuries has created a tradition that mating between relatives is unacceptable. It is not unusual for a small boy to say to his mother that when he grows up he wants to marry her, or for a girl to say the same thing to her father. Yet the parent makes it unmistakably clear to the child that this is unacceptable. The laws of the church and of the country are precise on this matter, and severe punishment is meted out to any who transgress this rule. It is, therefore, not surprising that adolescents run the risk of developing a severe Oedipus complex when they realize that they are sexually attracted to one of their parents.

If, on the other hand, at the beginning of adolescence the child has been given an opportunity to have normal associations with the opposite sex, and he is not criticized or teased for any interest that he shows in the opposite sex, he will go on to normal development. Unfortunately, parents frequently, on the appearance of the secondary sexual characteristics, immediately warn the child that he or she is going to have to face many dangers, that if he has anything to do with someone of the opposite sex, then pregnancy or venereal disease is sure to follow, and thus the youngster is scared away from normal activity. Many times girls even gain the idea from their parents' admonitions that if a boy should kiss her, she will get into trouble. Some parents may even go so far as to make a threat that should the girl "get into trouble," she would be disowned or thrown out of the home, and, consequently, it is not surprising that such a girl would develop fear of any association with boys.

RETREAT TO HOMOSEXUALITY

Because of these fears, young people may withdraw from association with the opposite sex. Yet within themselves they have an urge which seeks expression. If they cannot find such expression with the opposite sex, then they may find an outlet with persons of the same sex. All we need to do is to look over society as it is now constituted to see the result of such a method of training. Many individuals, although married, fundamentally have a conflict over intimate contact with the opposite sex and have, therefore, retreated into homosexuality. These individuals may have married simply because their families wanted them to do so, because they felt it was the thing to do, or because they wished to get away from the situation they were in, without a real, sincere desire to make an adjustment to the person of the opposite sex. A girl may find that she cannot tolerate her home. Yet she cannot support herself on her own. She may, therefore, marry for a meal ticket. The man, also feeling that he wishes to get away from his home, may marry a woman primarily to get a housekeeper. These individuals are concerned with self-pleasure. They are not interested in what they can give to the other person. They are not interested in mutual pleasure. Therefore, these individuals are fundamentally still in the homosexual stage of development and have either not progressed beyond this stage, or have retreated to this stage because they have not succeeded in making an adult adjustment.

It is this homosexual urge which is the basis for the creation of all the various types of organizations, such as men's clubs, women's clubs, and many of the other secret organizations about the country which limit the membership to persons of the same sex. Although many of these organizations justify their existence because they attempt to work toward civic betterment, they, nevertheless, could accomplish as much good if they were not limited to the

same sex. The normal individual, the one who is emotionally mature, prefers the company of the opposite sex and functions more normally in such a relationship.

SELF-PLEASURE

When the person remains in, or retreats to, the homosexual level of development, he may not find it possible to express his desires with another person of the same sex, and so looks for the pleasure within himself or herself. He resorts to masturbation, or self-pleasure. Again society and the church have placed much taboo on this practice and make many threats, such as hell-fire, or insanity. Scientific study has never shown that masturbation has ever caused insanity, although the person's worry over the practice may cause much emotional anguish. Little is it realized that there are many forms of self-gratification which may be classed as masturbation, such as alcoholism, smoking, gossiping, fingernail biting, thumb-sucking, gum-chewing, and so forth, but no one thinks these will cause him to lose his mind.

THE REPRODUCTIVE INSTINCT

One of the strongest urges in the normal human being is toward mating and the fulfillment of the orgasm. Everything in nature leads to this ultimate goal, and man is no exception. The Kinsey Reports bring out nothing new, but simply tend to confirm the fact that human beings, both male and female, seek to satisfy that urge. Without the fulfillment of that desire, there is frustration and dissatisfaction.

Unfortunately, civilized man has tried to condition that urge, and to change it into something ugly and unacceptable. The result is emotional sickness and distress.

HOW ABOUT THE OTHER INSTINCTS?

Although the Reproductive Instinct is generally the most commonly frustrated instinct, the other urges within the

person may also be blocked in expression, and so the resultant personality may be warped.

Fortunately, few children in America grow up with the danger that the Existing Instinct will be frustrated, but much of the rest of the world is subject to deprivation.

In a world of insecurity and threat, the children of this generation are finding more and more frustration in the Security Instinct.

With the change in our social structure during the last several generations, the family as an institution is losing its firm foundation, and there is a marked regression to the more primitive behavior of the herd. Because of insecurity and disintegration of our social system, the Social Instinct is being frustrated. Certainly society needs to re-evaluate these principles. Youth has been fearful that its Individual Instinct will find no expression and so protests against the preceding generation.

The child has to be guided carefully in the expression of the Aggressive Instinct, otherwise we have lawlessness and disregard for others, and yet there must be some opportunity for the growing child to show his feelings if he is to become a mature personality.

The child who is denied the right to understand these basic instincts and their proper control will be a poorly integrated personality—a frustrated individual, an unhappy and inefficient person.

CHAPTER III

The Origin of Guilt

The individual is not born with a conscience, but from the time of his birth the environment, usually consisting of parents or nurse, starts a process of conditioning or training to fit him into that social situation. As has been brought out before, the newly born infant is an unsocialized being and is only concerned with his own pain and pleasure. He, within himself, seeks for pleasurable sensations and tries to relieve the tensions which are built up. When pleasure is obtained, then there is a desire to repeat the activity, and the more times the action is repeated, the more fixed becomes the pattern of behavior. The parents, on the other hand, usually have some definite ideas as to what they want the child to do and how he should act, whether he gets pleasure or not. Consequently, when the child does something that is unacceptable to the parents, he is told not to do so, or he will be punished, and, therefore, made to feel pain or displeasure. By the constant repetition of these directions, the child comes to realize that he is not supposed to do certain things, because they are unacceptable, and that he should feel guilty when he does.

The process of conditioning continues throughout the life of the individual but is most intense during the first few years. The child gradually learns that part of his behavior is acceptable, and other behavior is unacceptable, but because he still wishes to satisfy his own urges and does not want to be frustrated in obtaining this satisfaction, he, therefore, may attempt to do things without his parents' being aware of it. Nevertheless, on frequent occasions he is

apprehended or is told that this behavior is wrong; he is threatened with punishment or is punished. Consequently, he grows up with a sense of guilt. It can't be overemphasized that the child is not born with this feeling of guilt and only develops it as he is taught. The stricter the parents and the more dogmatic the environmental training, the more the individual grows up with a sense of guilt. A definite pattern of thinking is, therefore, firmly established deep in the personality and is known as the conscience. This conscience continues to control the individual's behavior the rest of his life.

There is no doubt that this conditioning process is well under way by the time the child enters public school, and most certainly by the time the child is ten years of age he has a well-established conscience which will attempt to control his every action. His instinctive urges may wish to express themselves under proper stimulation, but he will find that on many occasions these urges are in opposition to his training. His conscience will try to prevent him from following through with his activity, and will create a definite feeling of guilt if he dares to disregard his training, and make him feel that he must be punished for this wrongdoing.

Throughout the centuries, various societies have established rules of conduct and systems of taboos, such as the Ten Commandments, which have helped to create a sense of guilt. These rules have been taught early and late, many times without rhyme or reason, until the person grows up with a fear of most certain pain if the rules are broken.

Every tension or emotional disturbance that an individual develops is based on either frustration or guilt. If the individual cannot find satisfaction in what he does, he finds the situation unpleasant, and instinctively he does not wish to continue that activity. He has an urge within him to remove himself from the unpleasant situation, to run away, or to retreat. Where he finds that the situation is pleasant, he, of course, wishes to repeat it, and if his behavior is acceptable to his environment, he does not feel rejected. If he refuses to admit the dictates of his environment and

insists on satisfying his own desires, his conscience starts to bother him, and his guilt hounds him at every turn.

Because the personality has grown up in an environment where wrong-doing is always punished, when he feels guilty, it is perfectly natural that he should feel the necessity for punishment. This sense of guilt may be so strong, and the need within the individual for punishment so overpowering, that he cannot escape from it.

It is obvious, therefore, that every action in life can be analyzed into whether it is pleasant or unpleasant to the individual. If the person's desire is satisfied, and if the tension within the individual is relieved, then it is pleasant. On the other hand, if the individual gets no satisfaction as a result of the action, and there is no relief from the tension, then the person is said to be frustrated, and the feeling is unpleasant.

Many classifications have been made of the pleasant and unpleasant reactions in the body, but suffice it to say that these reactions may be considered as emotions and have many ways of expressing themselves in what are normally considered as attitudes or dispositions. A working classification is the following:

	EMOTIONAL REACTION	*ATTITUDE*
1.	EXPRESSIVE:	
	(Pleasant)	
	Joy	Cheerful (Fervor)
	Ecstasy	Zealous
	Exuberance	Romantic (Sparkle)
	Wonder	Devout (Faith)
	Satisfaction (Elation)	Contented
	Mirth	Frivolous
	(Unpleasant)	
	Anxiety	Uncertain (Afraid)
	Grief	Despondent
	Shock	Dazed
	Restiveness	Erratic
	Surprise	Startled
	Hope	Resignation
	Regret	Dejection
	Dread	Fear

2. DEFENSIVE:

(Unpleasant)

Fear (Flight)	Cowardly
Fear (Combat)	Courageous
Disgust	Aversive
Timidity	Cautious
Embarrassment	Defensive
Shame	Reserved
Awe	Servile
Shyness	Withdrawn
Modesty	Frigid

3. AGGRESSIVE:

(Pleasant)

Pride	Ambitious
Pride	Arrogant
Exultation	Bold

(Unpleasant)

Anger	Hostile
Hatred	Vindictive
Envy	Malicious

4. SOCIAL:

(Pleasant)

Affection	Devoted
Cordiality	Friendly
Gratitude	Attachment
Admiration	Loyal

(Unpleasant)

Pity	Compassionate
Scorn	Supercilious
Detestation	Antagonistic
Suspicion	Distrustful
Revenge	Sullen

5. REPRODUCTIVE:

(Pleasant)

Love	Affectionate
Coyness	Flirtatious
Tenderness	Motherly

(Unpleasant)

Lust	Lascivious
Jealousy	Jealous

6. INDIVIDUAL ITEMS:

(Pleasant)

Belief	Credulous (Hope)
Cleanliness	Orderly

(Unpleasant)

Restiveness	Nomadic
Acquiring (Hoarding)	Avaricious
Disbelief	Skeptical
Doubt	Perplexed
Belief and Disbelief	Biased

THE UNCONSCIOUS

About sixty years ago Sigmund Freud compared the human mind to an iceberg. As with an iceberg, most of the mind is out of sight, hidden away in the Unconscious. Thinkers throughout the world had long been aware that mental activity was not confined to the level of consciousness; they understood well that much goes on below the surface. Freud not only documented and deepened this insight, but mapped the kinds of mental activity at each level reaction.

Freud divided the mind into three parts, which he named the Id, the Ego, and the Superego. The Id, which he located in the Unconscious, he described as the seat of primitive instinctual drives, harking back to the hereditary past. The Ego, which is situated in the conscious level of the mind, adjusts desires arising in the Id to reality; the Ego learns the rules of society and decides whether and when the Id's desires can be fulfilled. The Superego is the conscience and tells the Ego whether its decisions are morally or socially acceptable. The Superego is buried in the Unconscious; and, essentially, it represents idealized rules of behavior taught so strongly and so early in life as to have penetrated far below the conscious mind.

If a baseball is taken as a symbol of the total personality, the string of the baseball represents all the experience since

birth, wound on smoothly, or tangled and knotted along the way. The smooth progress of life is pleasant, but the knots and tangles are unpleasant or painful experiences, which have left an indelible impression on the person's mind. Over the knots, the string is taut and under tension, and so in life the personality is tense when one of these experiences is brought back to memory. Every time the bat of life hits the ball over one of these tension points, the veneer may crack and break open, and the unconscious material comes to the surface.

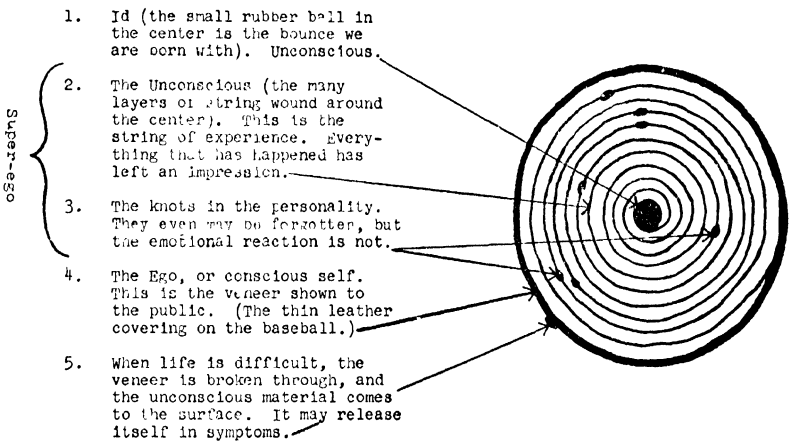


FIGURE 5. THE CIRCLE OF LIFE

Freud came to the conclusion that unfulfilled or unfulfillable sexual desires were responsible for emotional disturbance. He also concluded that satisfaction of sexual desires was man's chief object in life. In his early writings he made libido or the sexual instinct the principal force in personality development; and the terms libido and sexual instinct always had a strongly sexual content. In later years he broadened his conception of life's urges to take in other forms of pleasure-seeking, from a liking for food to love of music.

One of Freud's early collaborators, Alfred Adler, concluded that because every individual feels he has some physical abnormality, his emotional conflict comes from feelings of inferiority. Another associate of Freud, C. G. Jung, pointed out that the relationship between parents and between parent and child is the important factor in forming the personality of the child. This is known as identification, or the formation of character through imitation. Jung also emphasized influences from the "collective unconscious," which is made up of unconscious memories going back to man's primal past. He broke with Freud because he contended that the Unconscious holds a distinct, non-sexual creative instinct as well as a sexual instinct.

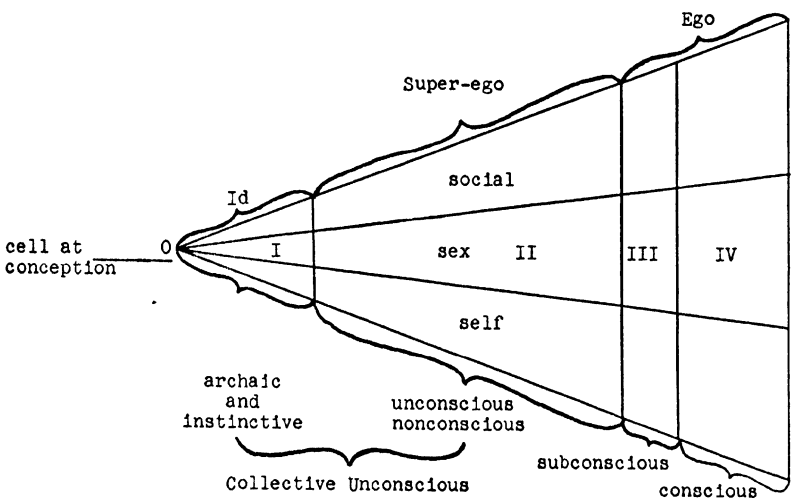


FIGURE 6. PERSONALITY TRIANGLE

According to Freud, the *Id* (I) is the instinctive material a person is born with; the reservoir of the fundamental instinctual desires. Physical organism produces energy which demands an outlet. If no outlet is found, tension and consequent discomfort arise, of which the individual must rid

himself; he must seek the pleasure of relief from tension. This is infantile. The Id being inborn and inherent, it remains unaltered from birth to death.

The *Super-ego* (II), or the conscience, is unconscious material. The conscience, whose function is to warn the Ego of the tension due to Id impulses and to help the person to control their expression. Through help of parents he learns to control these impulses.

The *Ego* (III, IV), or the "I," is the conscious self. It is the person's critical, perceptive faculty or awareness of himself. He tries to relieve his Id tensions by allowing the energy outlets that accord with the dictates of reality.

To Freud's classification could well be added a thin zone (III), composed of things not really unconscious and not really conscious, the twilight zone. The more monotonous the situation becomes, the more unconscious does the material become. Either section may predominate over the others, but the balanced personality does not allow one section to completely overrule the others.

Freud was a strong traditional moralist, although he was charged with promoting immorality. He taught that man's libido had to be suppressed in the interest of society. But Freud's critics point out that if Freud is right about the psychic role of libido, then man is doomed to eternal frustration.

This objection to Freud's theories is raised explicitly by the so-called Cultural School of psychoanalysis. This school grew out of a generation of work in anthropology, other social sciences and psychiatry. It was well established in the United States in the nineteen-thirties. Its prime movers were Adolph Meyer, Erich Fromm, Karen Horney, and Harry Stack Sullivan.

The Cultural School takes a more hopeful view of man's psychological destiny than did Freud. According to this school, personality is shaped primarily by social and cultural forces, which can be, and constantly are being, changed. Man has fewer instinctual patterns of behavior at birth

than any other animal, and he can develop along many different lines, depending on the society into which he is born.

As an example, today in American society it is quite all right for babies to cry when they want something, but older children behaving in the same way get stern disapproval. Emotional conditioning originates from such social pressures. Thus a child may be made deeply anxious by a parent who demands too much from him, or he may be led to odd attention-seeking behavior as a result of having been denied attention he needed and should have had.

In its denial to instinct of any important part in personality, the Cultural School represents a sharp break with Freud. The majority of psychiatrists today do not go that far, however, any more than they accept Freud's exclusive emphasis on libido. They feel that there is truth on all sides of the question. "It is obvious that the sexual instinct plays a considerable role everywhere in life and thus also in the neuroses," says Jung, while Ernest Jones says, "but it is obvious that the power drive, the many forms of fear, and the individual necessities are of equal importance."

NOTHING REMAINS STATIONARY

It is evident that although there are many opinions as to the genesis of conflict, one thing is certain, and that is that in dealing with human behavior, one must realize that nothing can remain stationary. It is impossible to stand still. Even in inanimate objects there is either a building-up or a breaking-down process going on at all times. You paint a building, and within a few days there is a change in the color, and there is a deterioration in the surface. Eventually, the building has to be repainted. A steel structure is erected, and immediately the metal starts to corrode. Most certainly, the human body is constantly building up and breaking down. In the first years of the person's life, the progress of growth overshadows the breaking down of the tissues, but we are all aware of the fact that in due time the process

appears to be reversed, and the destruction of tissue overshadows the building up. This process goes on also in the emotional side of the individual, and if the person does not advance in his adjustment to life, he is absolutely certain to go backward, or to regress.

To interrupt this destructive process, the individual must have a clear understanding of himself. He must realize that through the process of self-analysis the situation can be prevented or straightened out. Unfortunately, most individuals are too close to themselves and cannot analyze themselves without prejudice. Therefore, it may be necessary to seek counsel from someone who is trained in the process of analysis. In the process of analysis, the pychiatrist tries to lead the person to think through every life situation, and it is, therefore, obvious that the psychiatrist must at all times maintain an unprejudiced attitude. He cannot take sides, and must assume the attitude that there is nothing right or wrong except as the individual himself may feel that it is so. In order that an analysis may be successful, the analyst must lead the person through the maze of material that is brought up into consciousness. The object is to help the individual convince himself that his activity is not reprehensible, and that it is perfectly normal for him to desire pleasure in life.

Just as the individual is prejudiced in his own favor and, therefore, has many blind spots in his thinking, he may find it impossible to indulge in self-analysis to the extent necessary to gain emotional stability. He may go to lectures and read books on the subject of self-analysis and psychiatry and may feel that he has a clear understanding of his own desires, but because of his basic training, he cannot get away from the dominance of his conscience. He may go for guidance and counsel to a minister, a priest, or a rabbi, or perhaps to a parent or a trusted friend, but here again he is apt to run into a certain amount of prejudice for or against his behavior or his feelings, and although he may be helped to make peace between his ego and his super-ego, quite frequently he finds himself persuaded against his own

urges and, therefore, blindly accepting the philosophy of someone else.

SELF-ASSERTION

As stated before, from the moment of his birth through the first years of his life, the child is constantly being told what he should and what he should not do. He is being conditioned to accept the dictates of his elders, whether they be parents or teachers. But as adolescence comes on, he finds that the urges within him become increasingly insistent, and he oftentimes finds that the philosophy which has been given to him by his elders is unsatisfactory. He, therefore, ventures to try thinking for himself. He is trying to work out a conduct of life, or a religion, which is more satisfactory to himself. Because of this conflict, many young men and women turn from the teachings of their earlier years and insist that they are atheists. Yet, in talking with these individuals, one discovers that they do not deny the existence of a power beyond themselves. But there is no question that they are rejecting the dogmatic rules that were given them by their elders. That is one reason why philosophy is taught in college—in order to get the students to think through their own feelings and to establish some pattern for themselves, instead of accepting blindly the dogmatic teachings of past generations.

If young people are encouraged to think through these problems of life without prejudice and without fear of unpleasantness, then they come to the realization that the dogmatic teachings of their elders were given them in childhood as a means of keeping them out of difficulty, and that these teachings came as a result of all the thinking of the previous generations in their struggle to understand and develop a workable philosophy for living. Unfortunately, many adults refuse to indulge in self-analysis or to think out a workable philosophy for themselves, and in turn insist that their children follow unquestioningly this same pattern.

When the person starts to analyze himself, he must first

decide whether or not his behavior and thoughts result from his own inner urges, and whether they are pleasant or unpleasant to himself. He must then evaluate his activity or thoughts in the light of his environment and decide whether it is acceptable or unacceptable to his associates, his family, and his community. If a person were living alone, away from contact with others, he might follow through with his own urges without conflict, but since he is living in a society of individuals, he cannot completely disregard other people, and if he does, he will sooner or later find himself in conflict with his environment. This process of analysis can be expressed in the following chart:

ACCEPTABLE	
Pleasant	Unpleasant
1 (normal)	3 (neurotic)
UNACCEPTABLE	
2 (neurotic)	4 (psychotic)

FIGURE 7. A SCHEME FOR PERSONAL ANALYSIS

Everything that happens in life, and everything that the individual does or thinks, can be put into one of these four groups. What is pleasant and acceptable will cause no conflict and no tension within the individual. Anything within this category is constructive, and the more the individual follows this category, the more normal will he be as an individual. On the other hand, if the person follows his own desires and disregards the feelings of his society in the matter, he is indulging in what is classed as anti-social behavior. Doing something which is pleasant but unacceptable will obviously sooner or later get the individual into trouble with his environment. He will live under a great deal of tension because of his sense of guilt and the fear that he will be punished for his behavior. This second category, therefore, is neurotic.

Previously it was pointed out that from the time of birth the individual is taught to conform to certain rules, which may be so firmly ingrained that he is unable to satisfy himself without first considering the feelings of others. He, therefore, may always do the acceptable thing, even though it is unpleasant to him. This, of course, creates a sense of frustration and will cause conflict and tension. The individual must have some self-satisfaction in what he is doing, for the ego urges must find expression. It does not always mean that the individual has to blindly do what he pleases, but he may find that he can release this tension in an acceptable manner, such as by competitive sports, play acting, crying or laughing. On the other hand, if an individual continues to do only the acceptable thing without regard to his own feelings in the matter, his tension must be released, and quite frequently he will develop physical symptoms as an outlet.

Anything that is pleasant and unacceptable, or anything that is acceptable and unpleasant will create tension and will create a neurosis, which is simply an attempt of the unconscious to help the individual to adjust to his environment. Most individuals in society suffer from some degree

of neurosis because they are unable to wholly satisfy themselves in an acceptable manner, and they, therefore, indulge in one or the other of categories two and three to make life bearable.

Where a person continues to use neurotic behavior but makes no progress in adjustment to life, he finds himself slipping backwards. He may eventually end up in a situation where he has run away from the realities of life and is acting in an unacceptable manner which gives him no pleasure. In such a situation, the individual may be completely out of control of himself and might be classified as antisocial or psychotic. He has regressed to the state of his infancy when he was not concerned with other people's opinions and did what he pleased. Thus, he may find himself deprived of all means of self-satisfaction and shut up in an institution. The unconscious does not usually allow this state to continue any length of time, and, consequently, some means of self-satisfaction will be found. So the individual who has run away from reality and has developed a psychosis continues to regress back to infancy where he acts as he pleases without regard to what other people think. Therefore, in psychiatric hospitals patients act as they please without regard to what other people may think of their behavior.

In order to help a person recover from a psychosis, it is necessary to help that individual realize that his behavior is infantile, and that in order to get along as a normal individual he must consider, at least to some extent, the wishes of those with whom he is living. The more he considers the wishes of his environment—without completely disregarding his own feelings—the more nearly normal will he become.

An example of this process is the case of a man and a woman who were trying to make their marriage work. The wife's cooking was a point of conflict. She expected her husband to compliment her on her cooking—as he should—but he could do so only to a degree. He felt that she should

not be complimented. However, he realized that if he did not compliment her, she might create a scene, and so the unconscious helped him out, and he developed a gastritis. She urged him to go to see the doctor, who examined him and said he had to be careful of his diet. He could now refuse to eat his wife's cooking, or dictate what he wanted, and, as a result, he got his way. That man had a gastric neurosis.

In another case, the husband insisted on telling his wife off, and told her he did not like her cooking, and that his mother could cook much better than she could. Consequently, the wife went into a crying spell. She felt sorry for herself. She did not know what to do. Should she leave him? As a result, she developed a headache, which took her to a general practitioner who took down her history and found that she had had a bad cold. He, in turn, suggested that she go to an eye, ear, nose and throat specialist, who examined her and discovered that she had a post-nasal drip, diagnosing sinus trouble. Now she could talk about her terrible sinus headaches. She was justified in calling her husband home from the office, in demanding that he be more considerate of her, and relieve her of the care of the children. Unconsciously she developed a symptom which got what she wanted. She is no more to blame for her sinus headaches than the man with his gastritis.

Perhaps these people were just trying to get what they wanted when they developed their symptoms, or perhaps they felt guilty in wanting their own way, and thus developed their pains and aches as a means of compensating for not living up to the standards set for them. They had been raised to feel that guilt is always followed by punishment.

Most American women today are educated. Being educated, they are dissatisfied with routine, for education tends to bring dissatisfaction. Three or four generations ago, the majority of women had only one object in life: to get married, have children, and stay in the home. On the other hand, women have as much intelligence as men, and, like

men, if the work does not challenge the intelligence, they become bored. Housework and tending to the baby become humdrum. True, there are clubs and organizations which use their intelligence, but these do not always give emotional satisfaction. Although most American husbands want their wives to be able to talk about world affairs, and to be equal in intelligence with them, they do not want the women to challenge them emotionally.

Children who are raised without physical punishment have more stable personalities. Such punishment is usually administered in the heat of anger, and if a child does not know what it is all about, he builds up a feeling of resentment and feels that he is misunderstood. He develops a sense of insecurity and guilt. Most criminals were severely punished as children. They are immature personalities.

On the other hand, overindulgence also spoils the child, because he feels he can get away with anything he tries. If he is allowed to grow up knowing that he is able to get away with everything, whether good or bad, he will continue the same way as an adult. Such individuals disregard the rights of others.

Thus, there must be sanity in personality formation and a proper balance between pain and pleasure. The individual should have a sense of guilt but should not be ruled by guilt.

CHAPTER IV

What of Dreams?

In the previous chapters it has been emphasized that everything that happens to an individual leaves an indelible impression upon the brain tissue, and, although the human mind tends to repress or forget unpleasant experiences, actually nothing is ever forgotten. It may be pushed back into the unconscious and deeply buried under other experiences, yet it remains stored away till some time when there is sufficient stimulation to bring it up into consciousness again.

A study of ancient races and aboriginal tribes would indicate that specific behavior patterns may even be transmitted from one generation to another, and that certain ways of thinking continue from generation to generation. This instinctual material and dream disguise may be a result of just such experiences in the distant past.

As long as the individual is conscious and has possession of all his thinking processes, he prevents himself from recalling unpleasant memories. Nevertheless, he may be thrown into certain situations which remind him of some of these past experiences, even though they may extend back into early childhood. The human mind can repress only a certain amount of material without building up excessive tension. During the waking state a person may not allow himself to think of certain past experiences or to plan for the fulfillment of certain desires which may be stimulated by the instincts, and as long as his consciousness remains in control, he does not get out of hand. On the other hand, when he goes to sleep, only the conscious part of his mind

goes to sleep, while the storehouse of his unconscious is given its freedom to wander as it pleases. As a result, we have dreams.

Dreams are the playground of the unconscious, and although some people may remark that they never dream, this is not so. Everybody dreams every night. What the person does not allow himself to think about during the waking state, he thinks about when he is asleep, and he may act out in his dreams what his unconscious would like to act out while awake.

For centuries people have been mystified by the meaning of dreams, and numerous explanations have been given, some entirely superstitious and supernatural, and others scientific. Certainly during this last half century the analysis of the human mind has brought out some convincing conclusions, but there is yet much to be learned. Since the advent of the electroencephalogram (EEG), and the recording of electric impulses from the brain, this technic promises some further understanding of the process of the dream.

People have been intrigued by the idea that thoughts could be transmitted from one person to another, by mind reading, mental telepathy, or extra-sensory perception. Persons who have been considered mentally ill have many times been diagnosed to have delusions or hallucinations, and yet the patient in question is quite positive that he or she can hear, see or feel things which those around him cannot. Then there are persons who have had vivid dreams, or visions, which they feel are real, and interpret as messages from some departed dear one. Evidence has been accumulating which indicates that perhaps these experiences may not be all imagination.

EXTRA-SENSORY PERCEPTION

Some individuals appear to have the power to perceive stimuli by other than the usual channels, known as the special senses. These persons are said to have extra-sensory per-

ception (ESP), and the study of this phenomenon is known as Parapsychology. These people have an uncanny ability to interpret stimuli of which the average person is unaware. Perhaps it is a nervous system that is specially tuned to high frequency, similar to the dog which can hear a special whistle which the human ear cannot hear. Some animals can smell things that humans cannot. Perhaps patients who have delusions and hallucinations are so tense that they do have extra-sensory perception and actually do hear or feel things that the normal person cannot. In any case, by the use of the electroencephalograph, we are able to record the changes in the electric current sent off in different mental conditions. This may give the answer to this age-old problem.

If, fifty years ago, a person had dared suggest that a special apparatus could be invented capable of sending through the air words and pictures that could be perceived many miles away, that person would have been considered insane. Yet today we have television. Perhaps in time the currents sent off by the brain will be interpreted as thoughts, and so we will be able to understand mental telepathy. Perhaps two people, who are in tune with each other, will then realize that thoughts can be transmitted, asleep or awake. Yes, the EEG may yet help us to interpret dreams. Most certainly it proves without a doubt that the mind is working while asleep, just as the pulse and the electrocardiogram (EKG) show that the heart goes on beating all the time.

Although an English physiologist, Caton, detected electrical activity in a rabbit's brain in 1875 and startled the entire scientific world with this announcement, the electric potential of the brain (EEG) was of very low voltage, only 1/100th that of the heart (EKG). This low intensity could not be properly recorded until the development of the vacuum tube, which can amplify minute currents.

In 1929 Hans Berger recorded for the first time the electrical impulses originating in the human brain. He also detected and recorded the different kinds of brain waves,

and even laid a foundation for later diagnostic research by observing typically abnormal tracings obtained from individuals with certain forms of brain disease.

THE ELECTROENCEPHALOGRAPH

Electroencephalography gives a continuous graphic recording of the constant changes in the electrical impulses coming off the cortex of the brain. To achieve this result, the minute impulses emanating through the intact skull and scalp are picked up by electrodes and conducted through a powerful vacuum tube amplifying system. Every fluctuation in the amplified current is then recorded on a tape. The changes in the cortical potential actuate the writing point at right angles to the moving tape, which moves at thirty millimeters (1¼ inch) per second. This graph line shows waves which differ considerably from individual to individual. The waves also vary from one part of the brain to another in the same individual, and with the physiological or pathological condition of the cortex.

The pathological variations usually take the form of abnormally fast or high waves. Since the current is always conducted from an electrode attached to the scalp, any abnormal tracings indicate excessive electrical activity in the cortex immediately below the electrode. If the cause of pathological changes in potential is a lesion or tumor, the electroencephalogram can thus locate it with uncanny accuracy. Hence the great diagnostic value of the technic.

Berger named the span between the two extremes as the *amplitude,* and the number of times the current rose and fell per second as the *frequency,* which is the number of alternations in each thirty millimeter length. The currents recorded are of the order of millionths of a volt (microvolts).

The shape of the electroencephalographic curve that is recorded is the result of changes in the frequency and the amplitude. In a record of high frequency the peaks come

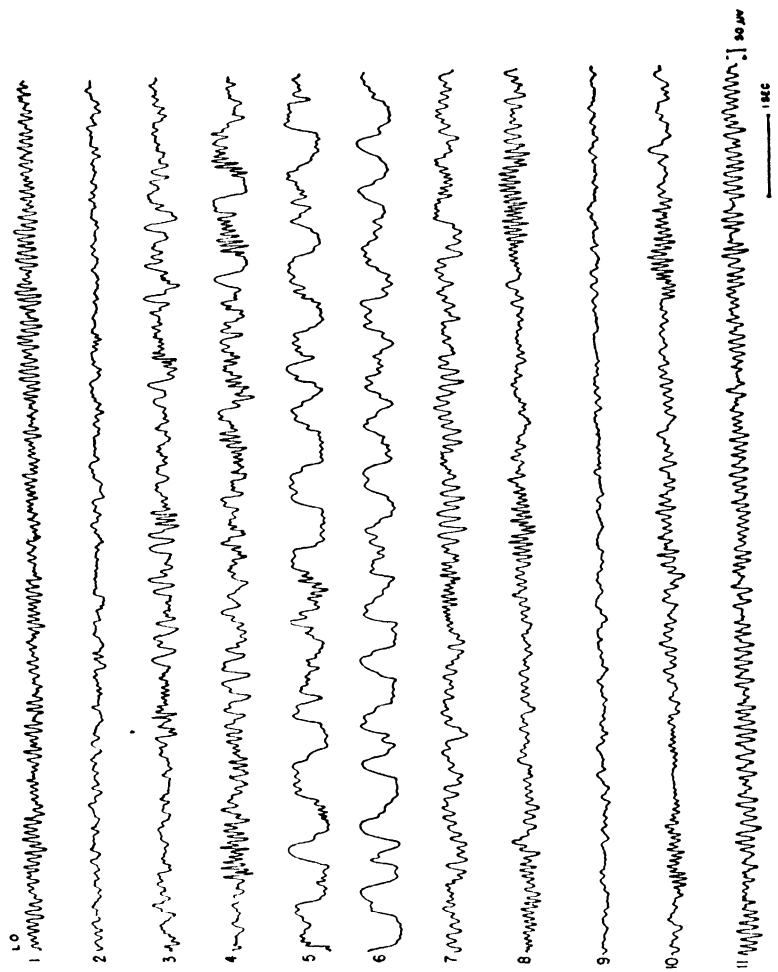


FIGURE 8. ALL-NIGHT SLEEP IN A NORMAL PERSON

1. Awake at 11:30 p.m.
2. Drifting sleep at 11:45 p.m.
3. Light sleep at 12 midnight.
4. Moderately deep sleep at 12:30 a.m.
5. Deep sleep at 1 a.m.
6. Very deep sleep at 2 a.m.
7. Deep sleep at 2:15 a.m.
8. Deep sleep at 2:40 a.m.
9. Deep sleep at 3:30 a.m.
10. Light sleep at 6:45 a.m.
11. Awake at 7 a.m.

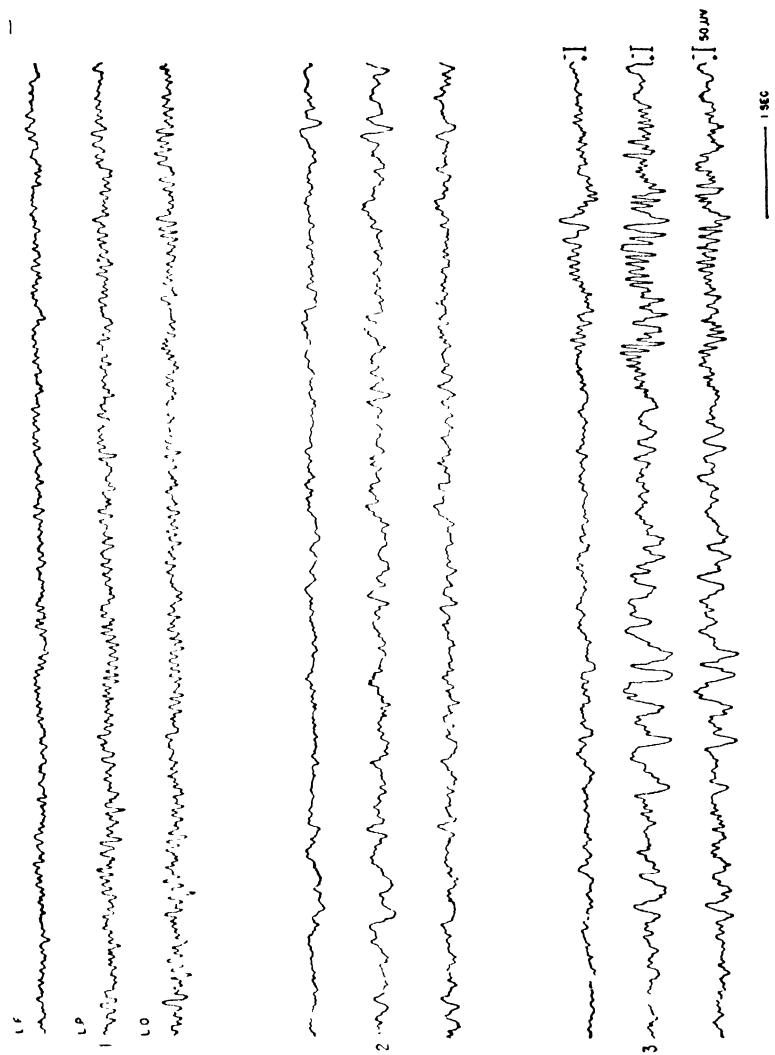


FIGURE 9. AFTERNOON SLEEP IN A NORMAL PERSON

1. Awake with leads from front part (L.F.), middle part (L.P.), and back part (L.O.), of left side of brain.
2. Drifting sleep.
3. Deep sleep.

closer together horizontally, giving them a sharper appearance. The greater the amplitude (voltage), the higher and sharper these needle-like waves become. Very sharp peaks are commonly called "spikes." When used for diagnosis, the frequency of recording indicates the type of pathology, while the amplitude shows the intensity of the disturbance.

Metallic electrodes moistened with saline paste for maximum conduction are usually attached to the scalp areas. Wires connecting pairs of electrodes then conduct their differences of potential to posts provided with switches. These enable the operator to register the currents between any combination of "leads." This "bipolar" procedure measures the difference of potential between two areas of the brain.

The "monopolar" procedure is when a "lead" is attached to any scalp area and its mate to a neutral or "indifferent" spot, such as an ear lobe. The electrical state of the cortex immediately under the first, or "significant" lead, is thus recorded.

Leads are usually attached to eight electrodes located in the following areas of the skull: right and left frontal, right and left parietal, right and left occipital, and right and left temporal. The "indifferent" electrodes are attached to the ear lobes. Each electrode picks up the wave pattern characteristic of the brain area immediately underneath it, without interference from the impulses furnished by other cortical areas.

Every electroencephalogram gives evidence of a number of different wave patterns, each having its own frequency and amplitude. These are:

(1) The *Alpha Waves* or the so-called "Berger Rhythm," are predominantly of occipital origin, usually of 6 to 13 per second frequency, and of 10 to 75 microvolt amplitude. Abnormalities in frequency, amplitude and regularity of pattern shape have great diagnostic importance. If definite enough, they indicate specific diseases, such as the various types of epilepsies.

(2) The *Delta Waves.* These appear in very slow frequency and considerable amplitude. They are normally present in very deep sleep. When recorded in waking hours, they indicate pathological brain conditions.

In normal individuals, the *Alpha* waves occur 6 to 13 per second, with an average of 10, and with acceleration of one or two per second when the eyes are opened.

Thus we can see that the brain continues its activity even when the person is asleep or unconscious. A study of the brain waves under various conditions show variations in the pattern. The person can be put to sleep by hypnosis or drugs and certain thoughts suggested, and the resultant changes in the EEG noted. The brain waves and specific thoughts have not yet been correlated, but experimental work shows that when the subject makes a special effort to think, there is special activity in the electroencephalographic tracing.

SUPPRESSION AND DISGUISE

Because the activities of the unconscious in the dream state are frequently unacceptable to the conscience, the individual, in the process of waking up, either completely suppresses the memory of the dream, or disguises the dream in such a way that it is acceptable. That is the reason why most dreams that are related by a person are confused or unintelligible to an untrained person. Actually the dream is a betrayal of a person's unconscious desires.

Dreaming is one way in which the unconscious may release its pent-up feeling, and, since human beings have been raised not to express themselves freely, the unconscious expresses these feelings in symbolism. The more intricate the idea to be expressed, the more intricate is the dream likely to be. The dream, therefore, might be well compared to a cartoon. Both are meaningless except to the person who knows something about the situation back of the symbol. Both the dream and the cartoon are pictorial symbolism

whose elements require interpretation, and neither entirely conforms to reality.

People frequently state that the eating of some indigestible food before retiring may have caused them to dream. Yet research has clearly brought out the fact that everyone dreams, irrespective of what they may have eaten. The fact that the digestion may have been disturbed only keeps the individual from sound sleep, and therefore, he is more apt to recall what was going on while asleep. A person who sleeps soundly and allows himself to waken slowly, goes through the process of repression, which completely puts these thoughts out of mind, or applies the method of symbolism, as does the cartoonist. The dream, therefore, tells some buried thought but is not intelligible to everybody. If the unconscious is anxious to transmit its message to the outside world, then it is apt to bring out vivid symbolized dreams, and much of the feeling within the individual is, therefore, dissipated in the expression.

There is no doubt that the EEG activity that underlies dreams is intensified by certain physical disharmonies, and that the awareness of dreaming is increased by the lowering of the threshold of sleep, but this does not explain the content of the dreams. The sensitizer of dreams is similar to the developing solution that is washed over the surface of a photographic film, but it is not the explanation of the areas of light and shade that appear on the surface of the film. The solution merely brings out what was already there, impressed on the brain cells, and what was already there depends on circumstances that are in no way connected with the developing solution.

The incidents of most dreams are simply memories covering certain episodes in the person's life, and contain places and people that are quite familiar to the individual. These elements are brought together in an apparently haphazard way in the dream, representing different threads of interest. Each of these threads leads to a long avenue of recollections, feelings, and thoughts, and the dream brings these threads

together in order to release repressed desires. A dream, therefore, might be regarded as a patchwork pattern of unreleased unconscious interests. The formation of the pattern develops from the bringing up of these interests into the consciousness levels. The dream is thus a safety valve and helps the person to dispose of objects of conflict. The dream mechanism produces new and unthought of patterns, which cannot be interpreted without extended analysis. This is a fact that people recognize when they say in the presence of an unexpected or extraordinary event, that no one would ever have dreamed it possible.

The dream arises out of the individual's interests in that its component parts are people, events, and places that are familiar, although they may be disguised, but its method of combining these parts is distinctive and unpredictable. The camouflage that is used to cover up the motivation behind the dream is at times mystifying, and obviously must be dredged up from the depths of the archaic storehouse. Many of the symbols that are used are not directly traceable to the person's past experience, but, in getting him to associate with these symbols, there is no doubt that there is significant meaning.

The symbol of the serpent has been used throughout the centuries to represent evil, danger, lust, and, more specifically, the male or the male genital. It is a frequent symbol used in dreams, both by males and females, since it is taboo for anyone to contemplate such a sexual object. Dreaming of a snake may be pleasant or unpleasant, as the case may be.

C-3 was a young man, 23 years of age, with an I.Q. of 124, who was referred for psychiatric care because he was not sociable, had a marked feeling of inferiority, and was generally fearful of girls. He had a domineering, financially inadequate father, and a very efficient, financially independent mother. At the age of twelve, he was initiated into genital play by an older man, who exposed his penis and asked him to manipulate it. Following this experience, the

boy had frequent dreams in which he was being chased by a rattlesnake, or being choked to death by a snake.

C-4 was the wife of a college professor, with two children, and was referred because she was nervous, very tense and underweight. She was a small woman, while her husband was large and heavy, and was unreasonable in his demands upon her. She admitted her attraction for him was primarily sexual, although she insisted that all sexual activity was disgusting, and she did not want to have any more children. Repeatedly she had the dream of having a large, smooth snake curled up in her lap, which she would stroke affectionately. When she would wake up from her dream, she would wonder why she got so much pleasure out of such activity.

C-5 was a woman of 30, married and having two children. She had had to live with her in-laws for the first two years after marriage and had frequent arguments with them. She was much in love with her husband but had never experienced an orgasm. She had had an affair with another man and felt very guilty about this. Seven years after her marriage she was referred because she feared that she was going to lose her mind, and she had trouble going to sleep. A recurring dream was that there was a large, hairy spider on her arm, and she would wake up screaming. Association brought out the fact that the spider was symbolic of a woman, and that she was afraid that her mother-in-law would break up her marriage and take away the children.

Obviously, the analysis of a patient's problem is not dependent on the understanding of one dream. Many dreams may have to be sifted through during the course of a psychoanalysis, but the dream material is a valuable aid to insight into a person, as the Unconscious tries to reveal the basic conflict.

C-6 was born in China, the daughter of an American missionary, and was sixteen years of age when she was referred for treatment. She had a rather precocious nature

and a lively imagination, to which she gave expression in prose or verse. She was linguistically inclined, so she was well educated in languages and literature. Her temperament was intuitive and highly nervous. She displayed nervous symptoms such as are frequently first manifested during adolescence: alternate fits of depression and exaltation, and attacks of headache. At the time of her referral, she told of an infatuation for a young woman whom she knew only by sight. To this older woman she wrote the most passionate of her poems; her great desire was that her love should be returned. This unreturned love made her very sad and often increased her headaches. Yet she liked the sadness and diligently cultivated it.

On going into her history, it was found that she was four years old when her father died. Since then she had lived in intimate association with her mother, to whom she was greatly attached. Before she was sixteen she already had had several passionate homosexual friendships. One of these was for a girl cousin ten years older than herself, with whom she was in close touch when she was herself twelve years old. At thirteen, she idolized her teacher at school. But none of her former passions had been so overwhelming as that by which she was now consumed for this woman whom she had not met.

This passion lasted for several months. Eighteen months before the analysis started, she had had a dream, and she was convinced that it contained a prophetic vision of the object of her affection. She had this dream during the night following her fifteenth birthday.

She related her dream as follows:

> "I was in a huge forest. An old woman said to me, 'Come with me; I have something to show you.' I was frightened, but I went with the old woman, who said to me, 'If you look in the glass you will see some one whom you will meet later and whom you will love.' I looked in the glass, and at first I could see only my

> own image; then the place of my own image was taken by that of a woman in mourning." (The unknown woman with whom she was infatuated was dressed all in black when she saw her first.)

Having told her dream, she went on talking. She wondered why she had given her "lady love" the fancy name of Regina. "It is not a name I am fond of!" She knew that "Regina" meant "*reine*" or "queen." She had come across the name "Reine" when studying French and translating a book entitled, *My Uncle and Vicar.* This was the name of a girl in the book "who wanted to be married, and with whom at the end somebody falls in love." The name also recalled to her memory a love poem by Louis Duchosal.

If there had been any doubt as to the character of the girl's passion, these associations clearly showed that she was really in love.

The next thing was to consider the associations with the people in the dream, bearing in mind at all times that dream material and imaginative material are "outcroppings" of the Unconscious, or symbolism in which feelings, predominantly unconscious, are constantly undergoing translation into images.

"Old woman" called up the idea of "witch." This suggested one of the symbols of the "collective unconscious"; the symbol of the "dread mother." The words of the old woman, "Come with me; I have something to show you," called up the memory of the same words uttered by the girl's mother the day before the dream (her birthday). What her mother had to show was a birthday present, two volumes of verse—Louis Duchosal's *Thule* and Victor Hugo's *Les Contemplations.* She had read both the books, and had expressed a wish to have them for her own.

The above were the immediate associations, but a few days later she stated that her memory had been at fault, and that on her fifteenth birthday she had only been given *Les Contemplations,* while *Thule* had been given to her on

her sixteenth birthday. This was "a condensation of two kindred memories," which is a common phenomenon when recalling memories of childhood, but the instance in this case was rather remarkable as it concerned memories so recent and so important. It is well to note also the liberties her imagination had taken with reality, for it is then not difficult to understand how easily so imaginative a mind could merge the memory of a dream with the actual sight of a woman in mourning, and so become inspired with the conviction that the vision of the dream and the actual vision were identical.

The girl had looked forward with special eagerness to her fifteenth birthday, since she had felt that it would be a momentous occasion upon which a sort of miracle was to occur. She had a naïve fancy that on this day she would "suddenly grow up." This expectation gave rise to a suggestion, to which her impressive dream was a response.

The "glass" recalled to her mind the cousin to whom she had at one time been so deeply attached. This cousin, when she was going to sing publicly somewhere, used to disport herself for a long time in front of a glass, and C-6 used to say to her, "You'll be late."

The mirror is a common symbol of autoerotism, or homosexuality, as clearly brought out in the myth of Narcissus. In the dream the mirror in which she is to see some one whom she will love, shows her at first her own image. The words, "You'll be late," addressed to some one who is spending too long a time admiring her own image in the mirror, might be regarded as the expression of an arrest of emotional development at the homosexual stage.

An endeavor was made to explain to the girl that her infatuation was the outcome of suggestion, to show her what had been the influence of expecting a miracle on her fifteenth birthday, and to make her aware of the retrospective touching-up of her dream. An attempt was also made to show her that the woman in mourning was akin to her own image, which had been replaced in the mirror by the

other; that this vision was a part of herself; and that consequently she possessed it in herself, and that she was mistaken in her search for it outside herself. She listened with interest to the explanation, but she was so much obsessed by her passion that she continued to offer resistance to any acceptance.

Referring to early childhood memories and to a prose poem, "The Veiled Lady," which she had written when she was thirteen, remoter origins for her fancy were searched for, with the result that it was found that she had "always represented to herself the person to whom she was greatly attached as being dressed in black." One day when she was eight years old, one of her cousins was going to a concert. This cousin was wearing a blue dress. She said to her: "Why aren't you dressed in black? You would look so much prettier." Now the prototype of this image in black, of this "veiled lady," was her mother after the father's death. Here she remarked that most of the people she had idolized were in mourning. The school teacher to whom she had been devoted when she was thirteen had been "in mourning for her father"; another flame had been "in mourning for her husband"; another, "in mourning for her father"; and so on.

Furthermore, she remembered that when her father died, her mother had considered her too young to wear mourning. A year later, she had said, "I do wish some one would die in the family, so that we could go into mourning." For her, to wear mourning signified to be no longer a child. Now, to be no longer a child was the miracle to which she was looking forward on her fifteenth birthday. Primarily, therefore, the young woman in black, who had appeared to her in a dream, and whom she subsequently recognized as "Regina," was the image of herself grown to womanhood. This is why, in the mirror, the image of the woman in mourning took the place of her image; the woman in mourning had her hair down her back, just as she did. As for "Regina," she had black eyes like hers, and she was "the only one in the family to have dark eyes." In this image of

herself, she externalized the unfulfilled wish of childhood "to be in mourning," and further, "to be in mourning for her father." This gives a hint of her infantile feelings towards her father.

In actual fact, however, her love vacillated between this image of a second self and the image of her mother. Her idols were sometimes "in mourning for their husbands." But in both cases, and especially as far as "Regina" was concerned, the maternal traits were more in evidence. The objects of affection were older than she; the cousin was ten years older; the school teacher was much older; "Regina," the unknown woman, was a married woman with a little boy. C-6 was greatly attached to her mother, and her first love passions were for grown women who were more or less maternal in type.

Her passion remained unrequited, and the resulting effect was converted into headaches. She wrote to Regina and sent her poems—she received no answer. But as far as her consciousness was concerned, her love remained as fervent as ever. Below the threshold, in the twilight of her consciousness, however, improvement was beginning. A month after the analysis had been started, she related the following dream:

> "Regina was dead. She was in a large room. On the table was a coffin draped in black, and there were four candles, for it was late in the evening, or at night. In the coffin Regina was lying dressed in white, arms crossed on the breast, her hair loose. The husband brought her little boy. Both were crying, and I cried also. The husband said, 'You must not bear a grudge against her because she did not answer your letter; she was already ill.' "

The patient ingenuously volunteered the information that she had dreamed this several times "during the last month." She added, "I don't think I dreamed it before my first visit to you." She was afraid that the dream portended

Regina's death. It was explained to her that it was only within herself that something was going to come to an end, as the result of the analysis. But there was nothing mournful about this end. She was happy; and, spontaneously, "mourning" was replaced by "a white dress." She remarked that in the dream she had on the night following her fifteenth birthday, the woman in the mirror had worn a white dress. A month earlier, when she first told this dream, she had said that the woman in the glass wore mourning. It was then explained to her that her imagination was caught in one of those retrospective distortions which it inflicts upon dreams. This was an additional reason why she was no longer impressed by the pseudo-recognition of an image previously seen in a dream. In any case, the substitution of the white dress for the mourning was a good sign, for it indicated that she had begun to escape from being obsessed by an infantile image. A week later, she had another significant dream:

> "A woman told me that Regina would have to undergo a serious operation."

The "serious operation" was the analysis itself. Up until this time C-6 had hardly changed; for although the explanations given her had more than once made her think things over, nevertheless, she had never consciously said that she accepted them. On the other hand, in the Unconscious there had been much change.

Now came a great surprise; Regina answered one of her letters. This did not portend an end to the infatuation. She was delighted. Regina sent her photograph to her, and by looking at it, she would develop a trance or spontaneous "hypnotic" state. She related this phenomena as follows:

> "Sometimes, pretty often, but not always, when I look at the photograph I find I cannot turn my eyes away from it. What happens is this: Gradually my mind seems to become clouded, my senses are dulled, I no longer think of anything; I am unable to make the

slightest movement; then my eyes grow heavy; then I begin to feel sleepy. At such moments I feel as if I should be able to write a splendid poem, but I cannot hold a pencil; it drops from my fingers, and I lack the power to pick it up. I could stay for hours and hours without moving or speaking. When this sort of trance passes off, I regret its disappearance as a condition of restful tranquility: I should like it to last forever."

When she had to do anything disagreeable or difficult, she had merely to glance at the photograph, and everything grew easy, even though she did not pass into hypnosis. As an example of this effect, she gave the following incident:

"I had a composition to write. My teacher told me to choose my own subject. I was bored; I did not know what to write about; and I could not collect my thoughts. My eyes suddenly fell on the photo. Mechanically, I took it up, and then, still bored, with the photo in front of me, I seized my pencil once more. But now, as by a miracle, I found a splendid subject, and I began to write with marvelous ease."

She was convinced that "Regina" exercised a mysterious influence over her. What really happened was stimulation of unconscious memories. In her state of mind these memories were of words or phrases which had been read or heard, but not consciously retained. This was an indication of the extreme suggestibility of the subject, and only upon the basis of such hypersuggestibility can the genesis of such an infatuation be understood. From the point of view of the analysis, the interesting fact is that "Regina" had become the suggester. "Regina" had been substituted for the analyst. A "reversal of transference" had taken place, and the analyst's influence declined, whilst the obsessive image correspondingly regained power. It was as if the patient were unconsciously making an effort to elude the analyst and to attach herself more strongly to the guiding fiction.

She discontinued her analysis for about a year and applied herself to her school work. However, "Regina" wrote that she was planning to spend the winter in the same town but then changed her mind and decided not to come after all. Then she discontinued correspondence. The girl, consequently, grew desperate, and she finally came back to me for advice:

> "What am I to do? I wanted to attract her in any way I could, but hitherto I have failed. Apparently my poems do not interest her, for she never refers to them. Besides, I have given up sending them, for what is the use? I had counted on them to soften her heart, and I am quite at my wits' end. I have tried everything, all shades of feeling; I have exhausted the most affectionate, the most loving words; I have put all my soul into my letters, and more than my soul. Nothing; not a word in reply."

Several months elapsed, during which she suffered more or less continually with almost unbearable headaches, but at last calm was restored. The explanations which she had been given more than a year earlier, and which she had unconsciously noted without outwardly accepting, were now rediscovered by herself, and were related voluntarily to me. Her passion had been "sublimated," and she discontinued having headaches. She understood now what she had previously been unwilling to admit, that "Regina" was within herself. She no longer wanted to see "Regina," and she destroyed the photograph which had exercised such a power over her. She had another dream:

> "I met Regina and said to her: 'For me you are a soul, a god; I do not want to know you personally, for as soon as I know you, you will cease to be a god for me.'"

Simultaneously, the imagery of her poems, which had

hitherto been invariably concerned with feminine and maternal characteristics, was directed towards masculine traits. She had "outgrown" the stage of homosexuality. As was pointed out in a previous chapter, this stage is normal in a girl's adolescence, but in this patient's case it had taken an acute and almost alarming form.

C-7 was a young man, a college graduate, and a former German prisoner of war, who was referred because of colitis and frequent severe headaches. He had been married about half a year when he related the following dream:

> "I was lying under a sink and getting all the dredgings. Japanese-looking creatures were laying all over me. I was trying to reach up and get the hanging strings, almost like seaweed, hanging down under a sink. I was told to strip and get clean before we all ate. Arms entangled me and held me, and I seemed to be sinking down under a mess of the stringy legs."

After telling the dream, he said, "I woke, lying on my stomach, with arms cramped under my chest. I was very tired and uncomfortable."

On associating with "dredgings," he said he remembered salvaging garbage and rotten horse meat at the prison camp incinerator, because he and the other American prisoners had been literally starving. They made a stew of it, and, although he couldn't eat it himself, the other men filled themselves, and several got very sick from it. "Arms entangled" brought back the memory that the prisoners had to sleep together to keep warm. He slept with his wife, and he was not afraid any more.

C-8 was a married woman with three children, unhappy in her marriage and feeling guilty about the way she was treating her children. She had been somewhat promiscuous, and she had heard that her mother had been likewise. She was fearful that her daughter would follow in her footsteps, and had been referred because she was afraid to leave the

house and could not get herself to travel on buses or trains. After several months under analytic treatment, she had the following dream:

> "I was in a house, and downstairs in the cellar there were two dogs. One was ferocious. One was tied at the top of the stairs. The other was loose. In the middle of the cellar floor was a large piece of meat. There were flies all around. To get downstairs, you would have to squeeze through an opening. There were two such places in the house. My mother and daughter were with me. There was a small toy red cuckoo clock on the wall, which didn't work sometimes. My mother told me my father had bought it for a sister, who was born before me, and died. He had bought her a red box. I wanted them, but I couldn't have them."

"Cuckoo" was the name given by her mother for her genitals, and as a girl, her mother would tell her to keep her "cuckoo" covered up. To "squeeze through an opening," she remembered the first boy who tried to have intercourse with her was in their cellar. Her brothers ("the dogs") told her she had to keep out of the cellar. To "a red box," she remembered her father was disappointed that she was a girl and frequently told her he had wanted a boy, and to "I wanted them," she wished she had a penis like her brothers.

C-9 was a woman, who had three children and was very unhappily married. She was referred because of insomnia, excessive drinking, and a fear that she would harm her children. She brought out during the analysis that she was undecided as to divorcing her husband and had the following dream:

> "A group of gardeners, including at least one woman, came to cut the grass. This was at some strange place in the country. The ground was covered with snow and ice, and they said they would come back later. Then I

was in a sort of junk and secondhand book store in the same vicinity, selling some books. One was a big book called *Three Crops.* The man paid me with a whole handful of big coins, quarters and half dollars."

Her Unconscious had decided she should leave her husband, and that her husband would support her. "Three Crops" was symbolic of her three children. Later she had the following dream:

"I was in a hospital or some kind of convalescent home. I was in a private room, though it had three beds. There was some talk of giving this room to someone else. You (the analyst) and I were in a car, driving over a viaduct which spans a lot of railroad tracks. We looked down at the trains, and you said they were wonderful."

She had been afraid she would become psychotic and would "lose" her mind. Since working on her problem, she realized that she would not become psychotic but would be able to learn how to enjoy life again. The "trains" are symbolic of sexual intercourse.

As a patient works on his problem through analysis, his dreams are an accurate guide to his progress into insight. In the beginning of the process, the dreams are almost wholly symbolic, and the underlying meaning is very well disguised. As treatment continues, the patient continually reveals his unconscious desires and conflicts in the relating of his dreams. As he improves emotionally, his dreams become clearer. In other words, his dreams are less symbolic, and after the dream he remembers exactly what he experienced in the dream. He gives up his conflicts over his instinctive desires, and so he gives up his symptoms.

CHAPTER V

Diagnosis

Unfortunately, there are still many persons in the community who think of psychiatric disorders in terms of "insanity," and who consider the psychiatrist as some fearsome individual who has occult powers that make it possible for him to make a diagnosis by just looking at the patient. They seem to be satisfied when the patient is duly examined and committed to a hospital. Thus they feel that "the family skeleton" has been safely "locked away in the closet" and is thereafter to be only mentioned in hushed voices. If the patient should recover and return home, he henceforth lives under a veil of apprehension. His family and friends lack confidence in him; the neighbors feel sorry for him and continue to offer the alibi that there must have been "a bad streak in the family somewhere." Society in general is suspicious of all his behavior, and he is accused on the slightest provocation of being "crazy."

If the patient's symptoms are not extreme, and if he co-operates with the physician, then the situation is discussed in terms of "nervousness." The family want to be assured that it is not a "mental problem," and that a psychiatrist is not necessary. They may blindly go from one doctor to another, trusting to luck that the patient will recover from the "nervous breakdown." It is explained to the patient that he is "run down" and needs a tonic, or if he is troubled with insomnia, he is given a sedative. He is then patted on the back and told that there is nothing the matter with him, and it would be wise for him to take a trip or go to the country for a few weeks. Sometimes categorically a physical

disorder is diagnosed, and treatment is given accordingly. If the physician does not wish to be bothered with this troublesome case, he is likely to refer him to another doctor to get him off his hands. The patient thus stands a good chance of becoming a chronic psychiatric invalid, and is apt to drift away from qualified physicians to become the support of some quack or cult.

Before 1900 a psychiatric illness was only diagnosed and the patient was left to work out his own salvation without the help of a psychiatrist. If he was very disturbed, he was confined in an "insane asylum." In recent years physicians have been paying more attention to the human emotions. They have become aware of the fact that the total personality must be considered if the patient is to be properly diagnosed and scientifically treated.

It has been brought out in the earlier chapters that both mental and emotional activity are made up not only of ideas or concepts, but also of their accompanying affect or feeling tones. The affect may become detached from its original concept and become attached to an altogether different concept. When any part of repressed material and its affect break through their repression into consciousness, their genesis is not recognized, and, therefore, they appear in a highly disguised form, which is never recognized by the patient, and is oftentimes overlooked even by the examining physician. It is, therefore, most important that in the study of every psychiatric case a full history be obtained, and that the essential facts concerning the constitutional make-up and the life history, as well as the immediate condition which causes the patient's discomfort be examined and assessed. The data are then put together and evaluated; and if the study has been reasonably successful, a good understanding of the predisposing and precipitating causes of the illness will be evident. Only when this understanding has been reached will a proper diagnosis be possible.

The study of the past history of the patient and his personality make-up is, of course, time-consuming, and this is no doubt the main reason why many general physicians

do not wish to be bothered with psychiatric problems.

When a patient goes to a psychiatrist, he will be asked many questions. After the family history has been taken, inquiry will be made as to the condition of the mother during her pregnancy and labor at the patient's birth. This is followed with questions about the physical condition of the infant during the first years of life; the feeding and weaning problems; the age of walking and talking; the child's reaction to training in control of the bowel and bladder; the disposition, whether happy or tearful; and the occurrence of tantrums, fear, and night terrors. Many of these points will give significant insight into the psychiatric disorder.

The doctor will then ask about the patient's intellectual growth and social development, and special attention will be directed toward the sex manifestations, both psychological and physical. At this point he will try to get a picture of the family, the family life and atmosphere, and the relations of each member of the family to the patient, and the patient's attitude toward the members of his family. Many of the habits of thinking and reacting are acquired by example and training and have a great bearing on the development of the personality.

A complete history of all injuries and physical illnesses is taken, including exposure to toxic influences, the use of alcohol and drugs, including all medication. Different people react differently to medicines. Some are actually excited by sedative drugs, and it is not uncommon to find persons who are allergic to certain preparations. The patient's attitude and reactions toward them are, therefore, ascertained.

This was brought out vividly in the case of C-10. This woman was given considerable physical attention because of a paralyzed arm. Unfortunately, no thorough history had been taken of the case, but since no organic basis for the paralysis was found, the patient was referred for psychiatric opinion. When the history was gone into, it was evident that the woman's emotional instability, which had centered upon her left arm and shoulder resulted from an addiction to phenobarbital, coupled with a tense family situation.

It is important to know something of the patient's output of energy as shown by his ability to apply himself to recreation and work; to learn his feelings about his inner self and about other people, his attitude toward his environment, the practicability of his ideas about the realities of life, and his interest in abstract and mystical subjects and superstitions; to ascertain the type of his religion and its practice, the range and quality of his emotional reactions, and his general feeling of adequacy or inadequacy toward his life responsibilities. It is, of course, important to determine exactly how the patient reacted in certain situations, such as kissing, petting, sex intercourse, love affairs, marriages in the family, and death. The occurrence and nature of any previous emotional illnesses are studied in detail.

In studying the present illness, the psychiatrist tries to get a clear account of the patient's complaint and the patient's opinion as to why it developed. Early in a disorder most of the precipitating factors will be found in the account as given by the patient, but as time goes on, exact details fade out, and more remote matters and rationalization take their place. The mental trends and the account of the psychological moment of onset often give a direct clue to the whole situation and to the mechanism of the emotional upset. It is thus evident that the earlier the psychiatrist sees a patient, and the more complete the account of the onset obtained, the better the case is understood.

A careful inquiry is made as to the presence of any acute physical disorder; but, if there is one, restraint is exercised in ascribing undue importance to it in the presence of psychological symptoms. There is no question that somatic or physical illness may cause psychiatric disorders, and that it may materially influence the course of either. Physiological changes are common in acute psychiatric disorders. In elated states there may be vasomotor disturbances, increased basal metabolism, and increased sugar metabolism. In depressed and apathetic states there frequently is a retardation of these functions.

Of course, physical disorders sometimes impair the psy-

chological defense mechanisms and act as a release to personality disorders which then dominate the clinical picture. These symptoms often disappear when the physical disorder has been corrected. Somatic conditions may also act as precipitating factors or means through which the personality can express itself in terms of psychopathology. This is commonly seen in the psychiatric disorders that not infrequently accompany pregnancy, childbirth, or the *postpartum*—the period after the birth. On the other hand, there are many typical somatic symptoms without actual physical cause. Cases of goiter or hyperthyroidism precipitated by emotional causes are not uncommon. The vasomotor or blood vessel changes, and gastrointestinal or stomach and intestinal changes occur in fright, worry, and embarrassment. Cases of spurious or false pregnancy with the accompanying distension of the abdomen and enlargement of the breasts in women fearing or longing for pregnancy, and cases of morning vomiting in the same situation are quite common.

The psychiatrist usually depends on the family physician to do a complete physical examination, but if there is some indication of involvement of the nervous system, the psychiatrist will do a complete neurological examination and check the nerves throughout the body. He will see if the reflexes are normal, and if the sensations respond as they should.

It may be necessary to determine the intelligence of the patient by administering a battery of psychological or psychometric tests—usually the Stanford-Binet Test or the Wechsler-Bellevue Test. These tests will take an hour or two, but they may be administered by a psychologist. Tests of emotion are also helpful in reaching or confirming a diagnosis. The Rorschach Test is perhaps the most widely used for this purpose. It consists of a series of ink blots on cards, to which the patient is asked to react and to tell what he sees. These cards have been tried out on thousands of patients of every conceivable type, and so have been well standardized. Several other tests may be used, such as the Thematic Apperception Test, the Machover Figure Drawings, and the Minnesota Multiphasic Personality Inventory.

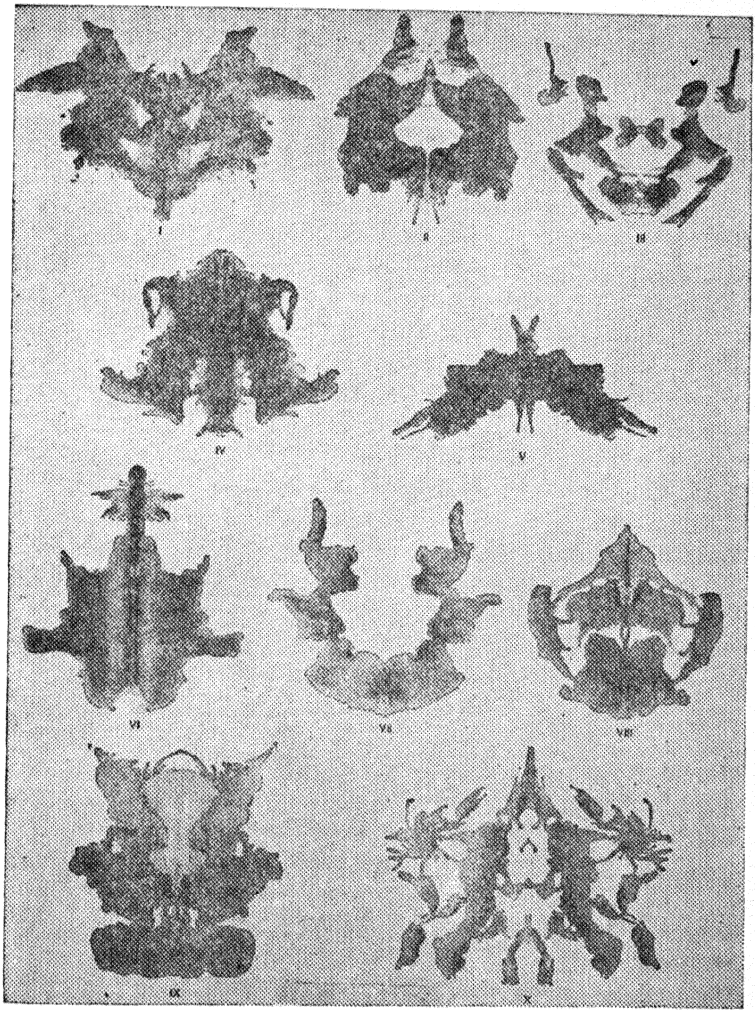


FIGURE 10. THE RORSCHACH METHOD OF PERSONALITY DIAGNOSIS

In the past there has been much confusion in the terms used in psychiatric diagnosis, but the American Psychiatric Association has recently introduced a standard nomenclature, which is as follows:

DISORDERS CAUSED BY OR ASSOCIATED WITH IMPAIRMENT OF BRAIN TISSUE FUNCTION	Private Practice (3,000 Cases)		Institute of Living (635 Cases)		N. Y. State Hospitals (19,116 Cases)	
Acute Brain Disorders						
Disorders due to or associated with infection:	0.1%		0.2%		0.2%	
Acute Brain Syndrome associated with intracranial infection.		–		–		–
Acute Brain Syndrome associated with systematic infection.		–		–		–
Disorders due to or associated with intoxication:	1.1%		1.8%		–	
Acute Brain Syndrome, drug or poison intoxication.		0.9%		0.6%		–
Acute Brain Syndrome, alcohol intoxication.		0.2%		0.9%		–
Acute hallucinosis.		–		–		–
Delirium tremens.		–		0.3%		–
Disorders due to or associated with trauma:	0.1%		–		–	
Acute Brain Syndrome associated with trauma.		–		–		–
Disorders due to or associated with circulatory disturbance:		–		–		–
Acute Brain Syndrome associated with circulatory disturbance.	–		–		–	
Disorders due to or associated with disturbance of innervation or of psychic control:		–		–		–
Acute Brain Syndrome associated with convulsive disorder.	–		–		–	
Disorders due to or associated with disturbance of metabolism, growth or nutrition:	0.1%		–		–	
Acute Brain Syndrome with metabolic disturbance.		0.1%		–		–

Disorders due to or associated with new growth:	0.1%		–		–	
Acute Brain Syndrome associated with intracranial neoplasm.		0.1%		–		–
Disorders due to unknown or uncertain cause:						
Acute Brain Syndrome with disease of unknown or uncertain cause.	–		–		–	
Disorders due to unknown or uncertain cause with the functional reaction alone manifest:	–		–		–	
Acute Brain Syndrome of unknown cause.		–		–		–
Chronic Brain Disorders						
Disorders due to prenatal (constitutional) influence:	0.2%		–		–	
Chronic Brain Syndrome associated with congenital cranial anomaly.		–		–		–
Chronic Brain Syndrome associated with congenital spastic paraplegia.		0.2%		–		–
Chronic Brain Syndrome associated with Mongolism.		–		–		–
Chronic Brain Syndrome due to prenatal maternal infectious diseases.		–		–		–
Disorders due to or associated with infection:	0.7%		–		2.8%	
Chronic Brain Syndrome associated with central nervous system syphilis.		0.1%		–		2.2%
Meningoencephalitic.		0.6%		–		–
Meningovascular.		–		–		–
Other central nervous system syphilis.		–		–		0.3%
Chronic Brain Syndrome associated with intracranial infection other than syphilis.		–		–		0.3%

DISORDERS CAUSED BY OR ASSOCIATED WITH IMPAIRMENT OF BRAIN TISSUE FUNCTION	Private Practice (3,000 Cases)		Institute of Living (635 Cases)		N. Y. State Hospitals (19,116 Cases)	
Chronic Brain Disorders						
Disorders associated with intoxication:	0.2%		1.1%		6.3%	
Chronic Brain Syndrome associated with intoxication.		–		–		–
Chronic Brain Syndrome, drug or poison intoxication.		–		–		0.4%
Chronic Brain Syndrome, alcohol intoxication.		0.2%		1.1%		5.9%
Disorders associated with trauma:	0.4%		–		0.7%	
Chronic Brain Syndrome associated with birth trauma.		–		–		–
Chronic Brain Syndrome associated with brain trauma.		0.4%		–		–
Chronic Brain Syndrome, brain trauma, gross force.		–		–		–
Chronic Brain Syndrome following brain operation.		–		–		–
Chronic Brain Syndrome following electrical brain trauma.		–		–		–
Chronic Brain Syndrome following irradiational brain trauma.		–		–		–
Disorders associated with circulatory disturbances:	1.6%		2.1%		18.2%	
Chronic Brain Syndrome associated with cerebral arteriosclerosis.		1.6%		1.9%		17.8%
Chronic Brain Syndrome associated with circulatory disturbance other than cerebral arteriosclerosis.		–		0.2%		0.4%

Disorders associated with disturbances of innervation or of psychic control:	0.9%		0.3%		1.2%	
Chronic Brain Syndrome associated with convulsive disorder.		0.9%		0.3%		1.2%
Disorders associated with disturbance of metabolism, growth and nutrition:	0.5%		1.8%		13.5%	
Chronic Brain Syndrome associated with senile brain disease.		0.2%		1.6%		13.1%
Chronic Brain Syndrome associated with other disturbance of metabolism, growth or nutrition (Includes presenile, glandular, pellagra, familial amaurosis).		0.3%		0.2%		0.4%
Disorders associated with new growth:	0.3%		0.2%		0.5%	
Chronic Brain Syndrome associated with intracranial neoplasm.		0.3%		0.2%		0.5%
Disorders associated with unknown or uncertain cause:	1.2%		0.5%		0.6%	
Chronic Brain Syndrome associated with diseases of unknown or uncertain cause (Includes multiple sclerosis, Huntington's chorea, Pick's disease and other diseases of a familial or hereditary nature).		1.2%		0.5%		0.6%
Disorders due to unknown or uncertain cause with the functional reaction alone manifest:	—		0.3%		0.1%	
Chronic Brain Syndrome of unknown cause.		—		0.3%		0.1%
MENTAL DEFICIENCY						
Disorders due to unknown or uncertain cause with the functional reaction alone manifest; hereditary and familial diseases of this nature:	3.1%		0.6%		1.8%	

MENTAL DEFICIENCY	Private Practice (3,000 Cases)		Institute of Living (635 Cases)		N. Y. State Hospitals (19,116 Cases)	
Mental deficiency (familial or hereditary)		—		0.6%		1.8%
Mild		0.1%		—		—
Moderate		1.7%		—		—
Severe		1.3%		—		—
Disorders due to undetermined cause:	—		—		—	
Mental deficiency, idiopathic.		—		—		—
Mild		—		—		—
Moderate		—		—		—
Severe		—		—		—
DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED PHYSICAL CAUSE OR STRUCTURAL CHANGE IN THE BRAIN						
Psychotic Disorders						
Disorders due to disturbance of metabolism, growth, nutrition or endocrine function:	1.9%		7.2%		8.2%	
Involutional psychotic reaction.		1.9%		7.2%		8.2%
Disorders of psychogenic origin or without clearly defined tangible cause or structural change:	21.7%		49.7%		34.3%	
Affective reactions.	6 0%		10.4%		4.7%	
Manic depressive reaction, manic type.		3.9%		4.1%		—
Manic depressive reaction, depressive type.		2.1%		1.6%		—
Manic depressive reaction, other.		—		0.8%		—
Psychotic depressive reaction.		—		3.9%		—

Schizophrenic reactions.	13.8%	37.1%	29.1%	
Schizophrenic reaction, simple type.	0 4%	1.9%	—	
Schizophrenic reaction, hebephrenic type.	6 1%	0.9%	—	
Schizophrenic reaction, catatonic type.	1 5%	4.7%	—	
Schizophrenic reaction, paranoid type.	5.0%	14.3%	—	
Schizophrenic reaction, acute undifferentiated type.	0.3%	4.9%	—	
Schizophrenic reaction, chronic undifferentiated type.	—	8.0%	—	
Schizophrenic reaction, schizo-affective type.	0.5%	2.2%	—	
Schizophrenic reaction, childhood type.	—	—	—	
Schizophrenic reaction, residual type.	—	0.2%	—	
Paranoid reactions.	1.9%	1.4%	0.5%	
Paranoia.	1.8%	—	—	
Paranoid state.	0.1%	1.4%	—	
Psychotic reaction without clearly defined structural change, other than above.	—	0.8%	—	
Psychophysiologic Autonomic and Visceral Disorders				
Disorders due to disturbance of innervation or of psychic control:	0.8%	0.8%	—	
Psychophysiologic skin reaction.	—	—	—	
Psychophysiologic musculoskeletal reaction.	—	—	—	
Psychophysiologic respiratory reaction.	—	—	—	
Psychophysiologic cardiovascular reaction.	—	0.2%	—	
Psychophysiologic hemic and lymphatic reaction.	—	—	—	
Psychophysiologic gastrointestinal reaction.	0.5%	0.6%	—	
Psychophysiologic genito-urinary reaction.	—	—	—	
Psychophysiologic endocrine reaction.	—	—	—	
Psychophysiologic nervous system reaction.	0.3%	—	—	
Psychophysiologic reaction of organs of special sense.	—	—	—	

DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED PHYSICAL CAUSE OR STRUCTURAL CHANGE IN THE BRAIN	Private Practice (3,000 Cases)		Institute of Living (635 Cases)		N. Y. State Hospitals (19,116 Cases)	
Psychoneurotic Disorders						
Disorders of psychogenic origin or without clearly defined tangible cause or structural change:	52.8%		15.8%		5.8%	
Psychoneurotic reactions.	52.8%		15.8%		5.8%	
Anxiety reaction.		28.4%		5.8%		—
Dissociative reaction.		0.2%		0.9%		—
Conversion reaction.		9.8%		0.6%		—
Phobic reaction.		1.0%		—		—
Obsessive compulsive reaction.		5.2%		0.8%		—
Depressive reaction.		8.2%		7.1%		—
Psychoneurotic reaction, other.		—		0.6%		—
Personality Disorders						
Disorders of psychogenic origin or without clearly defined tangible cause or structural change:	10.5%		15.7%		1.7%	
Personality pattern disturbance.	2.4%		1.2%		—	
Inadequate personality.		0.7%		0.3%		—
Schizoid personality.		1.0%		0.9%		—
Cyclothymic personality.		1.5%		—		—
Paranoid personality.		0.2%		—		—
Personality trait disturbance.	4.2%		3.7%		—	
Emotionally unstable personality.		1.4%		2.7%		—
Passive-aggressive personality.		2.0%		0.8%		—
Compulsive personality.		0.8%		—		—
Personality trait disturbance, other.		—		0.2%		—
Sociopathic personality disturbance.	3.5%		10.8%		1.7%	
Antisocial reaction.		1.6%		4.8%		—

Dyssocial reaction.		0.1%		0.4%		–
Sexual deviation.		0.4%		0.4%		–
Addiction.	1.4%		5.2%		–	
Alcoholism.		1.3%		3.0%		–
Drug addiction.		0.1%		2.2%		–
Special symptoms reactions.	0.4%		–		–	
Learning disturbance.		0.1%		–		–
Speech disturbance.		0.1%		–		–
Enuresis.		0.1%		–		–
Somnambulism.		0.1%		–		–
Other.		–		–		–
Transient Situational Personality Disorders						
Transient situational personality disturbance:	1.7%		0.5%		0.6%	
Gross stress reaction.		0.1%		–		–
Adult situational reaction.		0.2%		–		–
Adjustment reaction of infancy.		–		–		–
Adjustment reaction of childhood.	1.4%		–		–	
Habit disturbance.		0.7%		–		–
Conduct disturbance.		0.4%		–		–
Neurotic traits.		0.3%		–		–
Adjustment reaction of adolescence.		–		0.2%		–
Adjustment reaction of late life.		–		0.3%		–
Diagnosis deferred:	–		1.4%		3.5%	
Male:	44.8%		45.2%		49.5%	
Female:	55.2%		54.8%		50.5%	

ACUTE BRAIN DISORDERS

These are the brain conditions from which the patient recovers, such as are present in acute alcoholic intoxication or "acute delirium." The disturbance of the brain tissue may release symptoms such as hallucinations, transient delusions, and behavior disturbances of varying degree. Thus, the underlying personality is brought to the surface.

C-11 was a married woman of 25 years of age, who had been married five years and had four pregnancies; her housework got the best of her, and she depended on gin to keep her going, drinking a quart or more a day. When referred, she was unable to sleep, was very jittery, and complained of many physical symptoms, but no physical pathology could be found. When she was taken off alcohol for two weeks, her symptoms cleared up.

CHRONIC BRAIN DISORDERS

These chronic conditions result from permanent impairment of the cerebral tissue. While the underlying physical process may respond to treatment, as in syphilis, there still remains brain tissue destruction. The chronic brain syndrome may become milder, vary in degree, or progress, but some disturbance of memory, judgment, orientation, comprehension and affect or emotion persists permanently. Other mental disturbances of psychotic or neurotic nature may be superimposed on the brain pathology. As in the previous disorders, the basic personality pattern may be brought to the surface as the disease progresses.

If there are indications of brain pathology, then an electroencephalogram is usually done. As soon as any unusual or pathological pattern is detected in the electroencephalogram, it can in most cases be traced with certainty to the specified area where it is originating. The location of a tumor, area of trauma or infection can be deduced by

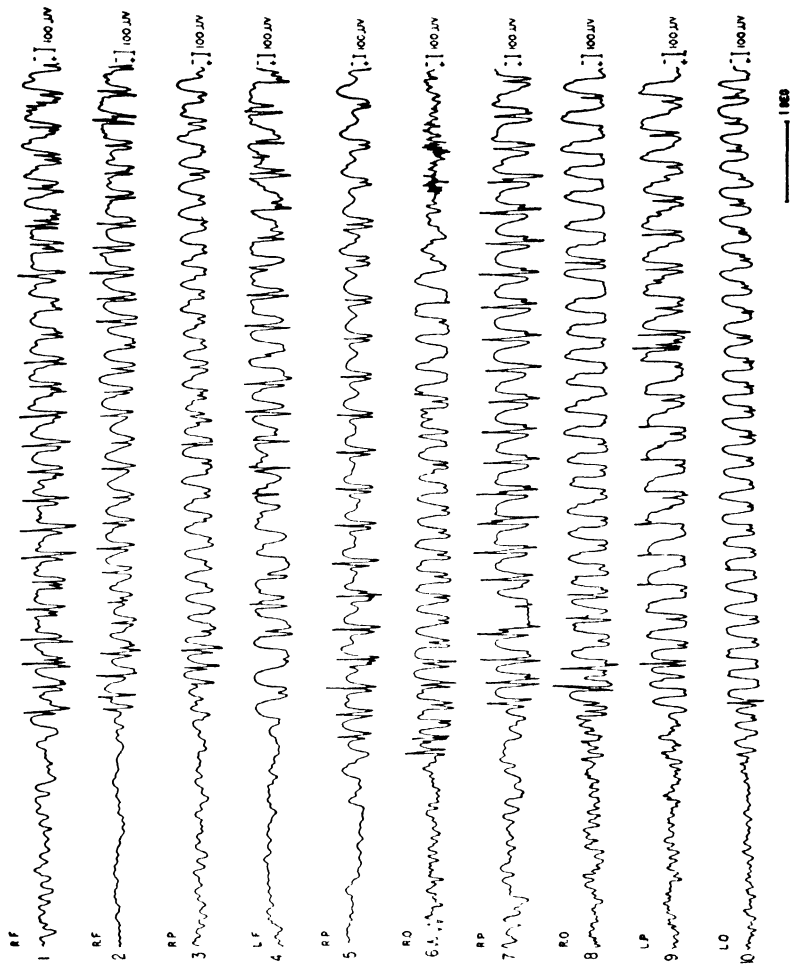


FIGURE 11. PETIT MAL EPILEPSY

1. Male, age 13—suffering from petit mal epilepsy.
2. Male, age 15—suffering from both grand mal and petit mal epilepsy.
3. Male, age 29—suffering from both grand mal and petit mal attacks.
4. Female, age 5—suffering from petit mal epilepsy.
5. Male, age 13—suffering from petit mal attacks 2 or 3 times daily.
6. Female, age 16—started petit mal attacks a year before.
7. Male, age 9—frequent petit mal attacks for a year.
8. Male, age 17—had frequent petit mal attacks for several years.
9. Male, age 24—began attacks at 5 years of age.
10. Male, age 15—five attacks daily since 5 years of age.

matching the greatest pathological disturbance in the graph with the electrode on the area where it originates. Later operation has proved that 84.5 per cent were accurately located. Epileptiform or convulsive disorders, particularly petit mal and hysterical seizures, can be also diagnosed. All types of epilepsy are characterized by definite changes in the patterns of the *alpha* waves. Each of the three main types of epilepsy, *petit mal, grand mal,* and *psychomotor seizure,* is accompanied by a readily recognizable wave pattern.

In *petit mal,* the alpha wave's alternation between its minimum and maximum becomes a sort of gallop rhythm of about three per second frequency. There is a very characteristic combination of a spike with a slow, rather dome-shaped wave. It is variously and descriptively named as "spike and cusp" or "dart and dome." The "dart" is a single fast wave; the "dome" a slower one.

These patients may have "blackouts" and have a loss of memory for these periods, or an amnesia. During these periods they may commit antisocial acts, for which they cannot legally be held responsible.

In *grand mal,* the normal 10 per second beat of the *alpha* wave becomes too fast. It is speeded up to 16 or even 22 per second and the amplitude is often violently increased in a rapid crescendo. It is interesting to note that in superstitious peoples the patient who suffers from epileptic seizures is thought to have the power of divination, or to have E.S.P.

In *psychomotor seizure* the characteristic shape of the wave is flat-topped. These slow waves alternate with high voltage six per second waves. In the stupor following a seizure, very slow waves are observed.

In order to make a diagnosis of a brain injury, or intracranial neoplasm, or brain tumor, the EEG may not be sufficient. In such cases, after a detailed neurological examination, it may be necessary to make a "spinal tap," in which under local anesthesia a needle is passed into the

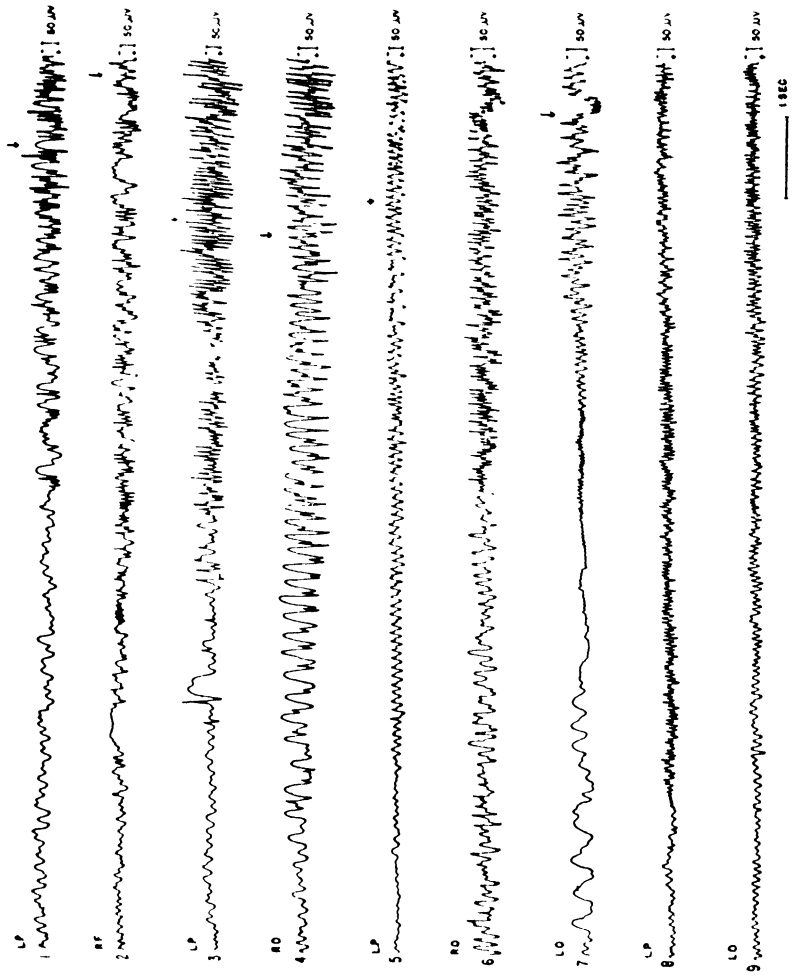


FIGURE 12. GRAND MAL EPILEPSY

1. Male, age 12—skull fracture at 6. Grand mal epilepsy since 9.
2. Male, age 28—no history of head injury. Grand mal attacks since 19.
3. Female, age 15—started attacks at 7 years of age.
4. Male, age 29—attacks began at 14.
5. Male, age 14—onset of grand mal epilepsy at 5.
6. Male, age 33—began at 15 to have attacks.
7. Female, age 10—onset of grand mal at 9.
8. Male, age 21—began at 20.
9. Male, age 29—grand mal attacks began at 26. No history of injury.

spinal canal at the end of the spinal cord. The spinal fluid may be found under increased pressure and to have unusual chemical content. When the spinal fluid is withdrawn, air is put back in its place, and then an X-ray picture of the skull is taken from several directions. The air in the spaces in and around the brain causes a contrast in the picture so that any tumor or displacement caused by a tumor will be shown. This method of diagnosis is called an encephalogram or airogram.

ALCOHOLISM

One of the major health problems in America is alcoholism, because ten per cent of the people are unable to drink alcoholic beverages without developing a dependency on them. Taking the country as a whole, six per cent of the men and one per cent of the women are now dependent on alcohol. These persons show chronic brain changes, which are revealed in the EEG. It takes about ten years for a person regularly indulging in alcohol to develop this chronic brain disease. The epileptic is one type of person who cannot use alcohol.

C-12 was a 35-year-old man who had begun drinking when he was fourteen. Both his parents had been regular drinkers, although they did not consider themselves as alcoholics. The young man had had convulsions once as a child, and he had a violent temper. He had graduated from college and was commissioned in the Navy. While in the Service, he drank even more heavily. On discharge, he got married. His wife found life with this man intolerable, as he had such a violent temper, was suspicious of her actions, and jealous of everybody she talked with. One day, in anger, he assaulted a woman and almost killed her. He was arrested, and his EEG showed a pathological picture, which excused his antisocial behavior. He was certified to a psychiatric hospital because of the degeneration of his brain tissue.

MENTAL DEFICIENCY

This diagnosis is made for those cases showing primarily a defect of intelligence existing since birth, without demonstrated organic brain disease of known prenatal cause. These cases were formerly known as familial or "idiopathic" mental deficiencies. The degree of intelligence defect is specified as *mild, moderate,* or *severe.* In general, *mild* refers to functional (vocational) impairment, as would be expected with I.Q.'s of approximately 70 to 85; *moderate* is used for functional impairment requiring special training and guidance, such as would be expected with I.Q.'s of about 50 to 70, and such patients are accepted by state schools for mental deficiency; *severe* refers to the functional impairment requiring custodial or complete protective care, as would be expected with I.Q.'s below 50.

C-13 was a 9-year-old girl, who was referred because she was a problem in school, could not do the school work assigned to her, and because of her size she felt out of place in first grade. She bullied the smaller children and was sexually precocious. A Stanford-Binet Test gave her an I.Q. of 65, which indicated that she could not adjust to a regular academic education. The family were advised to have her certified to a state training school, where the education is fitted to the child, and not the child to the school.

PSYCHOTIC DISORDERS

In psychotic disorders the patient has retreated from reality and has psychologically run away from life's problems. There is a varying degree of personality disintegration and failure to test and evaluate the environment correctly. In addition, individuals with such disorders fail in their ability to relate themselves effectively to other people or to their own work.

INVOLUTIONAL PSYCHOTIC REACTION

In this category are included psychotic reactions characterized most commonly by depression occurring in the involutional period, commonly known as the "change of life." These patients are without previous history of manic depressive reactions. The condition is found usually in individuals of compulsive personality type. The illness tends to have a prolonged course and may be manifested by worry, intractable insomnia, guilt, anxiety, agitation, delusional ideas, and somatic concerns. Some cases are characterized chiefly by depression, others, chiefly by paranoid ideas. Often there is preoccupation with physical complaints.

C-14 was a cultured woman, 62 years of age, when she was referred for treatment. She had developed her symptoms shortly after her husband's death six years before. She could not sleep. She expressed unworthiness and told of being untrue to her husband. She listed many physical complaints: headaches, dizzy spells, nausea, and a fear of cancer. She said nobody loved her, and she was a burden to her children with whom she lived. She had had two previous depressions about two years apart and had functioned normally in the intervals between them.

MANIC DEPRESSIVE REACTIONS

These patients have severe mood swings, and a tendency to have repeated attacks of the disease. Various accessory symptoms, such as illusions, delusions, and hallucinations, may be added to the fundamental affective or feeling alteration.

The basic personality of these individuals makes them more extroverted and interested in other people. They feel they should put themselves out for others and be of service to mankind. When something goes wrong, they try to make

amends. Generally, they are sociable and self-effacing. They revolve around the world.

MANIC DEPRESSIVE REACTION, MANIC TYPE

This type is characterized by elation or irritability, with overtalkativeness, flight of ideas, and increased motor activity. Transitory, often momentary, episodes of depression may occur.

C-15 was a college girl, 25 years of age, who had had a similar attack five years before. She had always been very sociable and active in all school and church organizations. She took on more and more obligations until she found she could not sleep and was on the go all the time. She didn't even have time to eat or bathe. She refused to heed all advice to slow down and so was referred for treatment. Even then, she refused to admit that there was anything wrong with her.

MANIC DEPRESSIVE REACTION, DEPRESSED TYPE

These individuals show a depression of mood, with mental and motor retardation and inhibition; in some cases there is much uneasiness and apprehension. Perplexity, stupor or agitation may be prominent symptoms. The patients are usually suicidal and need to be kept under constant care.

C-16 was a married woman, 38 years of age, with two children. During high school and college she was subject to periods of depression, but it was not until she was thirty that she had her first severe depression, which was diagnosed as above. She had considered suicide and expressed unworthiness, although her friends recognized her as an excellent wife and mother. She was an efficient housekeeper but never felt she could get her work done. About every two years she would get so depressed and confused that

she didn't even want to get out of the bed each morning, lost her appetite, and had no interest in her family.

SCHIZOPHRENIC REACTIONS

This diagnosis is the same as the formerly used terms dementia praecox or schizophrenia. It represents a group of psychotic reactions characterized by fundamental disturbances in reality relationships and concept formations. There are affective, behavioral, and intellectual disturbances in varying degrees and mixtures, and the emotions which are displayed are inappropriate. The disorders are marked by strong tendency to retreat from reality, by emotional disharmony, unpredictable disturbances in stream of thought and conversation, regressive behavior, and in some, by a tendency to "deterioration."

This is one of the most devastating diseases in the whole field of medicine, as it fills more than half of all the 650,000 beds in the mental hospitals in the United States. It affects people without regard to sex, race, social status, or education. These patients, after developing the illness, may live a long lifetime, a care to their families, or a constant expense to the state. Yet, the beginnings of this disease are in childhood. Injurious experiences during infancy and childhood, especially social and psychological stresses, prevent the development of a normal personality. The physical make-up also appears to be inadequate. Faulty methods of child training, frustrations, and overindulgence by the parents, broken homes and loss of security, unreasonable punishment, and the Oedipus situation all combine to lay the foundation for Schizophrenic Reaction in later years. The persons are conditioned to feel that their own desires are all-important, and that they have to struggle against the whole world. They are apt to be introverts, self-centered, and unsocial. They may be great inventors, artists, or musicians, but what they do is only for their own pleasure. The

world revolves around them. These individuals break down when they encounter the difficulties of life, such as adolescence, marriage, sex, childbirth, war, and everyday economic and social problems. When something goes wrong, they feel sorry for themselves and tend to blame everyone but themselves.

SCHIZOPHRENIC REACTION, SIMPLE TYPE

This type of reaction is characterized chiefly by reduction in external attachments and interests, and by impoverishment of human relationships. It often involves adjustment on a lower psychobiological level of functioning, usually accompanied by apathy and indifference, but rarely by conspicuous delusions or hallucinations. The simple type of schizophrenic reaction characteristically manifests an increase in the severity of symptoms over long periods, usually with apparent mental deterioration, in contrast to schizoid personality, in which there is little if any change.

C-17 was a 60-year-old man who showed the first manifestation of his disease at 14 years of age. He had worked as a gardener over the years, but had lived alone with his mother, and had no friends. He was just considered an eccentric and harmless individual who never talked to anybody. One day when his mother did not appear as usual, a neighbor investigated and found him sitting beside his dead mother. He had mashed in her skull with one of his heavy work shoes.

SCHIZOPHRENIC REACTION, HEBEPHRENIC TYPE

These reactions are characterized by shallow, inappropriate affect, unpredictable giggling, silly behavior and mannerisms, delusions, often of a somatic nature, hallucinations, and regressive behavior.

C-18 was a college graduate, 34 years of age—the young-

est of three children. She was very strictly raised and was never allowed to do what her schoolmates were allowed to do. She was told frequently that she was homely, and that she could not expect boys to pay attention to her. She did not want to go to college, but her parents insisted that she should do so. She was slow in adolescent development, and her breasts did not fill out like those of her companions. She was afraid of boys and fearful of sex. Although she began to show symptoms of her disease when in second year high school, she did not break down until two years after graduating from college, when she was urged to go out with a young man she was afraid of. She began to talk to herself, bite her finger nails, and caress her hair. She was a restless sleeper and would wander about the house at night. Her conversation was disjointed and without purpose. She was unable to concentrate and was a chain smoker. Her emotional expression was inappropriate. She would laugh without reason. She had no ambition and expressed much resentment against her family.

SCHIZOPHRENIC REACTION, CATATONIC TYPE

These reactions are characterized by conspicuous motor behavior, exhibiting either marked generalized inhibition, such as stupor, mutism, negativism and waxy flexibility, or excessive motor activity and excitement. The individual may regress to a state of vegetation and lie immobile in bed and have to be force-fed to keep him alive.

C-19 was a doctor, one of four children, the only one with a college education. The whole family had sacrificed to put him through college. After graduation he lived riotously and wasted his energies. When one of his patients died because of an error on his part, he retreated to a psychosis. He refused to recognize his family, refused to eat, took off all his clothes, stretched out in bed, but at times would assault his attendants. He defecated and urinated in bed, worked on his teeth until he'd pulled them

out, and plucked out all the hair on his body. Whenever he talked, he would talk in gibberish and resisted all help. He would lie for hours without moving a muscle, and if an arm or leg was moved, he would leave the member in the position in which it had been placed for an extended period.

SCHIZOPHRENIC REACTION, PARANOID TYPE

This type of reaction is characterized by autistic, unrealistic thinking, with mental content composed chiefly of delusions of persecution, and/or grandeur, ideas of reference, and often hallucinations. It is often characterized by unpredictable behavior, with a fairly constant attitude of hostility and aggression. Excessive religiosity may be present with or without delusions of persecution. There may be an expansive delusional system of omnipotence, genius, or special ability. These persons are apt to commit murder.

C-20 was a young veteran, one of three sons, and very much attached to his mother. He resented all other women and felt he was appointed by God to punish women for their sins. One day when a streetwalker tried to seduce him, he strangled her with his bare hands. He showed no remorse and justified all his actions. He insisted he could not be convicted, as he was an agent of God.

PARANOID REACTIONS

In this group are those cases showing persistent delusions, generally persecutory or grandiose, ordinarily without hallucinations. The emotional responses and behavior are consistent with the ideas held. Intelligence is well preserved.

C-21 was a woman, 45 years of age, who insisted everybody was trying to poison her. She prepared all her own meals, but when she began to accuse the neighbors of pumping gas into her house, she was brought in for psychiatric care.

PARANOIA

This type of psychotic disorder is extremely rare. It is characterized by an intricate, complex, and slowly developing paranoid system, often logically elaborated after a false interpretation of an actual occurrence. Frequently, the patient considers himself endowed with superior or unique ability. The paranoid system is particularly isolated from much of the normal stream of consciousness, without hallucinations and with relative intactness and preservation of the remainder of the personality, in spite of a chronic and prolonged course.

C-22 was a missionary who went to China and insisted that the course of China's history depended on his efforts.

PARANOID STATE

This type of paranoid disorder is characterized by paranoid delusions. It lacks the logical nature of systematization seen in paranoia; yet it does not manifest the bizarre fragmentation and deterioration of the schizophrenic reactions. It is likely to be of a relatively short duration, though it may be persistent and chronic.

C-23 was a 30-year-old woman who felt that all her neighbors were picking on her and were critical of her. She was sensitive to every sarcastic remark and antagonized all her acquaintances.

EMOTIONAL DISORDERS

The patients listed as emotional disorders make up about two-thirds of the patients referred to the private psychiatrist, but these persons actually make up about 80 per cent of the population and are frequently handled by the general practitioner. Usually these individuals are referred only when their symptoms are extreme and have been in existence for several years.

PSYCHOPHYSIOLOGIC AUTONOMIC AND VISCERAL DISORDERS

This term is used in preference to "psychosomatic disorders" since the latter term refers to a point of view on the discipline of medicine as a whole, rather than to certain specified conditions. It is preferred to the term "somatization reactions," which term implies that these disorders are simply another form of psychoneurotic reaction. These disorders are between psychotic and psychoneurotic reactions.

These reactions represent the visceral or bodily expression of emotional feeling, which may be thereby largely prevented from being conscious. The symptoms are due to a chronic and exaggerated state of the normal physiological expression of emotions, with the feeling, or subjective part, repressed. Such long-continued visceral states may eventually lead to structural changes.

This group includes the so-called "organ neuroses." It also includes some of the cases formerly classified under a wide variety of diagnostic terms, such as "anxiety state," "sexual neurosis," "cardiac neurosis," "gastric neurosis," and so forth.

C-24 was a married man with five children. He was the youngest of three brothers who worked together in the same business, and he was very unhappy in the situation. Over a period of several months he had been having gastric distress, and finally he was diagnosed to have a gastric ulcer. He was anxious to dissolve the partnership with his brothers, to get away from the noise of his children and his domineering wife, and visit his mother, who was living in Florida. The family doctor had sent him for psychiatric consultation and had asked if a rest in Florida would clear up the symptoms.

PSYCHONEUROTIC DISORDERS

The unconscious object of the psychoneuroses is to help a person obtain what he wants, as he obtained it consciously

during his childhood when the trouble first began. The chief characteristic of these disorders is "anxiety," which may be directly felt and expressed. This symptom may be unconsciously and automatically controlled by the utilization of various psychological defense mechanisms, such as depression, conversion, or displacement. In contrast to patients with psychoses, patients with psychoneurotic disorders do not exhibit gross distortion or falsification of external reality, and they do not present gross disorganization or disintegration of the personality. The life histories of individuals with psychoneuroses usually present evidence of periodic or constant maladjustment of varying degree from early life. Special stress, such as frustration or guilt, may bring about acute symptomatic expression of such disorders.

"Anxiety" in psychoneurotic disorders is a danger signal, felt and perceived by the conscious portion of the personality. It is produced by a threat from within the personality, by supercharged repressed emotions, such as the aggressive impulses, hostility and resentment. This situation may be brought about with or without stimulation from such external situations as loss of love, loss of prestige, threat of injury, or death of a loved one.

In the past, psychoneurotic disorders have been given various names, such as neurosis, hysteria, conversion hysteria, psychasthenia, neurasthenia, pathoneurosis, hypochondriasis, traumatic neurosis, compensation neurosis, hysterical fugue, obsessive-compulsive neurosis, compulsions, and, during the world wars, the terms "shell shock," and occupational or combat "fatigue" were used.

ANXIETY REACTION

In this kind of reaction the anxiety is diffuse and not restricted to definite situations or objects, as in the case of phobic reactions. It is not controlled by any specific psychological defense mechanism as in other psychoneurotic reactions. This reaction is characterized by anxious expecta-

tion and frequently associated with somatic symptomatology. The condition is differentiated from normal apprehensiveness or fear. The term is synonymous with the former term "anxiety state," or "anxiety neurosis."

C-25 was a 38-year-old married woman, with one child, a son, twenty years of age, who was subject to the draft. Her husband was indifferent to her desires, both social and sexual, and she was left the entire responsibility of running the home. Her parents, after many arguments, had separated when she was eight years old. Her mother constantly nagged her and warned her about sex and the brutality of men. When ten years of age, a man had grabbed her in a dark hallway, but she broke away, and at sixteen, a man had exposed himself to her. Sex relations with her husband were both painful and unpleasant, and the birth of her child was terrifying. She was fearful of further pregnancies and insisted her husband take every precaution to prevent such. When her son became eligible for the draft, she began to worry about losing him, could not sleep, had weak spells, and complained of various physical symptoms. She put on excessive weight. Her energy decreased, and she was sure that she was going to die. When her family physician found she had anemia, he gave her an injection to which she had an allergic reaction and "passed out." Her anxiety increased, and she was referred to the psychiatrist.

DISSOCIATIVE REACTION

This reaction represents a type of gross personality disorganization, the basis of which is an emotional disturbance, although the diffuse dissociation seen in some cases may occasionally be mistaken for a psychosis. One or several groups of ideas become split off from the main body of the personality. The personality disorganization may result in aimless "running about" or "freezing." The repressed impulse giving rise to the anxiety may be discharged by, or deflected into, various symptomatic expressions, such as depersonal-

ization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc. In the past, this condition was diagnosed as "hysteria."

C-26 was a Navy veteran, 24 years of age, who had been home on leave. He was returning to duty when the train on which he was riding entered a tunnel. Three months later, he was picked up as a deserter when he was recognized. He did not know what his real name was, nor where he had come from. He remembered going into the tunnel, and then everything "went black." When he "came to," he was not in uniform, and there was no means of identifying himself. There were no signs of violence. He had worked at odd jobs and wandered from town to town for the three months. When picked up, his identity was verified by his fingerprints, and then by members of his family and his shipmates. At the Naval hospital, his amnesia was penetrated by hypnosis, and the story reconstructed. On his leave home before going to sea, he had found his wife was pregnant and in financial straits. He had never been to sea before and was apprehensive about leaving home.

CONVERSION REACTION

Instead of being experienced consciously, either diffusely or displaced, the impulse causing the anxiety is "converted" into functional symptoms in organs or parts of the body, usually those that are mainly under voluntary control. The symptoms serve to lessen conscious (felt) anxiety and ordinarily are symbolic of the underlying mental conflict. Such reactions usually meet the immediate needs of the patient and are, therefore, associated with more or less obvious "secondary gain." This condition must be distinguished from psychophysiologic autonomic and visceral disorders. The term is synonymous with "conversion hysteria." The patient may suffer a paralysis in any part of the body, lose his voice, his hearing, his sight, etc.

C-27 was a woman, 40 years of age, was an only child,

and had a tubercular infection of her left hip when she was a girl and had to remain in a cast for over a year. She was an attractive woman but refused to accept dates because of her hip condition. One day when crossing the street, she was knocked down by a car and lost consciousness. When she woke up in a hospital an hour later, her left leg was paralyzed and excruciatingly painful. Examination of the leg revealed no injury, internal or external. No physical treatment relieved her disability, and after seven months she was referred for psychiatric care.

PHOBIC REACTION

The anxiety of these patients becomes detached from a specific idea, object, or situation in the patient's daily life and is displaced to some symbolic idea or situation in the form of a specific neurotic fear. The commonly observed forms of phobic reaction include fear of cancer, syphilis, dirt, light, closed places, high places, open places, insects, animals, etc. (See Glossary and Index.) The patient attempts to control his anxiety by avoiding the phobic object or situation.

C-28 was a single woman, 32 years of age, an expert typist, who had been warned all her life by her mother that men were to be avoided. The men she worked with had made many suggestive remarks, and she was constantly fearful of rape. Finally, she became engaged, and when marriage drew inevitably near, she was terrified of going into New York City and traveling on the train. Any crowd put her in a panic.

OBSESSIVE COMPULSIVE REACTION

In this reaction the anxiety is associated with the persistence of unwanted ideas and of repetitive impulses to perform acts which may be considered morbid by the patient. The patient himself may regard his ideas and be-

havior as unreasonable, but nevertheless is compelled to carry out his rituals. The patient expresses such reactions as touching, counting, ceremonials, handwashing, or recurring thoughts (accompanied often by a compulsion to repetitive action). This category includes many cases formerly classified as "psychasthenia."

C-29 was a married woman, 27 years of age, who had given birth to a baby boy four months before. One day while washing a carving knife, she had the impulse to go into the baby's room and plunge the knife into her child. In spite of her attempts to dismiss the thought, it persisted. She ran out into the yard, then into her neighbor's home, and talked about everything she could bring to mind. Finally, the obsessive thought eased up, and she went home. That evening when her husband was helping her with the dishes, she saw the knife in the drawer, and she reached for it. Her terror was terrific, and she ran to her husband and blurted out her fears. He took her to the family doctor, who immediately referred her to the psychiatrist.

DEPRESSIVE REACTION

The anxiety in this reaction is allayed, and hence partially relieved, by depression and self-depreciation. The reaction is precipitated by a current situation, frequently by some loss sustained by the patient, and is often associated with a feeling of guilt for past failures or deeds. The degree of the reaction in such cases is dependent upon the intensity of the patient's ambivalent feeling toward his loss, as well as upon the realistic circumstances of the loss. This condition was formerly known as "reactive depression," as the depression is a reaction to a "shocking" situation. There is grave danger of suicide in these cases.

C-30 was a man, 45 years of age, who was a very religious person and greatly opposed to divorce. For years he had cared for his invalid wife. His only son married against his advice, and two years later the son's wife went off with

another man. The father went into a severe depression. He lost his appetite, couldn't sleep, felt he couldn't work, and had spells of crying.

PERSONALITY PATTERN DISTURBANCES

These individuals are more or less cardinal personality types, which can rarely if ever be altered in their inherent structure, although they may develop psychoneuroses or psychoses. Their functioning may be improved by prolonged therapy, but basic change is seldom accomplished. In some persons the "constitutional" features are marked and obvious. The depth of the psychopathology here allows these patients little room to maneuver their personalities under conditions of stress, except into actual psychosis. If such takes place, the underlying character determines the type of psychosis that develops.

INADEQUATE PERSONALITY

Such individuals are characterized by inadequate response to intellectual, emotional, social, and physical demands. They are apt to resort to lying without rhyme or reason. They are neither physically nor mentally grossly deficient on examination, but they do show inadaptability, ineptness, poor judgment, lack of physical and emotional stamina, and social incompatibility. These persons used to be diagnosed "psychopathic personalities."

C-31 was a woman, 35 years of age, a graduate nurse, who had always been excessively stout. She had indulged in numerous sexual escapades, usually on her initiative, but she could never retain her friends nor win her lovers. She had two children, one out of wedlock, and she had been divorced by two husbands. When she was arrested with her paramour after she had deserted her two children, she showed no remorse for the series of crimes she had committed.

SCHIZOID PERSONALITY

Inherent traits in such personalities are avoidance of close relations with others, inability to express directly hostility or even ordinary aggressive feelings, and fantasying or autistic thinking. These qualities result early in coldness, aloofness, emotional detachment, fearfulness, avoidance of competition, and day dreams revolving around the need for omnipotence. As children, they are usually quiet, shy, obedient, sensitive and retiring. At puberty, they frequently become more withdrawn, then manifesting the aggregate of personality traits known as introversion, namely, quietness, seclusiveness, "shut-in-ness," and unsociability, often with eccentricity. These persons formerly were known as "psychopathic personality, schizoid type."

C-32 was a young man of 19, one of two children, with a younger sister. He was a premature birth and always remained thin and poorly developed. His father rejected him from the start and punished him severely, while his mother was overprotective. He made few friends and never played rough games. As a child, he fantasied himself being a top executive and president of the firm where he planned to work. He finished high school with difficulty, yet he visioned graduating from college and being "an intellectual" and writing on philosophy. He was afraid of women and of all men stronger than himself. He was unable to concentrate on his work or studies, and he spent much time daydreaming.

CYCLOTHYMIC PERSONALITY

Such individuals need to be members of a group and are characterized by an extratensive and outgoing adjustment to life situations, an apparent personal warmth, friendliness and superficial generosity, an emotional reaching out

to the environment, and a ready enthusiasm for competition. They need constant approval. Characteristic are frequently alternating moods of elation and sadness, stimulated apparently by internal factors rather than by external events. The individual may occasionally be either persistently euphoric or depressed, without falsification or distortion of reality.

C-33 was a woman, 20 years of age, married, and a college graduate. She was in every activity possible in high school and college, and prided herself on her large circle of friends. She put herself out unreasonably to retain her friendships. She was filled with advice and argued on the slightest provocation. When she was criticized, she was easily reduced to tears. Her menstrual periods were painful, and at such times she was apt to be depressed, but she soon snapped back into excessive activity and might become euphoric.

PARANOID PERSONALITY

Such individuals are characterized by many traits of the schizoid personality, coupled with an exquisite sensitivity in interpersonal relations, and with a conspicuous tendency to utilize a projection mechanism, expressed by suspiciousness, envy, extreme jealousy and stubbornness.

C-34 was a married woman, 38 years of age, a school teacher, the youngest of four children. Her parents made a poor marital adjustment and were extremely prudish. She was jealous of her two sisters and brother and resented all children she could not dominate. Her breasts were small and her hips narrow. She had a marked sense of guilt about sex play, and yet she was envious of her husband's penis. She enjoyed teasing him and putting on a scene to get his sympathy and attention. She was suspicious of everybody and had difficulty keeping friends. She had much trouble assuming the responsibility of her home, and felt she was

superior to household duties and her husband's education. She expressed the idea that she was irresistible to men and blamed them for not paying attention to her.

PERSONALITY TRAIT DISTURBANCES

Persons who are diagnosed to have personality trait disturbances are individuals who are unable to maintain their emotional equilibrium and independence under major or minor stress because of their paucity in emotional development. Some individuals fall into this group because their personality pattern disturbance is related to fixation and exaggeration of certain character and behavior patterns; others, because their behavior is a regressive reaction due to environmental or psychological stress.

EMOTIONALLY UNSTABLE PERSONALITY

The individual with such emotional instability reacts with excitability and ineffectiveness when confronted by minor stress, as would a child. His judgment may be undependable under stress, and his relationship to other people is continuously fraught with fluctuating emotional attitudes, because of strong and poorly controlled hostility, guilt, and anxiety. The person is emotionally immature.

C-35 was a woman, 30 years of age, divorced and remarried. She was one of two children, with a domineering, alcoholic mother, and a non-demonstrative father. She was required to live by a very strict moral code and was made to feel guilty whenever she did not conform. At times she would lose her temper and break things, and then would be afraid of the consequences. She quarrelled over petty trifles. She had an over-ready temper and ever-ready tears.

PASSIVE-AGGRESSIVE PERSONALITY

Reactions in this group are of three types, although the three types of reaction are manifestations of the same under-

lying psychopathology, and frequently occur interchangeably in a given individual falling in this category. For these reasons, the reactions are classified together. These persons were "spoiled children."

PASSIVE-DEPENDENT TYPE

This personality is characterized by helplessness, indecisiveness, and a tendency to cling to others as a dependent child to a supporting parent.

C-36 was a 35-year-old man who had been very dependent on his mother throughout his childhood, and at eighteen he married a girl, two years his senior, on whom he was very dependent. He made no decisions without first consulting his wife, and he turned over his entire salary to her, and she would give him his carfare each day. He did not have intercourse with her unless she invited him to do so.

PASSIVE-AGGRESSIVE TYPE

The aggressiveness is expressed by passive measures, such as pouting, stubbornness, procrastination, inefficiency, and passive obstructionism.

C-37 was a 26-year-old man, married and with two children, who insisted he was very much in love with his wife. He, nevertheless, would not talk with his wife about mutual problems. If she got angry with him, he would just remain quiet, bury himself in his newspaper, or go to sleep. He delayed doing the necessary household chores but would repeatedly promise to get them done. He was always overdrawing his bank account.

AGGRESSIVE TYPE

These persons react to frustration with irritability, temper tantrums, and destructive behavior. Yet, a deep de-

pendency is usually evident in such cases. Some of these individuals react with a morbid or pathological resentment.

C-38 was a 16-year-old girl, an only child, who had always been indulged in her every wish. She resented all her classmates, so she made such a scene at home and school that she was finally exempted from attending classes. She would have a temper tantrum whenever she did not want to do anything. On several occasions she tore up a new dress which she did not like.

COMPULSIVE PERSONALITY

Such individuals are characterized by chronic, excessive, or obsessive concern with adherence to standards of conscience or of conformity to community rules. They may be overinhibited, overconscientious, and may have an inordinate capacity for work. Typically, they are rigid and lack a normal capacity for relaxation. While their chronic tension may lead to neurotic illness, this is not an invariable consequence. The reaction may appear as a persistence of an adolescent pattern of behavior, or as a regression from more mature functioning as a result of stress.

C-39 was a man of 30 who was an only child, a college graduate, and married. He would not drink or smoke. He worked long hours and was always putting himself out for others. He never missed church and observed all holy days. He insisted on visiting his parents twice a week and required his wife and two children to accompany him.

ANTISOCIAL REACTION

This term refers to chronically antisocial individuals who are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group, or code. They are frequently callous, cruel, and hedonistic, and self-satisfaction and pleasure are their chief aims in life. They show marked emotional immaturity, with

lack of a sense of responsibility, lack of judgment, and possess an ability to rationalize their behavior so that it appears warranted, reasonable and justified. They may be pathological liars and tangle themselves in their web of lies. Their sexual adjustment is poor, as they never think of their partners in the act. They do not commit suicide, although they may accidentally kill themselves in trying to get their own way. They have no sense of remorse or honesty. They may be classed as asocial or without a social understanding, conscience or Super-ego. In the past these cases were classified as "constitutional psychopathic state" or "psychopathic personality."

C-40 was a married man, 28 years of age, an ex-Marine and veteran of W.W.I. He was an only child, a high-school graduate, and was working as an auto mechanic. He was intemperate in his drinking, and frequently, when under the influence of alcohol, he would beat his wife, who at the time he was referred was pregnant with her third child. For about a year he had been having sexual intercourse with a divorcee, who had picked him up when he fixed her car at the garage where he worked. Once she got involved with him, she was afraid to break away, as he threatened to kill her if she left him. One evening when his wife went shopping and he was home with the children, the baby began to cry. When he could not quiet the child, he lost his temper and bashed the baby's head against the crib and killed it. When his wife got home, he casually explained the situation and said it was an accident. When the police came, he still maintained his innocence.

DYSSOCIAL REACTION

This term applies to individuals who manifest disregard for the usual social codes, and often come in conflict with them. They may be capable of strong loyalties. These individuals do not show significant personality deviations other than those resulting from adherence to the values of

their own predatory or criminal group. These persons used to be diagnosed as "pseudosocial personality" or "psychopathic personality with asocial and amoral trends."

C-41 was an 18-year-old boy born of Sicilian immigrants on New York's lower east side. The oldest of eight children, he had practically grown up on the street without parental supervision. He had been a member of a teen-age gang and had strictly abided by the criminal code. He had learned to steal as a small boy and had never squealed on any of his companions. He had contributed regularly to the support of his parents and siblings. He had been true to his "girl," and he had fought for her honor on numerous occasions. He never missed Mass on Sunday.

SEXUAL DEVIATION

This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenic and obsessional reactions. The term includes most of the cases formerly classed as "psychopathic personality with pathologic sexuality." The diagnosis specifies the type of the pathological behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation). These reactions will be discussed in detail in the following chapter.

GROSS STRESS REACTION

Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear. The patterns of such reactions differ from those of the neuroses or psychoses chiefly with respect to clinical history, reversibility of reaction, and their transient character. When properly treated, the condition usually clears rapidly, but may progress to one of the neurotic reactions. During the last World War this

reaction was known as "combat fatigue" or "operational fatigue." In civilian life this reaction has been known as shock, fatigue, syndrome, or nervous exhaustion.

C-42 was a 40-year-old woman who had been president of a women's organization the preceding year. Her son contracted polio and required her constant care. Then her husband had a heart attack and died. She found she couldn't sleep, lost her appetite, and she felt that she couldn't face the future. Sedation and a good night's sleep got her back in line.

ADJUSTMENT REACTION OF ADOLESCENCE

This diagnosis is given to those transient reactions of the adolescent which are the expression of his emancipatory strivings and vacillations with reference to impulses and emotional tendencies common to this stage of life. The superficial pattern of the behavior may resemble any of the personality disorders described before, but the symptoms are transient. In other words, the youngster will grow out of the disability.

C-43 was a 14-year-old boy, the oldest of three children and was about six feet tall. He was good in sports but was doing poorly in his studies. His parents wanted him to plan on college, but he wanted to quit school at 16 and go to work. He ran away from home and was not located for several days. Obviously, he was a normal adolescent who had been mishandled.

ADJUSTMENT REACTION OF LATE LIFE

This diagnosis includes those transient reactions of later life which are an expression of the problems of physiological, situational, and environmental readjustment. Involutional physiological changes, known as "the change of life" or menopause, retirement from work, breaking up of fam-

ilies through death, or other life-situation changes frequently precipitate transient undesirable personality disturbances, or accentuate previous personality disorders. Such disturbances are differentiated from other psychogenic reactions and from reactions associated with cerebral arteriosclerosis, presenile psychosis, and other organic disorders.

C-44 was a 50-year-old woman who had been having transient periods of depression for about three years. Her menstrual periods had been irregular, sometimes heavy and sometimes slight. This "change" had been going on for six years before, and she had withdrawn from a very active social and club life. She had too much time on her hands.

CONFUSION

Many times when patients come to the attention of a psychiatrist, the individual is suffering from the toxic effects of drugs or alcohol, and thus the picture is confused. In this condition, the individual is not only suffering from the deleterious effects of the resultant toxemia, but also from the essential symptoms of the personality reaction.

SUICIDE

It is, of course, natural that the psychiatric patient and his relatives are very anxious to be assured that the physician can do something to straighten out the patient's difficulties, and although the physician may give reassurance, he is usually careful not to give false hopes. If the patient does not get well as promised, in his disappointment he may give up all hope and commit suicide.

Suicide may result from such disappointment, a desire to revenge some fancied wrong, a fulfillment of honor, an attention-getting mechanism, or a wish "to be born again" and start all over. In any case, suicide has to be kept in mind when considering every personality reaction.

PRIVILEGED COMMUNICATION

Another point that patients, and less often the family, are anxious to be reassured on, is the strict secrecy of the interview and examination. A guarantee can be given in this matter, as all medical records are treated confidentially—particularly psychiatric records. In many cases this fact has been upheld in the courts of the land. Psychiatric records are usually kept under lock and key, and they cannot be subpoenaed by the court. Even as a sworn witness on the courtroom stand, the psychiatrist does not have to answer questions about what the patient told him. He will not reveal any of this information unless the mentally competent patient signs a release giving the psychiatrist the right to reveal whatever data he feels necessary for the good of the patient. No court will grant a search order allowing the district attorney or police to inspect psychiatric records. Thus, it is seen that what the patient says to a psychiatrist is kept in strictest confidence.

Everyone, the world over, rationalizes his lack of knowledge and understanding, his mistakes and successes, his inadequacies and potentialities. And so, both the patient and his family constantly tend to rationalize the patient's symptoms and state of health. The psychic mechanisms and tricks of the mind are something against which everybody must be on guard. He should not accept too readily the nearest explanation, the most plausible reason or the conventional diagnosis. Hard work and over-study do not bring about a "nervous breakdown" unless there are conflicts connected with them in some way. Worry is always associated with insecurity because it denotes a lack of understanding or a feeling of inadequacy in meeting problems.

CHAPTER VI

Sex: Normal and Abnormal

As pointed out in a previous chapter, the individual has many inner urges toward self-satisfaction. There is an eternal struggle of all nature, which ends in pleasure, a release of tension, a sense of relief, and a desire to repeat it all over again. From birth until death, the individual is constantly beset with morals and taboos, and although for many centuries men have tried to legislate against or to ecclesiastically control sex, mankind has been able to evade all these restrictions and in one way or another has found the ultimate of all pleasure, the orgasm.

Without the climax and its attendant relief from tension, there is no enduring pleasure, no urge to repeat the activity. But, once experienced, the orgasm possesses the individual and drives him or her to re-experience its ecstasy. Perhaps it will be reached in an immature or childish manner, or perhaps it will be as a result of a mature, adult expression of love, the ultimate of all that is pleasant.

The new-born babe gets his satisfaction through the lips, but a few months later he becomes aware of other pleasure areas in his body. The release of the anal sphincter gives a pleasing sensation. Then the next thing that the child discovers is that there is definite enjoyment associated with responding to the release of bladder fullness. So the child feels, though unconsciously, that the pleasure rests in the genital area.

Between these erotic zones the child usually fluctuates back and forth during the first few years of his life. If there are no abnormal fixations, by the time he is of kindergarten

age he will have stopped thinking primarily of pleasure within himself, and he becomes essentially a non-sexual individual. From then on, for the next ten years, or until the onset of adolescence, he plays with the opposite sex without any special sexual significance; and he identifies himself with persons of the same sex. If during this period undue emphasis is placed on sex, the child's attention may be fixed and the curiosity over-stimulated, resulting in constant conflict, as it is during this time that he tries to socialize himself. He plays with other youngsters and tries to adjust to the rules of his home, his school, and society in general. His play life is a sublimation of his inner urges, and he is thereby able to sublimate these tensions. During this period the child learns to play or forever he is unable to play.

If in this non-sexual or homosexual period the person should happen to suffer some emotional reaction or to become afraid of sex and its expression, he may not wish to venture beyond this stage. He may find an interest primarily in himself; and he may also find that it is more pleasant to associate with the same sex, with fewer complications. During this time if one or another of the erotic areas of the body is overly stimulated, the young adolescent may find that there is definite sexual pleasure in the activity, and he, therefore, has no desire to go on to a more adult expression. Thus, the individual is said to be arrested in psychosexual development.

Of 3,000 patients referred for private psychiatric attention, 42 per cent had clearly defined sexual deviations which indicated that they had been arrested in their psychosexual development. Obviously, this was not the only symptom of their emotional reaction. Of these patients, 3.5 per cent had gotten themselves into trouble with the law because of their sexual abnormality and, therefore, had sought psychiatric attention. Fortunately, many of these deviations can be corrected.

Heterosexuality, or attraction to the opposite sex, is an attribute of the mature personality, and from what has been

said before, it is evident that the adults with whom the child associates determine whether or not the individual will progress through the natural homosexual period and develop into an emotionally adult individual.

POLYGAMY AND POLYANDRY

Much has been written and said about the sexual practices of this generation, and the Kinsey Reports have focused anew our attention on this subject. Those with strict training say that it is all a sign of the decadency of the race, while the thinkers say that the standards of sex morals must be re-evaluated. Psychiatry has always known that human beings are apt to say one thing and do another.

Promiscuity, laxity in sex activity, and divorce have all been present for many generations, and society has tried to legislate controls. Although monogamy, or the association of one man and one woman, is now the pattern in modern society, polygamy and polyandry are more natural patterns, as emotionally mature human beings are attracted to the opposite sex no matter whether they are married or not. The only way to prevent promiscuity is through understanding and proper selection of partners. Otherwise, divorce or broken marriage is inevitable. With the present system of standards, many married people have to find sexual satisfaction one way or another outside of their marriage.

C-45 was a 53-year-old man, married 33 years. He and his wife were considered by all their friends as being an ideal couple, very much in love and ideally mated. Yet after their first week of marriage, they slept in different bedrooms. They found themselves physically incompatible and never again attempted sexual intercourse. They agreed that their sexual lives would be their private affairs and neither would check on the other. Over the 33 years, the husband had several lovers, and had as many as three mistresses at one time. The wife also lived an active sexual life. The partners were careful to see that neither conflicted with the other.

THE HOMOSEXUAL

There are many individuals who are latently homosexual, which means that they look to persons of the same sex for pleasure but are unable to express themselves in physical stimulation. They have never really identified themselves with the attributes of their own sex. There is actually little difference between sexual stimulation, or overt activity between two men, or between two women, or between a man and a woman, as the objective is the mutual orgasm. But sexual intercourse in public between human beings is considered antisocial, primarily because of the intense emotion it arouses in those who witness it. Adults of opposite sexes who are found participating in intercourse, and who are willing partners, are not treated as criminals. However, persons of the same sex so indulging are in conflict with the law.

It is an interesting fact that the majority of overt homosexuals seldom engage in anti-social activity, while the latent homosexuals are apt to develop emotional reactions because of their frustrations. It is well to emphasize that the emotionally matured, fully feminine, or fully masculine personality does not engage in anti-social activity.

The latent type of homosexual who usually has been conditioned to have a strong sense of moral rectitude is more apt to be a potential social menace. This type of man or woman does not engage in sexual intercourse with members of the same sex but flirts with and stirs the emotions of both sexes. These individuals are frequently found in bars and social clubs that may be accepted by the community. He or she often marries and produces children, but the children have a lessened chance of maturing into heterosexuality. These latent homosexuals have an impulse to hurt and be hurt, and these impulses are the fertile soil for later crime.

C-46 was a 30-year-old man, married, but without chil-

dren. He spent much time at the Legion clubhouse. One of his buddies was married and had a little daughter. One evening when the 6-year-old girl was left alone, asleep in bed, C-46, under the influence of alcohol, got into the house, and, after sexually playing with the child, he slashed her throat with a butcher knife. After his arrest, he told a story of being latently homosexual.

ALCOHOLISM

The problems of alcoholism are essentially due to sexual deviation. The compulsive drinker, the person who drinks alcoholic beverages because he or she finds it necessary to do so, is basically homosexual and orally erotic. In other words, the individual who finds he "needs" a drink, is primarily concerned with self-gratification and is not really interested in the pleasures of other persons. He overrides the desires of other people and is blinded by his own wishes. No matter what is socially acceptable, the urge to self-pleasure dominates the whole personality. Actually, the patient who so drinks suffers from a homosexual panic, or a fear that he is homosexual. He cannot reach the heterosexual orgasm without the help of alcohol, and even then he may not succeed.

The casual drinker, or the social drinker, may at first innocently indulge in such stimulants, but as he repeatedly discovers that he can relieve his tensions or forget his problems by drinking, he or she more and more resorts to this technic of gaining relief. In a period of years, on an average of ten years, such a drinker becomes a real alcoholic problem. Thus, it is evident that any person who drinks for effect is an alcoholic.

There is a tremendous variation in the incidence of alcoholism from country to country. In some, including the United States and Sweden, alcoholism is mostly a compulsive reaction. Of 88,000,000 adults over 21 in the United States, there are 4,000,000 alcoholics, or 4,550 (4.55 per cent) per

100,000. Of these the alcoholics among American men outnumber alcoholic women 6 to 1.

In the United States there are many compulsive drinkers among women past 35 years of age. At that age women may start drinking for a number of causes, such as a husband's infidelity, the death of a mother or of a child, or a loss of social status. It may be the symptom of a depressive reaction.

In Finland and isolated parts of America, there is the explosive drinker, who is a much greater problem than the habitual drinker. Individuals living in remote parts of the country, such as logging camps and ranches, come to the city once a month and go on a spree. After the third or fourth drink, knives sometimes come out, and violence follows. France has the largest alcohol problem in Europe. The problem is most acute in rural areas of France, and less acute in cities, which is the reverse of conditions in the United States. There are more than 1,000,000 alcoholics in France.

Loss of love and attention from alcoholic parents is one of the major contributors to juvenile neurotic reactions.

C-47 was a 16-year-old boy, whose parents never missed their cocktails before dinner, and at frequent parties they got "high." They felt that their children should learn to drink at home. As a result, at 14 their children were allowed to join the cocktail hour. At 16 this boy was coming home from teen-age parties drunk. It was "the smart thing to do," and the youngster was on the way to being a compulsive drinker, but blamed by his parents.

SOIXANTE-NEUF

A few years ago a great deal of publicity was given to a man, C-48, and a woman who indulged in a series of murders. They had met each other through a "lonely hearts club," and their defense was that they were psychotic because they indulged in what was considered a sexual devi-

ation. She placed his penis in her mouth and he used his tongue on her clitoris. They had repeatedly indulged in soixante-neuf, and it was only by the man's use of his tongue on the woman's clitoris that she was raised to the peak of a climax, although she had in her previous marriages and other love affairs indulged in penis insertion without orgasm. It was proved by the prosecution that mutual oral stimulation was a foreplay and not a completion of the act, and that by penis insertion this couple was mutually satisfied. It is not uncommon to find that such foreplay is indulged in by married couples, and it is in no sense a sexual deviation.

FELLATIO

Where either one of the partners in the sexual act seeks only self-satisfaction without satisfying the partner, it may be considered a deviation. An example of this was C-49, a senator's wife, who was referred after being married seventeen years, stating that in those years her husband had only indulged in vaginal intercourse twice, while almost every night he insisted that she bring him to orgasm by fellatio, or inserting his penis in her mouth. She tried to learn to like it, but, not succeeding in gaining any satisfaction for herself, she finally decided to get a divorce.

In this case it is evident that the husband might well have been considered a heterosexual individual in so far as he desired to indulge in fellatio with his wife, but in the true sense he was not a socially integrated individual, because he was primarily concerned with his own satisfaction rather than mutual satisfaction with his wife. Since she received no pleasure in sexual play, and he insisted on being gratified, it could well be considered a sexual perversion. The psychiatric findings would indicate that this man was latently homosexual, and that he would quite likely be as well satisfied with fellatio by a man as by his wife.

Fellatio may be a compulsive reaction for the woman

and become a conditioned response which is an end within itself. In such women fellatio is a regression to the oral erotic stage, and an orgasm is reached by such activity. Vaginal intercourse is not desired by such women and is likely rejected because of fear of pregnancy, fear of loss of virginity, sense of disloyalty if the vagina is used, etc., or, an earlier conditioning to oral pleasure by tongue or finger sucking. In some women fellatio gives them a sense of power, they are punishing the man, biting off the penis, etc. Smoking may sublimate this urge.

The indulgence of fellatio between males is a relatively common practice, and quite frequently one or the other partner is considerably older. C-50 was a 35-year-old man, who for about twenty years had indulged in fellatio, although on numerous occasions he had indulged in sexual intercourse with women on their initiation, but never with any satisfaction to himself. He was a beautician and was well-liked by his customers. He frequently indulged in fellatio, usually taking the active part, and the reason he was arrested was that a group of teen-aged high school boys had urged him to "do a job" on each of them. It was entirely a voluntary procedure, and the man could hardly be considered a criminal, yet he is now in Sing Sing Prison.

TRANSVESTISM

The public generally thinks of homosexuals as being effeminate individuals, yet this is seldom the case. These individuals suffer from transvestism, which is a form of sexual deviation in which the persons desire to play the role of the opposite sex. The transvestite sometimes carries on his masquerade in secret. This is a result of identification with the parent of the opposite sex, and because of circumstances the individual may be initiated into homosexual activity with someone of the same sex. A boy may be raised by his mother without the help of a male in the environ-

ment, and, therefore, the boy attempts to dress or act like a female. C-51 was a boy who had been raised by his mother and two aunts with no opportunity to play with other boys. His mannerisms by imitation were definitely feminine, and while working as an office boy he accidentally found that it was easy to pick up overt homosexuals who, for a fee, and quite frequently with lavish entertaining, would indulge in homosexual activity, either fellatio or sodomy. He was able to have an evening of entertainment accompanied with five or ten dollars in tips, while to continue working as an office boy he would get only twenty dollars a week. This boy at seventeen was badly conditioned but not incurably homosexual. Transvestism is not uncommon in this day where many women identify themselves with the male, either in dress or occupation, or in overt homosexuality, such as taking the part of the male by the strapping on of some instrument to serve as a penis, or the use of the tongue as a penis.

LESBIANISM

Although lesbianism is not thought of as being as common as homosexuality in the male, it actually is even more common. It is frequently initiated in girls' schools and colleges, and in a society where there is a preponderance of women, it is natural for a woman to find it necessary to gratify her love life in lesbianism. Such persons are frequently found in the professional field, and although they may indulge in sexual intercourse with males, they are usually frigid to the male, while sexually very active with their own sex. Again it is only a case of ego satisfaction and is dependent on an early conditioning, quite frequently based on a fear of pregnancy, or the responsibility associated with such pregnancy. These individuals may indulge in cunnilingus, or the using of the tongue on the clitoris, but more frequently they only indulge in petting. They enjoy contact with their own sex, and this may be satisfied by

either mutual masturbation, dancing, fondling of each other's breasts, or simply sitting beside each other, as is the case with male homosexuals.

C-52 was a 28-year-old woman, a college graduate, who had been sent to a girls' school and advised against going out with boys. Her parents were obviously unhappily married. She roomed with another woman and spent her evenings in the women's bars in Greenwich Village, where she got many thrills by playing "kneesies" with certain of the patrons.

FRIGIDITY

Numerous cases of frigidity that are referred for psychiatric treatment are based on latent homosexuality, as in C-53, a married woman, 45 years of age, who was referred for a depressive reaction, and who brought out very clearly in her history that she had developed an over-dependency on her mother, identifying herself with her mother, and being generally suspicious of all men. Her mother had well impressed upon her the idea that all men were out to rape her, and that she should allow no man to touch her. She found that she could only get pleasure in associating with women, and consequently, never progressed out of the homosexual stage.

Another woman, C-54, 28 years of age, married 8 years, and with two children, was having much difficulty getting along with her husband. She felt guilty whenever she allowed herself to enjoy sex relationship, and so repressed her desires. She was an only child, and the father never kissed his wife without kissing his daughter. Sunday morning she would get into her father's bed and talk over the activities of the week, or he might go to her room and do the same thing. When she was 12 years of age, one morning while lying beside her, the father had an erection, and placing his penis between her legs, he ejaculated. Since she did not menstruate when due, she concluded that she was

pregnant, and, being worried, her mother finally wheedled out of her what had happened. As a result, the husband was divorced. The daughter married a father substitute and had difficulty making normal sexual adjustment because of the traumatic experience.

NYMPHOMANIA

Women who have an excessive demand within themselves for sexual intercourse are said to have nymphomania. Under certain circumstances they are unable to control the desire and may seek satisfaction without discretion.

C-55 was a 35-year-old single woman, one of two daughters. She came from a broken home and had an overaffectionate father who was socially prominent. She had her first experience with sexual intercourse when 12 years old, and from then on she frequently seduced her boy acquaintances. During the fifteen years prior to coming for consultation, she had become pregnant four times and been criminally aborted. No matter who her date was, she would seduce him before the evening was over. One evening she was "stood up" by her date, so, after a number of drinks, she hailed a taxi, and on the way home she asked the driver to have intercourse. He obliged. A few weeks later, as a guest at an officers' club, she drank freely and realized the next morning that she had had intercourse the previous evening with three flight officers.

INCEST

Incest is considered a sexual deviation in modern society, although it has not always been considered a crime. Mormon society in the last century allowed overt incestuous relationship, and latent incest is common in society today. Mothers dominate their sons to such an extent that these sons can only think of adjustment to mother substitutes. Daughters may be dominated by the father in the same way. The

analyst frequently is presented dreams of incestuous nature. This situation may become overt enough for the incestuous desire to be expressed in lip to lip kissing. As adolescence begins, this bodily contact not infrequently precipitates what is well known as the Oedipus complex and may actually cause an acute schizophrenic reaction.

A mother who had been very close to her son over sixteen years, and who had been widowed three years previously, said with considerable pride that she had been "a real pal" to her son, C-56. They frequently got into each other's bed to discuss their mutual problems. She was receiving the attentions of a widower, and one evening when she thought her son was at the movies, they indulged in sexual activity in the living room with the lights out, when the front door opened, and her son walked in. He made no comment, and they thought that they were not observed, but the next morning he asked her if she would have intercourse with him since he loved her. He said that she had told him that when a man and woman loved each other, they have intercourse.

EXHIBITIONISM

Exhibitionism in the adult is a sexual deviation. It is a perfectly natural thing for a child to get satisfaction from indulging in antics which gain him attention. Where the individual has not found it possible to gain normal sexual satisfaction, he may regress to such narcissism. Consequently, in every day life we frequently find individuals who indulge in various forms of exhibitionism, such as argumentativeness, flashy clothes, or actual exposure of the body. This, of course, is found on the stage or on television, and may be a symptom of a basic sexual inferiority.

From his own bedroom window a man, C-57, observed a neighbor woman getting undressed in front of her window. He found that this aroused him sexually, and it was evident that she was aware of his observing her. He, by slow stages,

reciprocated by undressing so that she could observe him. This mutual exhibitionism continued for a number of months, but always was associated with a deep sense of guilt, which created impotency with his wife and almost forced him into a schizophrenic reaction.

PEDOPHILIA

Pedophilia, or perverted love for children, is a sexual deviation which may become especially serious if little girls are involved. Except for rape, the most traumatizing experience a child can have is that of witnessing an indecent exposure by an adult. Such persons may fondle children, perhaps their own grandchildren, for erotic pleasure. A case of this type was a minister, C-58, who especially liked to work with children, and on several occasions when he had a small girl alone with him in his study, he exposed his penis with the pretext that he was giving her sex instruction.

VOYEURISM

The converse of exhibitionism is voyeurism, or the "peeping Tom." This compulsion is based on an unsatisfied curiosity in childhood. As the person develops into adolescence, he discovers a definite sexual satisfaction in peeping, and not infrequently this compulsive behavior is only expressed while the individual is under the influence of alcohol. Such individuals do not indulge in sexual assault but may develop an obsessive-compulsive reaction, which causes difficulty in their later adjustment. The voyeur doesn't hurt anybody and usually doesn't commit any other offense. C-59 was a man who indulged in peeping on his parents when he was a young boy, and who, after marriage, found it necessary to go out of the house and peep through his own bedroom window to observe his wife undressing. Observing her in the bedroom did not arouse him, but not infrequently, while peeping from outside, he would become so sexually aroused that he would masturbate.

IMPOTENCY

The causes of impotency are too numerous to list, but suffice it to say that the greatest percentage of cases are due to emotional reasons. The man may be unable to obtain or maintain an erection because of an Oedipus complex and may feel guilty about performing the sexual act, or he may be preoccupied with previous experiences.

C-60 was a man who found that whenever he attempted to have coitus with his wife the memory of a satisfactory paramour came into his mind, and he felt so guilty that he detumesced.

C-61 found he could only maintain his erection when his wife wore silk stockings, no matter if she were dressed or undressed, as he had had his first experience with coitus with a girl who was wearing silk stockings.

C-62 was so anxious in his love-making that the relationship always ended in ejaculatory praecox, or ejaculation before entering the vagina.

SATYRIASIS

Excessive sex desire is not so common in men as in women, although some wives complain that their husbands are excessive in their demands.

C-63 was a 23-year-old married man, who for the two years of his marriage had never missed having intercourse with his wife six times in each twenty-four hours, even during her menstrual periods. There was no evidence that this activity had done him any harm.

FETISHISM

Fetishism is a sexual deviation which usually begins in childhood. In this condition the person is aroused by some non-sexual object.

C-64 was 22 years of age, an ex-Navy pilot, who as a boy was asked to take up the laundry for his mother, and he found that the contact of his face against his mother's silk underclothes was extremely pleasing. As he repeated these trips for his mother, he more and more looked for the repetition of the feeling until at the beginning of adolescence, he found that it was definitely associated with sexual arousement. When he was married, he found that he could not became sexually satisfied without putting a pair of woman's panties over his head.

C-65 was a young man who had been so conditioned in his childhood that he had the compulsion to take women's lingerie off clotheslines. He would take them home, masturbate in these articles, and return them to the clotheslines.

C-66 was a 24-year-old man who had an uncontrollable desire to steal old saddle shoes. He had been conditioned by wearing his mother's shoes in play and found as adolescence came on that he was very much aroused by seeing these shoes in rummage store windows. On several occasions he broke in and indulged in a sexual orgy, using the shoes as a vaginal substitute. He also would buy shoes and take them home, using them in his masturbation.

Fetishism is not so evident in women, but there are instances where women have substituted various objects for the penis, such as a douche nozzle, bottle, bed post, etc. Smoking is frequently erotic behavior, and the cigarette, cigar, or pipe may be a symbol of the penis. On occasions a woman is erotically aroused by odors, and finds that she likes her own vaginal odor or the body odor of the man.

AUTO-EROTICISM

When auto-eroticism, onanism, or masturbation becomes a compulsive reaction, it is a sexual deviation, but when it is indulged in with heterosexual fantasy as a temporary substitute for sexual intercourse, it is not a destructive practice. All children discover the sensation of pleasure in

the sexual area by auto-eroticism, but they frequently are given a sense of guilt about playing with the genitals and are warned against the act. As a result of these threats, they often develop a castration complex. Untold psychological damage has been done by the perpetration of the superstitious teachings against masturbation.

Actually, masturbation never causes "insanity," as is so commonly threatened, although most psychotic patients openly masturbate. Also, masturbation does not cause frigidity, impotency, or loss of the power of reproduction. Actually, there are many forms of masturbation, or self-gratification, some of which are fingernail biting, thumb or tongue sucking, gourmandizing, smoking, chewing gum, compulsive drinking, gossiping, taking enemas or cathartics, etc. Yet nobody threatens that these will cause "insanity."

The only danger of masturbation is that the individual may find so much self-satisfaction from the practice that he or she may not feel it necessary to seek the help of an associate to secure the orgasm. Thus, such persons are asocial, or without sociability. They are self-satisfied and self-complete. They love themselves and so are homosexual.

C-67, a 38-year-old woman, a college graduate, with two children, had discovered that by caressing her genitals and left nipple, she reached an orgasm, but her husband never discovered this combination and so gave up his attempts to satisfy her early in their marriage. Not being able to bring her to climax, he sexually deserted her and sought the pleasure with other women. She had to retreat to self-gratification, and became generally unsocial.

C-68 was a 26-year-old married man with one child, who was not adequately satisfied by intercourse with his wife and fantasied relationship with other women but never had the courage to indulge. He had a clear-cut Oedipus complex and at an early age had learned to masturbate with the fantasy of his mother. After marriage he would bring himself to ejaculation and when he had recovered his erection, he would satisfy his wife.

ANAL EROTICISM

Where an individual finds that he does not get adequate gratification in the sexual area, he is apt to regress to the anal area. The over-emphasis placed on bowel training in early childhood, and the advertising of various cathartics have created an awareness of the anal opening. Therefore, it is not infrequent to find individuals who make a poor genital adjustment but find gratification in anal activity.

C-69 was a man in his middle twenties, whose parents had over-emphasized the importance of bowel movements, and frequently he was forced by them to have an enema when he would hold onto his bowel content. In his late teens he obtained a position as a landscape salesman and found that on numerous occasions he was intrigued by the idea of having one of his customers give him an enema as his mother had in his childhood. He would state that the doctor had told him to take an enema, but he did not know how to do so, and the kindly woman offered to help him. Thereafter he not infrequently used this technic to satisfy his anal eroticism.

C-70, a woman, who was in a panic at the time of the paper shortage during the war, filled up two clothes closets with toilet paper because of her need for anal manipulation.

C-71, a woman teacher, had been so impressed in her childhood with the need for daily bowel movements, that she discovered that she could evacuate the bowel by inserting her finger in her anus, and by so doing, she definitely got erotic pleasure. She found that she obtained more sexual pleasure with her husband if she had previously manipulated her anus before sexual intercourse.

SODOMY

In some societies, especially where contraception is prohibited, sodomy, or sexual intercourse by anus rather than

by vagina, is a common practice. Some boys in experimentation try the activity, and in congregations of men, such as the army and navy, or prison, the opportunity is offered, even though it is considered a crime. Even some husbands find more gratification from anal insertion.

C-72 was a man of 42 years of age, who had found sodomy a pleasant experience when a teen-age boy, and twenty years later after marriage, he insisted that his wife give in to his wishes.

COPROPHILIA

This is a term applied to pleasure from caressing the buttocks. When orgasm is reached by rubbing against the buttocks, this is called *frottage*, which is common in crowded conveyances, such as trains, subways and buses. Many men have the irresistible desire to pat a woman's buttocks. It is not common for women to enjoy such activity.

C-73 was a man, an editor of a magazine, who would slap the fannies of every office girl as he passed. His sexual arousement with his wife depended on the patting of her buttocks.

ORAL EROTICISM

Again, some individuals may not find their satisfaction in the anal zone and may retreat further to the oral zone.

C-74 was a woman who had a marked conflict over smoking, brought out in her analysis that when she was a girl of four, her father had inserted his penis in her mouth, and that thereafter there was great emotional conflict around the oral zone.

C-75 was a man in his thirties, who found that he was unable to gain sexual satisfaction without indulging in cunnilingus, and C-76 was a 25-year-old man who was most easily brought to the orgasm if his wife would sit on his face while he manipulated his penis. In his analysis it was

brought out that as a small child when he was severely spanked or scolded by his parents, he would run and bury his face in his grandmother's lap. When 9, while wrestling with a girl cousin, she got him down and sat on his head, and he found that it caused him to have an erection. Frequently he would arrange to wrestle with her so that the pleasure was repeated. Eventually he found a girl who, although aware of his deviation, married him. In this case the deviation was so associated with punishment that on a number of occasions while walking across the pasture, he persuaded his wife to bury his face in cow manure, with the same results.

SADISM AND MASOCHISM

Just as in every normal individual there is a balance between homosexuality and heterosexuality, between introversion and extroversion, there is also a balance between sadism and masochism. At the time of birth, the child is endowed with a preponderance of sadism or aggressiveness, which, as the child becomes socialized, may swing too much in the opposite direction, and the person develops a desire to be dominated. In the sexual sense, the sadistic individual enjoys inflicting punishment, while the masochistic person enjoys being punished.

C-77, an alcoholic, was very much in love with his wife, but he found that he was unable to gain sexual satisfaction with her unless he first punished her. He had been conditioned to this response in early childhood but was unable to vent his feelings on his wife without first getting drunk. Every Saturday after receiving his pay, he would go to a bar, get himself drunk, go home and beat up his wife, and become sexually very much aroused, and they would then have a very satisfactory sexual relationship. His compulsive drinking was based on his sadism.

C-78, a sadistic woman found that the sexual act itself could be a means of punishing her husband. Over the space

of seventeen years of marriage, for periods of three or four months at a time, she would have such a sadistic urge that she would require her husband to have intercourse with her six or eight times a day. When he declared his inability to satisfy her, she would accuse him of indulging elsewhere.

Women are more frequently found to be masochistic because they are usually dominated in their childhood. Although their intelligence may lead them to resent such dominance, their emotions find greatest satisfaction when they find themselves subdued by their lovers. One of the main difficulties in marital adjustment is to get the female partner to overtly express her sex desires. Very frequently women are referred for psychiatric consultations who assume somewhat of an attitude of martyrdom. They unconsciously indulge in various methods of aggravating their husbands so that the male may lose his temper, scold them or assault them, and then finally make love to them. These persons are definitely masochistic and frankly admit that they enjoy the sex relationship more after such episodes than when indulging without such preliminary punishment.

BESTIALITY

Bestiality is sexual relationship with an animal. The practice is common, and this indulgence is frequent amongst dog lovers.

C-79 was a minister, who was referred with a conversion reaction, which had been precipitated by his coition with a bitch.

Women have trained their lap dogs to practice cunnilingus upon them, and larger dogs have learned to copulate with their mistresses. Children may fondle the genitals of their pets.

C-80 was a teen-age boy who was arrested for killing a neighbor's rabbits. He admitted he would force his penis into the rabbits' rectums and rip them apart.

C-81, a 23-year-old man, indulged in coitus with the mares

he cared for at the race track, and C-82, another man, worked in a chicken market, and when he cut off the chickens' heads, while they were still bleeding, he would force his penis into the neck and bring himself to orgasm.

UROLAGNIA

Both men and women at times have found pleasure in urinating on their partners. Men coming home from parties, under the influence of alcohol, have been known to expose themselves when passing a woman and have attempted to urinate on her. This has happened on the subway.

C-83 was a man, a divorcé, 35 years of age, who kept a mistress. After sexual intercourse, he would urinate on his partner, and on occasions, he would urinate before withdrawing from the vagina.

KLEPTOMANIA

Stealing may be a compulsive reaction, and is usually associated with sexual gratification. This may be fetishism and may depend on special articles or special technics of stealing.

C-84 was a woman, a lawyer's wife, who could afford anything she wished, but who was not happy in her marriage. At times she would go through a department store and shoplift, always dresses.

C-85 was a 52-year-old bachelor, from a rich family. He would go to the grocery store to fill an order for his sister, and, on the way out of the store, he would pick up some item. The groceryman just entered the item on the family bill.

PYROMANIA

Many fires of incendiary origin occur each year, some with malicious intent, and some as a result of pyromania, which is a compulsive reaction. There are numerous poten-

tial "fire bugs" who chase fire engines and go to fires for the thrill. Not all end in orgasm, but this is the object of the pyromaniac.

C-86 was a 9-year-old boy who was brought for psychiatric consultation because he had set fire to two garages. When he was a young child, his mother used to bathe him before a grate fire, and at times when he would struggle on her lap, she would turn him over and smack his buttocks. He remembered he got erections as a result. Later when watching his mother burning a pile of leaves, he became aware of an erection and a thrilling sensation. He then began to experiment with matches and set several fires, which increased in magnitude.

WHAT IS NORMAL IN SEX

Normal is considered what the majority do in a specific society or culture. What is normal in one community may be abnormal in other. In sexual activity emotional maturity is indicated by heterosexuality, which requires that the partners shall consider each other's satisfaction rather than self-satisfaction. In terms of psychiatry, normal behavior, including sexual behavior, is that which is acceptable to the society and at the same time is pleasant to the individual. The difficulty comes in trying to get these two factors to meet in order not to create either frustration or guilt.

Unfortunately, there is so much taboo on the whole subject of sex that there has grown up a multitude of superstitions about sexual conduct. Psychiatry and psychoanalysis have contributed a great deal to the understanding of sexual deviates and emotionally immature individuals, so that there is a better realization of what is normal.

One of the signs of emotional immaturity is sexual deviation, and therefore, conversely, a person who is suffering from a sexual deviation should be considered as emotionally immature. Persons are not born with sexual abnormalities, although, of course, they may be born with physical abnor-

malities which may predispose them to such activity or make it difficult for them to adjust normally to adult heterosexuality. Emotionally mature individuals are well-integrated, socially minded, enjoy the company of the opposite sex, and are able to function sexually to the mutual satisfaction of the heterosexual partners. Such mature persons do not feel guilty for their sexual acts, nor does the individual satisfy the libidinal drive without consideration for the desires of the partner.

Psychiatry has shown that everybody is born with a normal libido, and that if the child is given a normal example of adult expression of love, and taught what is normal in growing up, then the child will become a mature adult. If, along the way, the individual is conditioned to an abnormal expression of the sexual desires, then the pattern will be continued, unless intensive reconditioning through psychoanalysis is instituted. Over a period of thirty years, numerous patients with sexual aberrations were treated, and a large percentage were guided from emotional immaturity to a normal adult life.

CHAPTER VII

Individual Psychotherapy

Psychotherapy in some form or other is used by every physician, and although the surgeon may use it only occasionally, the internist and family physician use it constantly, even though they may not think of it as such. They may consider psychotherapy as persuasion, readjustment, re-education, psychoanalysis, hypnosis, suggestion, or even bluff. Every physician admits the use of placebos, and although he may dismiss the case as purely functional, imaginative, hypochondriacal, neurotic, or just faking, he usually realizes that the patient wants something done for him, and so he gives a prescription, an injection, a diathermy treatment, or a bottle of medicine with the hope that the patient will have the faith that it will cure him. This faith in the physician is highly fundamental, because many patients are treated by the best trained physicians, in whom they lack confidence, and are never cured, while other patients get better under the care of a young inexperienced physician who has inspired their trust.

In many cases, the type of personality with which the psychiatrist has to deal, the stubborn nature of the condition, whether physical or mental, or the existing insuperable environmental factors make the treatment, not to mention the cure, almost impossible. In other words, the case may seem inoperable. But, if the patient's symptoms are not too fixed, and if he sincerely co-operates with the physician, then the symptoms may be removed without difficulty, and the distorted personality corrected. It is unfortunate that as a gen-

eral rule a somatic disorder is categorically diagnosed without regard to the underlying personality, and the treatment instituted is purely physical. On the other hand, if symptoms arise that are obviously psychogenic and are apt to be troublesome, the physician may refer the patient to a specialist to get him off his hands, or he may dismiss him with an uncomplimentary remark and so drive him away from qualified physicians and force him to become the support of some quack or cult. Every person should remember that properly applied psychotherapy in the form of intelligent management will likely bring about a fair degree of adjustment in the majority of cases, and a true cure is not uncommon.

If the physician finds that the symptoms that he is called to deal with are mostly emotional, it is hoped that he will not tell the patient that there is nothing wrong, or that it is all imagination. He may justly resent the one as false and the other as insulting. The fact is, that a functional symptom is just as real as an organic one. Most patients would rather have an organic ailment and be done with it than one which generally gets scant sympathy from the family and indifferent attention from the physician. To insinuate that a patient makes believe, or that his complaints are not real, is a serious psychotherapeutic error which will quickly destroy his trust and confidence. He will at once attribute this to the ignorance or lack of understanding of the physician. It is just as grave an error to pat the patient on the back and tell him that he should forget his anxiety, phobia, or compulsion.

RAPPORT

The first thing that the psychiatrist does is to develop the patient's confidence, or to establish rapport, by taking the patient, or at least his complaint, very seriously. This is accomplished by obtaining, as meticulously as possible, a medical and social history, and making a very complete and thorough physical examination. No snap diagnosis is made, and no conjectures are expressed, but if no physical ailment

is found, the patient is repeatedly assured on that score, and the normal anatomy and physiology explained to him. On the other hand, he is told that a psychological, emotional or mental condition is just as real as a physical one, and that fright, shock, anxiety, or personal conflict may cause nervousness and create definite symptoms. As an example, he may be told the sweat that comes out on the palms of the hands when a person is frightened is just as real as the sweat that comes out after exercise; or that diarrhea caused by anxiety is just as real as the diarrhea caused by a dose of salts.

The psychiatrist is careful to use language that will be understood, as most persons, and especially neurotics, have a special capacity to misinterpret what is said to them, and may even conclude that if the physician uses the word mental, he has diagnosed them as "insane." Most people are afraid of going "insane," for that means commitment to the state hospital. On the other hand, although the psychiatrist may be understandingly sympathetic, he tries never to become facetious about the illness or descend to intimacy or levity. He preserves a sense of dignity and conveys the impression that he possesses sound medical knowledge and good insight into the problems of human behavior.

TRANSFERENCE

The patient should realize that when he goes to the psychiatrist for help, he should be willing to bare his very soul if necessary. As the patient seizes on every word and action of the physician without realizing it, he or she develops a confidence that is akin to infatuation or love, and which is called transference. If the psychiatrist allows any advances, or takes any liberties, he creates an emotional situation that may lead to grave complications unless properly handled. The so-called "bedside manner" of some physicians, such as putting an arm around the waist, patting the hand, kissing the patient, or holding the hand during the conversation, makes the relationship between the patient and the doctor a

personal matter and may block any constructive psychotherapy. Personal relationships are subject to censorship, and if there is a personal feeling between the patient and the physician, the patient will be reticent about discussing matters which may affect this relationship, and which nevertheless need to be brought to light if a readjustment is to be effected. This is the reason why psychiatrists seldom allow their patients to develop a social relationship with them. On the other hand, the psychiatrist tries not to give the impression that he is a judge, set above the patient, but rather a friend who feels that what the patient has done is neither good nor bad, moral nor immoral, beautiful nor ugly, decent nor indecent, but is the result of circumstances.

The psychiatrist tries not to give the impression that he is a wizard, set apart from the world, who can cause a cure by a wave of a magic wand. Psychotherapy is not a confessional, although a confidential talk may relieve many emotional tensions. It is not a sermon, or a lecture, or "psychologizing," or moralizing, or "psyching," nor does the physician bewilder the patient with stereotyped symbols, for these may only tend to confuse and befog the problem. Above all, the psychiatrist tries to be a human individual with understanding, self-control and common sense.

AUTHORITARIAN THERAPY

It is quite obvious that if some organic defect is found, an attempt should be made to correct it if possible. Unless the organic condition is paramount, it is unwise to emphasize it, as the patient may seize upon some minor or even major physical symptom and continue in his persistent refusal to face the more important problem of getting better. Some time ago, a young man, C-87, was seen. He was very much upset because he had been emphatically told that he needed an appendectomy without delay. In fact, the physician who had seen him had told him that he could see in the fluoroscope that the appendix was in very bad condition and about to

rupture. The young man wanted to know if he could stand an operation "nervously." A thorough physical examination clearly showed that the appendix was not involved, and that the abdominal discomfort was due to intestinal indigestion. The patient was calmed down, was put on a corrective diet, and his abdominal pain cleared up without delay. Nevertheless, the seeds of uncertainty had been planted in his mind, and, in spite of psychotherapy, he persisted in shopping among the specialists until he found one who would remove the appendix for a consideration. Yet, the personality was not corrected, and this was just the first of a series of operations that the young man underwent in his attempt to justify his neurotic behavior. The object of psychotherapy, the practice of which literally begins the moment the patient crosses the threshold of the doctor's office, is to influence the problems of personality, while the detailed physical examination, in addition to giving an understanding of the organic make-up under consideration, in itself becomes a psychotherapeutic measure.

The physical examination may lead the physician to the conclusion that some operative measure, medication, hypodermic injection, exercise, gymnastics, massage, diathermy, baths, rest cure, or what not, may be needed, but suggestion will play a very important part in these procedures. Perhaps the removal of a chronic appendix, or a fibroid, may help to remove the abdominal pain. Certainly, foci of infection should be properly treated and complicating organic infections should be properly attended to, but one cannot insist too often on the fact that no personality problem was ever cured by mechanical means. Neither surgery, hypodermic or other medication, nor any form of physiotherapy, will cure a deep-seated phobia, or dispel a paralyzing obsession. Operations, glandular therapy and other medication, are many times curative and necessary, but great numbers of patients have been invalided and their neurotic symptoms made permanently inaccessible by the unwise application of these methods.

Because of high-pressure salesmanship by drug firms, and lack of understanding on the part of physicians, narcotics and hypnotics are indiscriminately dispensed or prescribed. In general, it may be said that the less medication and the more psychotherapy, the better, although with inaccessible patients often all the physician can do is to prescribe some placebo. But even so, the effectiveness of many prescriptions is in direct proportion to the amount of suggestion they embody.

There is no objection to a patient's taking a trip, for a brief sojourn at a health resort, hospital, sanatorium, or spa, but obviously, the basis for such treatment resides in the efficacy of temporary removal from the aggravating environment. Since personality problems are rooted in inner and outer conflicts, and, since the patient takes the former with him, and must return to the latter, it is highly probable that no permanent benefit will be derived from a temporary or even a prolonged sojourn away from home.

Physicians are frequently confronted with the results of pilgrimages to places where faith or miracle cures are performed, and there is no doubt that isolated and spectacular cases of religious hysteria with outspoken conversion reaction have been helped. But these cases can all be explained by the effects of suggestion, and most other cases go unhelped.

It is necessary to remember that many environmental factors are beyond the ability of either the patient or the physician to cope with, and yet it is obvious that these factors may be the cause of symptoms, although the genesis of functional symptoms is not one of logic or intelligence. The subjective, emotionally tinged unconscious, is at the back of these symptoms, and besides the need for adjusting the personality to the environment, it is well to bear in mind that mentally created symptoms are in themselves a compromise attempt at adjustment. These symptoms may have been unconsciously grafted onto the personality pattern, during childhood or later years, through the method of suggestion.

Without realizing the source of these symptoms, the physician may attempt to reason them away through persuasion. Persuasion denotes an appeal to moral sentiments. The attempt aims consciously at resolving conflicts and reintegrating the personality. Obviously, this implies an intellectualistic concept of the etiology of emotional reaction, while actually, functional symptoms are rooted in deep-seated, unconscious conflict, and no amount of reason or persuasion can dissipate them permanently. If the symptoms disappear as a result of this procedure, then suggestion should be given the credit.

It is possible that by painstaking reconditioning, symptoms may be changed, and the personality re-educated, but even with this method, suggestion plays a major role.

SUGGESTIVE THERAPY

Suggestion is the oldest and most widely used method of psychotherapy, and history is replete with examples of miraculous cures based on faith in some inanimate or animate object. It cannot be too often repeated that it is impossible to eliminate suggestion from any form of treatment. Patients wish to be relieved of their suffering. Much of medicinal and surgical treatment owes its beneficial effect to the fact that the patients want to get well. The tradition of medical and surgical procedures is so firmly established that even the most enlightened patient feels that something is lacking when treatment is carried out without "a laying on of hands."

Suggestion is associated with the unconscious mind, and as a great part of the personality is unconscious, suggestion is at work in innumerable ways at almost every moment of the day. The person is constantly receiving suggestions, many of which lie hidden and apparently lost in the unconscious mind and yet are hourly and daily shaping the personality. Perhaps these suggestions were first planted during childhood, for the human being is at no time more suggestible than during childhood. So indelibly are the impressions of

childhood stamped upon the individual that they influence all the future life for good or evil to an extent that is astounding. Psychiatrists who have attempted to re-educate a warped or twisted character are impressed constantly with the necessity for seeking the cause of the warp or twist in the half-forgotten experiences and memories of childhood.

Most people are slaves to their unconscious, the product of ancestral times and early habit patterns, and they constantly accept many facts without wonder and without any sensation of witnessing the miraculous, simply because these facts have become familiar. That shame or pleasure will cause a flow of blood to the cheeks, is so familiar a phenomenon that it causes no wonder. But if the memory of some unpleasant experience should cause an allergic-like skin reaction, the patient is in a quandary. Everybody is familiar with the fact that worrying thoughts, or fright, have the power to upset the normal peristalsis of the stomach and intestines, but they may not realize that the secretions are altered, and indigestion, constipation, diarrhea, or colitis may be caused by the emotions.

Suggestions are constantly pouring in upon the personality from the sights seen, the sounds heard, the people associated with, the work done, the books read, the sermons or lectures heard, the advertisements observed, the radio or television programs, the plays, the movies, and the concerts seen and heard. Suggestions are in fact influencing the person the whole day long, and half the night. Some of them are accepted and acted upon, while others are resisted by countersuggestion from higher authority. Many are apparently forgotten, but nevertheless are stored for all time in the unconscious mind, and perhaps continue to influence one's life momentously. There is ample evidence to show that human beings are greatly influenced by the unconscious memories which in one way or another have been transmitted from centuries of ancestors. Humans fear the dark because of the unconscious memory of prehistoric days when the fall of night meant danger.

It is thus evident that not all suggestion comes from outside. The person may suggest ideas to himself. Some people live in constant apprehension, in constant expectation of developing some bodily ailment, and so are ready at any moment to interpret trifling symptoms as having a grave significance. Should they have slight indigestion and "heart burn," they are convinced by self-suggestion that they have heart disease, and promptly suffer palpitation and breathlessness. Fortunately, in most cases such symptoms vanish with examination and assurance by the physician. In other cases, however, matters are made worse by the statement of the unscrupulous or ununderstanding physician.

If an article of diet once upsets the digestion, the patient is apt, prompted by strong self-suggestion, to feel sick or be sick every time the article is served or even mentioned. There may be an allergy, but more often an unconscious fear. If the patient is raised to believe that fresh air is the mainstay of life, he will suffer agonies in a closed room, often quite disproportionate to the atmosphere of the room. Then there are the persons prepared to go on a voyage and to be sick according to the usual custom, who become sick before the ship leaves the port. Or the woman who has been told that nausea and vomiting are expected during pregnancy, so hyperemesis gravidarum develops. Perhaps a mother or grandmother suffered from dysmenorrhea, and the girl was told she could expect to be miserable when she menstruated, for all women had the "curse," and so painful menstruation continued the tradition in the family. It might also be a family trait to be constipated, to have sick headaches, or bilious attacks.

But just as harmful suggestions may cause havoc in the human body, so helpful, pleasant suggestions may bring good feelings and help the personality to express itself in a healthier manner. Take, for example, happiness: sudden and unexpected happiness, under the various forms in which it comes, is a most potent health-giving factor. When all medical remedies have failed to give relief, happiness

has the power of making an immediate and convincing appeal to the unconscious self, and in the space of a few days, perhaps in a few minutes, the external signs of ill-health are gone, the eyes are bright, the complexion clear, digestion normal, sleeplessness vanishes, and health is restored as if by miracle. A person may have a severe headache and be very depressed, yet some good news comes, or a friend calls up for a date, and immediately all the symptoms disappear.

As a rule, treatment by suggestion is given while the patient is awake, but in carefully selected cases, it may be best employed during sleep. When suggestions are thus given, the patient is put into a state of hypnosis. In this state, conscious resistance is reduced to a minimum, and the patient is placed in a condition of heightened suggestibility. Since the conscious mind is in abeyance, suggestions are accepted without criticism by the unconscious mind and are put into action.

HYPNOTISM

It is unfortunate that hypnotism suffered the fate of other methods of therapy which have become associated with charlatanism after having been hailed with undue enthusiasm. Its scientific administration was discarded for a time, but during the last ten years its use has been resumed. Unlike psychoanalysis, it deals largely with symptoms rather than with causes, so its curative results may not be lasting. But as an adjunct to other forms of psychotherapy, hypnosis is both scientific and helpful.

Hypnosis offers an approach to many psychogenic difficulties, since it allows the physician to directly influence the Unconscious. The dissociation brought about may serve as a gateway past resistances and allow indirect approaches to problems which otherwise could not be attacked. One of the greatest obstacles in psychotherapy is to get the patient to consciously accept therapeutic suggestions. Under hyp-

nosis it is possible to implant therapeutic ideas upon the Unconscious, and to have them take effect when endless numbers of suggestions given in the waking state would be given no heed or even actively resisted. Under hypnosis the patient accepts therapeutic suggestions, and acts upon them without conscious awareness and without building up defense reactions. Also, under hypnosis former dissociated experiences and amnesic material can be rendered available for reassociation and reorganization.

The application of hypnosis requires no unusual personality or "strong will" on the part of the practitioner, nor "weak will" or feeble intellect on the part of the patient. Any person willing to learn the psychological principles involved can perform hypnosis, but like psychoanalysis or any of the specialties, the practitioner should be duly qualified. If improperly applied, hypnosis may have a very bad effect on the personality. It should be understood that the use of hypnosis is essentially a technic of persuasive suggestion similar to that utilized every day in advertising and salesmanship. Just as almost anyone may be a hypnotist, so practically anyone may be a subject. The best subjects are highly intelligent patients with good powers of concentration. There apparently is no difference between the sexes, although the younger adults or adolescents are more receptive, and extroverts are more responsive than introverts.

Like any form of psychotherapy, the results of hypnosis are individually limited, and vary in degree and variety with every subject, depending, of course, upon the innate endowment of the patient. Furthermore, all phenomena do not necessarily occur in every subject, but they do appear as a general rule. Some patients fail to show this or that particular characteristic response to hypnosis.

The mechanism of normal sleep and that of hypnosis are the same. Normal sleep, like hypnosis, is a condition of dissociation. In fact, spontaneous somnambulism produced in normal sleep can be transferred into hypnosis, and this in its turn can be terminated in normal awakening or normal

sleep. The psychiatrist is not infrequently able to influence by suggestion a normally sleeping person and transport him into hypnosis without awakening him. It is still easier, in the reverse direction, to transform hypnosis into ordinary sleep by suggestion.

Physiologists have done a great deal of work with sleep in an attempt to explain its mechanism. There is no doubt that through the process of association the vasomotor reflex centers or blood vessel changes can be stimulated. Also the reflex centers for the closure of the *orbicularis oculi* or eyelid muscles may be stimulated, and thus call forth the processes which bring about sleep. This mechanism may also be brought about by exhaustion or drug action on the cortex. Stimulation of the vasomotor centers brings about an increasing anemia of the brain, with its accompanying dullness, and sleep. When this condition progresses sufficiently, then the person loses touch with reality, and dissociation takes place. Dissociation is the deflection of the normal constellations from their usual distribution and activity.

Hypnotic suggestion is a method of invading the associated dynamics of the brain. It may be used to dissociate that which was associated, or to associate that which was not associated before. From what has been said before, it is evident that at first its chief invasion is an inhibitory one, as it dissociates the associated automatisms of the brain. The dissociated dynamics of the brain of the person under hypnosis are in a condition of receptivity or hypotaxis, as compared with the well-concentrated and associated dynamics of the psychiatrist, which press suggestions upon the patient's Unconscious by way of the special sense organs. The patient becomes plastically moldable, and is more or less irresistibly compelled to adapt himself to the physician's suggestions. The cause of this apparent subordination does not lie so much in the strength of the physician as in the patient's feeling and conviction that he is being subjected to a dynamic influence. All persons are in a condition of

hypotaxis, or dissociation during normal sleep, and confuse the dream thoughts with actual occurrences. It is for this reason that sleep is advantageous for the application of suggestion. During sleep even the most "powerful" brain or well-integrated personality obeys the suggestion of an otherwise less "powerful" brain, which is awake and in an associated condition.

The psychiatrist who uses hypnosis knows how to convince his patients that he is capable of doing so, and he is able to induce some degree of enthusiasm for this form of treatment. Thus, in order to convince others, the practitioner is convinced himself, or, failing this, possesses a dramatic personality. Everything that fills a person with enthusiasm gains control over his brain activity, easily conquers all the contrary impressions, and leads the person into receptivity. Therefore, the hypnotizability of a person increases with his enthusiasm and with his confidence, as well as with the enthusiasm and former success of the practitioner. And, conversely, it diminishes with the abatement of the enthusiasm, with mistrust, and with failures. On the other hand, many other individual factors, as mentioned before, also assist in the application of hypnosis, such as individual plasticity and intensity of the impressionability, exhaustion, sleep capability, etc.

As the patient goes into hypnotic sleep, the field of consciousness narrows and external stimuli, except those given by the practitioner, lose their significance. Ultimately, the subject loses contact with the external world except for the operator. Essentially, the "conscious" loses control, while the "unconscious" is left in rapport with the physician. This rapport, which is one of the important phenomena of hypnosis, may be defined as a state of harmony between the patient and the physician, with a dependence of the former upon the latter for motivating and guiding stimuli, and is similar to the "transference" of the psychoanalytic situation. It enables the psychiatrist to remain in full contact with his patient while to the rest of the world the hypnotized

person remains unresponsive. Nevertheless, under hypnosis this rapport may be transferred by the command of the physician to any designated person.

As has been brought out, hypnosis comes as a result of co-operation. Without full co-operation between the patient and the physician, there can be no hypnosis. Unwillingness to be hypnotized, admitted or concealed, prevents this essential co-operation, and, consequently, hypnotic sleep does not and cannot occur.

As long as the aforementioned essential principles are observed, the exact technic of inducing hypnosis is of secondary importance, but the psychiatrist will vary the details of this technic to fit the individual patient. He will not promise to hypnotize anyone until he has made a trial, but the fact that a previous hypnotist was unsuccessful is not necessarily proof that he will fail. The first attempt may produce either a slow or a rapid sleep, but afterwards sleep as a rule is rapid. Occasionally after a rapid induction the patient resists sleep subsequently, and the second induction is slow. Although the patient's co-operation, as well as his consent, is necessary at the outset, once the patient has been hypnotized, the physician will thereafter have no trouble in placing the patient under hypnotic control if proper technic is followed.

When undergoing hypnosis, the patient first begins to be drowsy and to feel sleepy; and, if he wishes, he can at this stage stop the hypnosis. This stage is known as somnolence, and it is during this stage that external stimuli are most liable to distract the patient's attention. His confidence may thus give way and he awakens himself, refusing to follow further suggestions. In spite of the fact that he can resist suggestions, he can do so only with a certain amount of difficulty.

As the patient goes deeper into hypnosis, he concentrates more and more on what the psychiatrist is saying to him, external stimuli have less and less effect, and the patient finds himself doing automatically what he is told

to do. In this stage, known as hypotaxis, the patient's eyes are closed, and he cannot open them except on the express order of the physician. In fact, nothing can be done except it is ordered, and then it must be done. The patient may describe his feelings as if his mind were separated from his body, and as if he were able to watch his body behave as if it had nothing to do with him. He may recall this dissociated experience as if he were recalling a dream.

If the patient goes into deepest hypnosis, known as somnambulism, he has given himself up completely to the psychiatrist. He will walk about and perform all kinds of actions, and there will be complete amnesia, if the practitioner orders him to forget, or if the patient himself believes he will not remember what has happened. On the other hand, many patients are apprehensive about this point, and they must be reassured that they will remember everything that happens while they are under hypnosis, if they so wish. However deep the hypnosis, the patient will remember everything if he is told to do so.

Once a patient has been successfully induced into hypnosis, he can be conditioned to become dissociated instantly and deeply on future occasions in response to any signal which has been selected. This may be a stare, a click of the fingers, a written word, or a word spoken in a whisper. It is immaterial whether the patient is alone or in a crowd, he will understand the significance of the signal. He can also be conditioned to hypnosis by television, radio, or telephone. Reassociation in response to a signal occurs equally rapidly and, once again, dissociation. Both phases can be produced without any coincident eye change or alteration of the features, so that it may be impossible for an observer, even with the closest scrutiny, to identify the patient's condition. If re-entry is not desired, the psychiatrist will counterorder it before he wakes the patient. If this preventative is not administered, any of the three stages of hypnosis may occur spontaneously and may be mistaken for absent-mindedness, spontaneous trance, the loss of identity, or

something more serious. It is possible that some of the obsessive and compulsive reactions, and the hallucinations of the psychoses may be expressed by this mental miscarriage.

As previously discussed, thought processes passing through the brain can be detected by the electroencephalograph. Also, the temperature of the body can be raised and vasomotor changes effected by passing radio currents through the body. High fidelity and ultrasonic impulses have definite effect on body tissues. Sensitized persons suffering from atomic changes in their tissues may tune their special senses or brain cells into a specific radio frequency and so become sensitive to suggestions that are known to be always passing through the air, and which are normally not detected by the human senses. These "sick" persons are in various degrees of dissociation and hypersuggestibility and so may misinterpret these stimuli. On the other hand, these "radio" suggestions planted in the brain of the patient may set up autosuggestion and so lead to obsessions or compulsions, just as suggestions given to a patient under hypnosis may direct his actions after he awakens.

A patient may pretend to be hypnotized or may deny afterwards that he was under hypnosis. After hypnosis there is no yawning, and no laughter, although the patient may laugh if he is told to behave naturally. Under hypnosis, if he is told to walk about and do things, his eyes are as a rule directed forwards, and the lids almost closed. He opens his eyes directly he is told. Some patients maintain the upward rotation of their eyes as they walk about, and, being unable to see where they are going, bump against furniture; it is notable, however, that they do not grope their way as a blind man does, and as a man might if he were pretending to be hypnotized. The persistence of rotation and eye closing may be due to the physician's insistence on, "You cannot open your eyes," during the induction. Rotation sometimes persists with the lids open, but

ceases when the patient is told to look forwards. Flickering of the lids, due to restless eyes, indicates that the patient is not under hypnosis. It might be expected that the patient at the moment of dissociation would drop something which had been put into his hands, but he does not let go unless he is told to do so. The physician's influence over the patient's conduct has no special value for differential diagnosis, for, if the patient is pretending, he will do most unexpected things if he is told. If he has been under deep hypnosis, and has not been instructed to remember what he was told while asleep, he will recall nothing, but if he has been pretending, he may repeat the conversation out of ignorance.

Although a patient may become hypnotized during the procedure, it does not follow that he is under the physician's influence, and it may be found that he will not talk to the psychiatrist, nor can he be aroused. This condition may be due to his re-entry into the influence of a previous hypnotist, a state which the procedure has suggested. Also, the patient may appear hypnotized, while actually he has just fallen asleep. But, if the patient fails to follow suggestions, it is no evidence that hypnosis has failed.

The distance of memory recall and the subject's readiness, after being awakened, spontaneously to re-enter the psychiatrist's influence may be regarded as the criterion of depth of hypnosis. Whatever the apparent depth of the hypnosis, a patient may wake spontaneously even in the face of a continued order not to do so, or if a suggestion is unconvincing or unacceptable. On waking, the patient may rub his eyes and seem dazed, but he does not yawn. If he complains of headache, it is slight and transient. Some patients appear to have no knowledge whether sleep has been artificial or natural.

Failure to put a person under hypnosis the first time is fairly common, even though success can ultimately be attained, and the reason lies with the patient rather than the psychiatrist. He may be over-interested or distracted; a

tight garment or a distended bladder is enough to prevent hypnosis at the first trial. The patient may fall asleep or may sleep naturally after first passing though a brief stage of hypnotic sleep. There may be co-operation, and yet sleep may have been forbidden by a previous hypnotist, either when the patient was awake or under hypnosis. The patient may protest that he is co-operating, whereas he is strongly resisting, and this may be due to an anxiety about the procedure in general or to a fear of what he may be caused to do or say as a result of hypnotic suggestion.

If the patient is a receptive individual, and the psychiatrist properly applies the technic, there are many symptoms which can be removed by hypnotic suggestion. Of course, hypnotic suggestion will not cause the movement of an arm or leg that is organically paralyzed, nor will it bring back the memory of an amnesia victim in whom there is extensive brain destruction. On the other hand, a long-standing psychogenic paralysis that has resisted all other forms of treatment, may immediately disappear after one hypnotic treatment. A case of amnesia may be awakened into reality. An insomnia case may sleep like a baby. But many treatments under hypnosis may be necessary to remove a single symptom. In cases of obvious organic pain, such as childbirth, amputation or other operation, the patient may be able to go through the ordeal without flinching, without anesthetic, and the administration of an anesthetic will be helped if hypnotic suggestion is used.

PSYCHOANALYSIS

The term psychoanalysis is commonplace, but very few people really understand this type of psychotherapy. Much has been written, and very much more said about this subject since Freud delivered his first lectures on this topic in 1895. One thing is certain, and that is that psychoanalysis in the last fifty years has revolutionized psychiatry. Although there are still psychiatrists who do not practice the psychoanalytic technic, there are few physicians today who

do not call on the discoveries of the psychoanalysts to explain human behavior and psychosomatic symptoms.

Many persons, aside from psychiatrists, attempt to practice psychoanalysis, without realizing that it, like hypnosis, is a dangerous scientific technic that may disturb rather than stabilize a personality if improperly applied. Might as well have a hospital orderly perform a major surgical operation, or a first year medical student make a differential diagnosis. To be a psychoanalyst, the physician should be a qualified psychiatrist trained in the psychoanalytic technic and analyzed himself.

Psychoanalysis is not a panacea for all mental ills. It is much less and yet much more than that. It does not attempt to change the entire personality, but to give insight into the emotional or mental abnormalities which disable the individual. Of three thousand patients referred for psychiatric attention, only twenty-four per cent were found suitable for psychoanalysis, while the balance needed other forms of therapy. On the other hand, psychoanalytic understanding, if widely disseminated and taken in time, could probably prevent every mental or emotional disturbance which is not the result of organic deterioration. It is evident that psychogenic illness, or that due to unconscious causes, can be prevented. The backbone of mental hygiene is psychoanalysis.

Psychoanalysis is too accurate a scientific instrument to be mastered in one day. It requires close application rather than flights of fancy, a painstaking study of all details of the patient's life history rather than broad and facile generalization. A thorough-going character analysis may take years, and the patient may be closeted with his psychiatrist for three hundred hours or more. Yet, by using the psychoanalytic process, the adequately trained psychiatrist may guide a patient through a therapeutic analysis in sixty to a hundred hours, seeing him two or three hours a week. Many patients can be helped to a satisfactory adjustment by such a shortened technic.

Socrates in 400 B.C. was probably the first thinker to

realize the importance of the Unconscious, but Breuer in 1880 was the first psychiatrist to tie up the Unconscious with physical symptoms. He tried to remove hysterical symptoms through hypnotism, but found that he got better results if he got the patient to talk while under hypnosis. Breuer did not realize the importance of his discovery until Freud, who had been studying under Charcot, formulated his theory of the Unconscious. Freud continued to work with Breuer, and together they treated patients with "mental catharsis." Finally, Freud published the results of his experiments in 1893, and from this beginning has come what we know today as psychoanalysis, which has been added to by Jung, Adler, Stekel, Jones, Jelliffe, Alexander, White, and others. Psychoanalysis was not introduced to America until the autumn of 1909 and really did not get a foothold here until after World War I. Since World War II, there has been an increasing demand for this form of treatment, and many training centers have been established to meet this demand for properly trained practitioners.

As has been pointed out before, psychoanalysis is not the only method of treatment. Every method has its advantages, and it is well to remember that not every patient lends himself to psychoanalysis. Most psychiatrists lack the special technical skill, training, and personality to use this technic, and the method is so individualistic and time-consuming, that it cannot very effectively be employed in the great majority of cases. Perhaps the first criterion for the use of psychoanalysis is to gain insight into one's own character before trying to unravel the patient's problems. This means that the psychiatrist should undergo an analysis before attempting to analyze someone else. One thing is certain: individuals cannot learn to practice psychoanalysis from books and lectures alone. Above all, the psychoanalyst should have good sense, native understanding, and ethical conduct.

There are psychiatrists who are apparently well-trained in the technic of psychoanalysis, but they are slaves to

theory, and the technic masters them, and they can see nothing beyond the horizon of sexuality. Also, in every large city there are persons who call themselves clinical psychologists. These persons are lay practitioners, not physicians. They have been more or less trained in the technic, and may even have a Ph.D. degree, but they have no understanding of the physical side of the patient and so can hardly be expected to know whether or not the patient has an organic illness. The human personality is too complex to be handled by psychology alone.

To lend himself to psychoanalytic treatment, the patient must be intelligent, with an I.Q. of 120 or more, and sufficiently educated to understand the method and purpose of analysis. It is preferable that he have at least a high school education, and that he be between the ages of twenty and forty. He must want to get well, and perhaps be prepared to change his whole environment and outlook on life. In any case, psychoanalysis is expensive in time, energy, and money, for the analytic technic requires at least an hour daily, two to five times a week, and several months may have to be spent before any headway can be noted. The treatment may last a year or more before the problem is adequately resolved.

Whether the patient sits in an easy chair or lies on a couch, or even walks about the room, is immaterial. The important thing is that he shall be at ease. The reason why the couch is used in psychoanalysis is that most persons can relax better lying down and can let their minds associate with the past and recall memories better in this position. Also, lying down they can close their eyes if they wish, and they don't have to look at the analyst. The eye to eye contact is apt to keep the patient from saying things that he may feel ashamed of, and he may watch the physician's face for expressions of disapproval or amusement. If the physician smiles at what the patient feels is serious, he may unconsciously build up a great deal of resistance and hesitate to go into the matter any further. Unless this

resistance can be overcome, progress in the treatment will be stopped.

The patient needs to feel free to express his or her emotions as they come to the surface. Perhaps it will be anger, mirth, fear, or affection. All his life the patient may have been afraid to let himself go; at times he may have felt like crying, but he was trained to hold back his tears and was repeatedly told that crying was acting like a baby, now he can cry; he has wanted to laugh at amusing situations, but he has been taught not to laugh at other people's discomfitures, or at risqué stories, but now he can laugh; he has been told, or he has been shown by the example of his parents that it is wrong to express affection, to kiss or embrace, to say that he loves, but now he can express this emotion if he will. The psychiatrist is a vessel of expression, the means towards releasing tension, and a guide to the clearer understanding of these emotional feelings, so that the patient feels neither frustration nor guilt.

As the analysis begins, the physician requests the patient to tell him the story of his life, beginning with what he has heard about his ancestors and parents, his birth and first years of his life. He will begin to remember incidents in the second or third years of his life, although on occasion reinforced memory of birth or the first two years of life may be recalled. Then, systematically, each year of life is reviewed; illnesses, accidents, onset of puberty, school, love life, and so on. If the patient will spend about two hours alone for each hour spent with the psychiatrist, and record in outline his autobiography, the analysis will be expedited. Of course, these recordings should not be allowed to lie around the house where members of the family or other curious eyes can read them. Each session with himself, the patient should seal in an envelope, and carry with him at all times until delivered to the psychiatrist, or mailed to him. The patient obviously should not sign these papers, nor use family names when writing about incidents.

A good practice during an analysis is for the patient to carry with him a small notebook, in which he can record

memories or thoughts, that he wishes later to relate to the psychiatrist. This notebook should be placed by his bed when he retires, so that if he awakens with a dream, he can write it down. In the morning, before he does anything else, the patient should try to catch the dreams of the night. Even going to the bathroom may cause the patient to repress the dream memories. In writing the dream, as much detail as possible should be recaptured.

From the dream material, the psychiatrist will select words or phrases, which he will tell the patient in relaxation, and to which the patient will associate. These associations will reveal the true meaning of the dream and may cause the recall of significant memories. In other words, the Unconscious uses the dream as a way of bringing into awareness what it wishes to reveal.

In a few words, the object of the physician in analyzing a patient is to direct the patient in the analysis of himself, and to thus make him aware of the significance of unconscious impulses. By such direction, he gains insight into the meaning of the symptoms of which he wishes to be rid. The physician does not tell the patient what to do or say, nor does he lay down any rules, except possibly a few general ones. After all the unconscious material has bubbled over, and the patient's mind has literally undergone a catharsis, then the physician leads his patient into a synthesis and reintegration of his personality.

If the patient has been successfully analyzed, he is freed from unconscious conflict, and is capable of making an adjustment to difficult situations, or of at least meeting them in an objective way.

But not all analyses end in this theoretically ideal manner, because the character and personality may be too ingrained to permit a radical transformation. If a patient does not show definite progress for the better within six months, or give promise of gaining insight within a year, the analysis should be discontinued. There is nothing to be gained by continued analysis without progress.

The psychoanalytic technic has been frequently changed

within past years, and there is no indication that it has yet become stabilized. The Freudian psychoanalysts are inclined to claim that no further supervision or guidance is necessary after the completion of an analysis, while the Jungian psychoanalysts state that the analysis is never completed, and that there are no limits to personality development. It is obvious to every person that no one ever attains such a degree of excellence that no further aid from others is necessary. A sickness may be ameliorated or cured, but there is no telling when there will be a "re-infection" or relapse. Although psychoanalysis has contributed more to our knowledge of personality than any other method of investigation, as a form of psychotherapy, it is still in an experimental stage. Unwittingly, even before the announcements of Freud in 1895, physicians made practical application of the principles of psychoanalysis, and they undoubtedly will continue to do so as far as their experience and judgment will permit.

One thing is certain, no matter what school of psychoanalysis is followed, the success of the treatment depends on the transference. The patient must have confidence in the psychiatrist, must feel that the physician knows what he is doing, and must be able to establish rapport with the physician so that he can talk freely and express his feelings without hesitancy. If the patient feels that he has to be on guard and censor his comments and answers, then progress towards a cure will be slow.

Since all persons are more or less neurotic, they may need help in reaching an adult emotional adjustment. Children adapt themselves to psychoanalytic treatment, but unless the patient is in a position to be weaned from his family, he is not a good subject, primarily because of interference by parents. Persons over forty are so set in their personality patterns that they also are usually not good patients, and shorter technics of psychotherapy are used. Necessarily, because psychoanalysis is time-consuming, it is relatively expensive, as the charge has to be on an hourly

basis. On the other hand, when compared to the expenses incurred in major operations or chronic illnesses, the total expense for a therapeutic analysis is certainly not out of line.

The question is frequently asked whether or not psychoanalysis is a successful technic. After thirty years of using this method of treatment, this author can say, categorically, and in all honesty, that the disturbed, immature personality can be guided into a healthy mature existence, where the individual can enjoy a balanced life of happiness and efficiency, free from psychosomatic symptoms.

BIBLIOTHERAPY

Numerous books on psychiatry, mental hygiene, and personal adjustment have been written over the years. Some of them have been helpful. Others have undoubtedly been harmful. The printed word has an uncanny way of being accepted as authoritative, and many patients are impressed by what they read, so that the effects of books and articles on human behavior cannot be discounted.

Reading lists have been prepared by mental hygiene organizations, and not infrequently psychiatrists recommend that patients read certain books in order to expedite psychotherapy. In cases under analysis, it is generally inadvisable for the individual to read any of these books, as there may be some confusion between the statements made in the books, and those made by the analyst. After the completion of the analysis, reading one or another of the accepted texts may be helpful in correlating the thoughts that have been brought into consciousness.

CHAPTER VIII

Group Psychotherapy

Although group psychotherapy is considered as being a recent technic in the armamentarium of the psychiatrist, it actually is as ancient as the practice of medicine itself. Physicians have always discussed with individuals in groups the problems of public health, and have attempted to educate these individuals into a better understanding of their function. Since there is a definite shortage of psychiatrists, and individual psychiatric treatment is expensive, it is obvious that the individual treatment of patients will barely scratch the surface of the problem. Also a technic should be used that will reach not only the patient himself, but others in his environment. Consequently, during the past thirty years, group psychotherapy in various modifications has been used. It is effective in helping groups of children to release their feelings, groups of parents to gain insight into child guidance, and groups of college students to obtain understanding of their personality problems. In working with prisoners, there is not time for individual therapy. During World War II the case-load of the psychiatrist was so heavy that very little time could be devoted to individual therapy, and the greatest majority of the patients had to be handled in groups. In the private practice of psychiatry, group psychotherapy has been used to facilitate the readjustment of the patient, and to shorten the time necessarily spent in individual sessions.

THE AUTHORITARIAN METHOD

Group therapy may be conducted in sessions of two hours each, the first hour being taken up with a formal discussion of the mechanisms that go into personality formation, and the second hour devoted to questions from the floor, answered by the leader.

Individuals for the groups should be selected depending on the progress that they may have made in individual psychotherapy, the type of their illness, their intellectual level, as well as their sex. Some groups are made up of only men, others of only women, some just adolescents, and still others groups of couples about to be married. The most satisfactory group is that made up of ten or twelve people, men and women, having received individual therapy, or still receiving such treatment. It is found that persons who have at least graduated from high school are the most satisfactory participants. Persons of lower intelligence cannot grasp the significance of such group discussions and will not hold themselves to the confidence required.

As to the diagnoses of the individuals, the well-developed psychotics are not satisfactory patients for this type of therapy, although persons convalescing from a manic-depressive reaction are responsive, and a few mild schizophrenic individuals may be helped. The most satisfactory persons are those suffering from the psychoneuroses, in the age groups between twenty and forty. Children do not seem to fit well into two-hour sessions and are better taken care of in shorter sessions.

In conducting these groups, an attempt is made to integrate the sessions, the object being to help the persons attending the session to get a clear understanding of the basis of personality formation. In the first session it is brought out that the individual has to be considered as a total personality, and that personality is not predetermined

by heredity, but that it is conditioned by the environment. By diagrams and charts, it is shown that there are physical, psychological, social and emotional factors in personality formation, and a survey of these factors is gone into in detail. In the second session, the physical basis of personality is discussed, in which the construction of the brain, the nervous system, the circulatory system, and the endocrine system are closely interrelated. In the third session, the psychosexual development of the individual is gone into in detail, and it is brought out that the pain-pleasure principle is important in human behavior. The fourth session deals with the social adjustment of the individual, taking into account the socially acceptable and unacceptable factors, as well as the pleasant and unpleasant reactions to life's situations. The following sessions are taken up with the discussion of the various mechanisms found in human behavior, and how the person can make a readjustment to life's situations. Every problem is discussed as it is brought up by members of the group.

As previously stated, the object of these sessions is to try to correlate the work that has previously been done by the individuals in private sessions, and to help the other members of the group to gain some insight into the problems associated with personality adjustment. An attempt is made to lead the group into free discussion of the various problems brought up in the previous hour. Case histories are given to illustrate the various points. These are given in the light of the known histories of the patients present, although none of the case histories of those present are used, unless the individual members bring up their own stories. It is usually found difficult to get the patients to take part in the discussions during the first session, although by the second session they realize that they are not being singled out and can express themselves without fear of incrimination. The more freely they discuss their reactions to the problems brought up, the more at ease they become in the group.

These authoritarian groups are usually conducted for six sessions, and the members are requested to attend all sessions in order to get the continuity of thought.

THE ANALYTIC GROUP

Persons for these group sessions are selected in the same manner as above, but the sessions are conducted as a psychoanalytic technic. The members of this type of group are each sworn to absolute secrecy and sign such a pledge. They are then urged to discuss their individual problems with the group, with the assurance that their confidences will not be abused. The psychiatrist moderates and guides the discussion so that it is carried out in a constructive manner.

If a member of the group becomes unduly anxious, he is reassured by individual treatment. Thus, the patient is fortified against any destructive effect from misunderstanding. The individual is cautioned to make a distinction between his own neurotic reaction and the true attitude of the group, and to realize that there is a possibility that his attitude is an irrelevant and irrational distortion of reality. Actually, the group association helps the individual to build up an immunity to his fear that he is being singled out as a psychiatric problem, and it can help him realize that there are many others in the community who suffer from emotional disturbances similar to his own.

The members of the group are, of course, sensitized by their particular neurotic-symptom complex so that they can more accurately discern the significant points brought out in the discussion. Under individual treatment the patient necessarily has to review the details of his own life, and there is definite danger that the analyst will sometimes get lost in the maze of material. In the group set-up the patient puts on a veneer of protection and quite frequently presents a type of personality much different from that seen in private. The group also helps the patients to realize that

normal behavior requires an adjustment to other individuals.

Some patients outrightly refuse to attend the group because of their basic anti-social attitude. Other patients show their resistance by the seats that they take in the assembly room. They seem willing and even eager to allow others to take part in the discussion and not infrequently later in private session will malign these individuals, thus bringing out important factors in their own personality. This type of voyeurism is certainly significant self-exposure. If the patient can be led into taking a legitimate part in the discussion of the group, he will be helped to a more normal relationship.

Since sexual conflict is such an important part of most neurotic behavior, the sexual factors in individual development are bound to be brought out. The majority of individuals discuss sexual material with reluctance, especially in the group setting, as sexual discussions are usually prohibited in the original family setting. Unless the patient frees his own sexuality, he obviously is unable to make an adequate recovery. Once the initial resistance has been broken down, there is little difficulty in getting the patients to discuss such fundamental matters. It is important to note that confession has a catalytic effect in producing similar uninhibited discussion by others. Emboldened by the revelations of others, either in questions or discussion, each member of the group sees his counterpart and has less difficulty in exposing his particular difficulty. This not only helps in the group itself, but also expedites the individual approach.

Psychiatry has come to realize the importance of difficulties in interpersonal relationships, and to realize that the distortion of these attitudes may lead to neurotic or psychotic symptoms. It is, therefore, important to help individuals to learn to live together if they are to make a normal adjustment to life. It is, of course, necessary that the individual not only have a clear understanding of his own feelings, but that he be able to interpret these feelings in relation to others in the community.

Persons with emotional illness usually suffer from severe lack of self-confidence, which hinders them from utilizing their potential assets. They gain courage to face their problems if they are given sympathetic understanding by the group. Psychotherapy, whether in individual conference, or in group session, must supply such support in accord with the patient's needs. The problem of dependency, which is so well-known in individual therapy, tends to be less troublesome in group therapy. Because of this interdependence, the patient is apt to feel that the support comes from the group rather than from the group leader. This may make it more acceptable in that no obligation to any single person is incurred, and excessive transference may thus be prevented. Also, the group sessions help the individual patient to break his transference or dependency on the psychiatrist.

Also in the group there is an opportunity to stimulate attitudes which have caused the patient trouble. Thus, the patient can become fully aware of his inappropriateness of action in his everyday life. In the group setting, competition for the psychiatrist's attention, the individual's struggle for status in the group, differences in background and outlook amongst the individual patients, transference reactions to other members of the group, and the need for social approval all afford ample opportunity for activation of certain emotional factors.

Most psychiatrists discover that the patient's perception of his relationship with other people and their expectation from him depend on past experience. The mental mechanisms of neurotic and psychotic patients are founded in the reactions that, though once appropriate, are inappropriate in the group situation. Psychotherapy tries to help these patients to correct these distortions by attempting to bring them to an awareness of this fact, and to guide them into a revision of their reactions. The patient then attempts to apply this insight to everyday living but many times runs into opposition from the environment.

Private psychotherapy is essentially an unreal situation

and is an artificial relationship. In the private psychotherapeutic sessions, the patient is expected to explore himself without reservation, while the psychiatrist tries to keep himself in the background, maintaining as far as possible a completely impersonal and permissive attitude. This sort of relationship is necessary in individual treatment, as obviously the therapist cannot take a stand on right and wrong, although in the light of all the facts, the behavior of the patient may be very unacceptable to the world at large. As a result of private sessions, the patient may be left uncertain as to how others might react, and the patient must still test his attitudes outside of the office. The group situation may, therefore, assist the individual in this transition.

The patients in a group situation find themselves in an environment that is more like society in miniature, and members of the group may represent the different types of individuals that the patient is up against in his everyday life. Obviously, the individual has been raised to surround himself with a veneer when he faces the world, while in the therapeutic group, the attempt is made to get the patient to discard this veneer and to express his feelings as they come to the surface. Thus, in these group sessions, the patients tend to express their feelings more honestly and directly than in ordinary social groups. It is, therefore, a logical thing to introduce the patient who has been under private psychotherapy into a therapeutic group situation before requiring him to completely break away from the therapist. The group environment offers both incentive and opportunity for the patient to test his attitudes with respect to social reality, and the therapist may better evaluate the patient's reaction. If he finds that he is unable to correct the inappropriate reactions in the group sessions, then additional individual sessions may be indicated.

Obviously, all the social situations that a person is going to meet cannot be re-created, and especially is this so in private practice. Since the majority of patients referred are married, and since it will be necessary for the patient

to return to his or her spouse, it is at times advisable to create a situation in which the spouse will be required to think through some of the precipitating factors in the patient's life. Interviewing the spouse privately causes apprehension on the part of the patient and a feeling that perhaps some of the confidences that have previously been brought out will be revealed to the spouse, whereas in the group situation, information of similar type can be brought to the surface without a feeling that confidence has been abused.

In a clinic situation, the patient more or less expects that the psychologist and psychiatric social worker will be aware of all the details of his case, but in the private office, the patient resents a discussion of these personal details with other members of the staff. The patient who comes to a clinic more or less accepts the revealing of his private life, just as the surgical patient in the public ward expects that he will be examined by other doctors and medical students. In private practice this, of course, is resented, and even where several physicians are in association, the individual patient does not readily accept the fact that his personal experiences will be discussed with other physicians.

When using the psychoanalytic technic, there is no limit to the number of sessions. The group carries on as long as the members wish, or as therapy dictates. The members meet once a week, and may disband when the group as a whole so decides. Individual members may resign when they feel they have obtained maximum help. New members may be invited to join the group, as long as the group does not get too large. New members are usually only added to replace those who have resigned.

PSYCHODRAMA

It is common knowledge that a person may release a great deal of feeling in witnessing a play, an athletic event, a radio or TV program, or even reading a book. How much

more will he release if he can actually take part in the action! Realizing this fact, a form of group therapy is used, known as psychodrama.

In this type of treatment, patients are selected to act out various plays, and in so doing, they are able to release much of their pent-up aggression, frustration, guilt, etc. The expression of these emotional feelings before an audience has curative effect.

In a group setting, the urge to express conflict through "acting out" is natural. Group psychotherapy, in any form, is intrinsically an "acting out," rather than a "thinking out" type of experience. Here, a patient deals with conflict by projecting it into a relationship; he lives it out with the other persons. In this manner, inner, unconscious conflict is translated into outer, conscious conflict. It is this "acting out" in relationships which enhances the discharge of emotional tension. In this setting, the psychiatrist can work with the irrational elements of conflict, not in the form of fantasy, but rather in those forms which are projected onto the social scene. The group therapist may then translate this back into the context of the patient's inner conflicts. Because of the selective nature of the group process, however, some kinds of unconscious conflict may remain totally inaccessible, and so the psychiatrist may have to continue concurrently treating the patient in private sessions.

The group situation provides a wide range of possibilities, nevertheless, for the testing of reality. In this setting, social reality is not a fixed entity, but each member of the group, and each pattern of relationship, personifies a given form of interpretation of social reality. In this sense, social reality is constantly changing, relative, and is represented by multiple interacting concepts, rather than by a single fixed interpretation. As the group continues to meet, however, there is increasing unity and stability in these interpretations of reality. Each patient tests out on the group his fear of the real world, and his fear of his own impulses. In this setting, the clash between his impulses and the standards of social reality offers a chance to expand his emotional orien-

tation to his own nature and the nature of society. Such increased understanding may develop with or without therapeutic interpretation by the psychiatrist. Patients often spontaneously offer their own interpretations. Sometimes these are uncanny in their accuracy, sometimes utterly inappropriate because of the patient's egocentricity and projections. It is the psychiatrist's task to guide these emotional cross currents toward correct understanding, but he uses interpretation sparingly, and only when the emotional situation in the group becomes confused.

These sessions offer a broad opportunity for growth of insight, modification of social standards and values, and the development of healthier patterns of social adaptation. Of particular importance in a group is a growth of confidence in dealing with people, and a basic increase in self-esteem.

PLAY THERAPY

Along the same line as psychodrama, are the games that are played in high school, college, and later life. They release aggression and cultivate sociability and sportsmanship. Many persons attend prize fights and wrestling matches to vent their aggressiveness. Even watching a baseball or football game may have therapeutic value.

Disturbed youngsters can release much of their destructive feeling by puppet shows, finger painting and clay modelling. Playing soldiers, cowboys and Indians, cops and robbers, has the same results but needs to be kept under some supervision. Unfortunately, crime movies, TV and radio programs, and crime comic books may overstimulate the young mind, and, without adequate method for release, the stimulated child may be led into delinquency.

OCCUPATIONAL THERAPY

In 1810 Dr. Benjamin Rush, one of the first American psychiatrists, recommended to the Board of the Pennsylvania Hospital that "daily work, exercise and amusements

be provided, and these would act beneficially upon bodies and minds simultaneously."

World War I gave a tremendous impetus to occupational therapy, as, for the first time, many doctors in the military service realized the importance of the benefits to be derived from its use. It was first used extensively as rehabilitation and vocational guidance for wounded military personnel. Stimulated by the remarkable results achieved by the Armed Forces in World War II, the medical profession has become increasingly aware of the value of getting the patient up early and keeping him occupied. This is, of course, suited to the individual patient's needs, interests and talents. Any form of work, properly executed, is therapeutic.

In a restricted sense, "occupational therapy is a method of treatment for the sick or injured by means of purposeful occupation." It is, in effect, an adjunct to direct medical treatment—a "work cure."

In years gone by, the mentally ill did simple maintenance work only, but in modern occupational therapy, the treatment is directed toward the individual patient's needs, although patients usually carry on in groups. The occupation is evaluated only in terms of its effect on the individual patient treated. The primary goal is clinical rather than artistic or utilitarian. If the patient produces attractive and useful articles, well and good, but this is of secondary importance.

Occupational therapy helps to reconstruct, rebuild and re-educate the patient emotionally, physically, and socially. It arouses and develops attention, creates new interests, gives opportunity for self-expression, eases emotional stress, gives outlet for repressed aggressive energy, and exerts a normalizing influence through filling an inherent desire to be occupied. It also enables the patient to find practical and interesting hobbies which may serve as emotional outlets. Thus, occupational therapy tends to raise the morale of the patient, to develop responsibility and co-operation, as well as to give opportunity for social contacts and normal activities.

Work is constructive for the individual only as long as it encourages his personality development; otherwise, if pursued too long, it is harmful. It must be balanced with rest, exercise, and recreation. Whether work is a blessing or an ordeal can to some extent be determined by each individual, but if the person tries to make life all play, or finds all work drudgery, then he is unadjusted, immature, and sick. For him, one of the first steps back to health is the discovery that work is not all boredom and drudgery, but that it can also be pleasant.

For the patient who will never be gregarious, hobbies can give him an interest that will help him to feel independent, accomplished, and sure of the sanctity of his individuality. Although he may never join a choral group, a dramatic workship, or a ceramics class, he can be a busy and a happy person, although group activity is most to be desired and is a sign of mature behavior.

Solitary hobbies can be therapeutically beneficial as acceptable outlets for antisocial feelings, for needed isolation, for expression of resentment, and for a socially approved way of shutting one's self off from the family when there is need for solitude.

Conversely, there is need for social hobbies for certain patients after they return to their families. Although men seem to need refuge from being a member of a group all day, every day, women who are homemakers often lead a lonely or drab existence and want a hobby that gives them a point of contact with other people. A hobby which is an avenue to new friendships, and which offers an opportunity to share an experience, is of great importance therapeutically. The patient needs to learn that in his life at home, a hobby, or "a diversion of thoughts," can be informal, done for pleasure, and not followed too seriously. It can be an avocation which serves his particular social need, and offers some contrast to his regular daily life.

Occupational therapy may become a guide to vocational choice. It is often a younger patient's first experience with regular work, involving carrying through on a project, in-

creasing skill, and developing work standards. Each day he may gain a sense of achievement. Occupational therapy may thus bring the satisfaction of work and of play, of feeling useful, of being a part of a group, and also of being a unique individual. The patient is brought closer to others, and at the same time he gains a feeling of personal dignity.

It should be remembered that an occupation is therapy only when it prevents or relieves illness, or makes it more tolerable. To be helpful or medically effective, occupational therapy must be purposive, constructive, skillful, and preferably artistic. It should provide self-expression through intelligent emotional discipline. It counteracts absorption in suffering, teaches skills, creates interests, indicates the need for relaxed effort, and encourages the acceptance of frustration with a minimum of personality disturbance. Occupational therapy corrects handicaps and teaches that sickness is not an adequate excuse for prolonged idleness. By restoring confidence, it strengthens the sick ego, minimizes the sense of separation from other human beings, and helps the person to become a more mature personality.

Unfortunately, people are sometimes at a loss to know what they can do, what they would be interested in doing. They can be given vocational tests to determine their skills, their aptitudes, and their interests, and they need to be started only on activities at which they will succeed. Many avocations and hobbies, which at first sound dull, actually may prove most interesting and emotionally constructive. The following list is suggestive.

HOBBIES

Americana
Antiques
Appliqué
Archery
Art collecting
Astrology
Aviation

Badminton
Baking
Bead work
Bird watching
Block printing
Boating
Book collecting
Botany
Bowling
Butterfly collecting

Cabinet making
Card games
Ceramics (clay modelling)
Choir singing
Choral singing
Church work
Club work
Coin collecting
Cooking
Crewel work
Crocheting
Crossword puzzles
Cutwork

Dancing
Dramatics
Drawing
Driving

Electronics
Embroidery
Etching
Exploring

Farming
Fencing
Fishing

Flower arrangements
Fly tying

Gardening
Glass work
Glee club
Golfing
Gun collecting

Ham radio operator
Handicraft
Hemstitching
Hooking
Horsemanship
Hunting

Indian lore
Inlay work
Interior decorating
Inventing
Iron work

Jigsaw puzzles
Judo

Kite flying
Knitting
Knot craft

Lace making
Languages
Lathe work
Leather work

Magic
Matchbook collecting
Minerology (stones)
Models
  Boats
  Planes
  Trains
Mountain climbing
Music

Needlepoint

Orchestration

Painting (water colors or oils)
Parakeet training
Parlor games
Pets
Photography
Politics
Puzzles

Quilting

Record collecting
Reed work
Roller skating
Rug making

Scouting
Scrap books
Sculpturing
Sewing
Shell collecting
Silk screening
Silver work
Skating
Skiing
Stamps (philately)
Sunday-school work
Swimming

Target practice
Tatting
Tile craft
Trapunto
Travel

Upholstery

Ventriloquism

Weaving
Wood carving
Woodworking
Writing (story, poetry)

Xylography

Yoga

Zoology

CHAPTER IX

Physical Treatment

In order to understand the forces which tend to maintain physical equilibrium in the personality, it is necessary to integrate the findings of biochemistry, physiology and neurology with psychology and psychiatry. When a person thinks of physical treatment, he thinks of hydrotherapy, sedation, "truth serum," shock, or lobotomy. Several other therapeutic methods are being tried out at this time, but they have not yet proved their value. These are acetylcholine therapy, photoshock, intravenous ether, hystamine, radar waves, etc. As is customary in medical practice, the introduction of any new form of therapy which promises to relieve human suffering is received with enthusiasm, but a long period of clinical and experimental testing is necessary in order to evaluate it objectively. In no other branch of medicine is this perhaps more difficult than in physical treatment in psychiatry.

INSULIN SHOCK

Insulin shock or coma treatment was introduced in 1936. This is also known as hypoglycemic shock, as by the injection of insulin, the sugar in the blood is reduced so low that the patient becomes unconscious and goes into coma. This therapy may benefit many patients, provided they have not been ill for more than a year. In this treatment, very large doses of insulin are injected, with the result that when the blood sugar is lowered below the normal limit, the patient

goes into a state of shock. During this time the tissues are deprived of oxygen. After the patient has been allowed to stay in this shock condition for a certain period of time, sugar is administered, which brings the patient out of the shock condition.

After the insulin has been given, the room is darkened, made as quiet as possible, and the patient is encouraged to rest. At first the patient is quiet and drowsy, but after two or three hours, the signs of shock begin to appear. There is flushing of the face, profuse perspiration, salivation, hunger, slurred speech, confusion, apprehensive restlessness—sometimes extreme and difficult to control—a panicky demand for food, followed by coma. This type of treatment must, of course, be given in a hospital, where the patient can be kept under close observation by the doctors and nurses.

This treatment is repeated two or three times a week until the desired results are obtained. Twenty or more shock periods may be needed. The patient usually puts on weight as a result of this treatment.

SUB-COMA THERAPY

Some patients are helped by being given smaller doses of insulin than are required in the previous treatment. The patient does not go into shock and can be treated on an ambulatory basis. After the injection of the insulin, the patient feels relaxed and can go home. Such treatments may be given two or three times a week, and during an extended period of several months.

METRAZOL SHOCK

Another form of treatment which was started in 1936 is known as metrazol shock. With this treatment, a measured amount of the drug known as "metrazol" is injected into a blood vessel, causing a convulsion. Previously a pad has been placed between the patient's teeth to prevent him from

biting his tongue. The injection is given quickly, and within thirty seconds after the injection, the patient's eyelids begin to quiver, the face becomes pale, and he appears greatly frightened. Then the patient goes into a convulsion. Before going into the convulsion, the patient expresses a great fear that he is going to die. Following convulsion, the patient passes into a brief coma-like sleep, after which he is confused. He then is permitted to rest and to sleep if he desires. He is kept under constant observation, although usually after about two hours' rest he is able to resume his usual routine on the ward.

This type of treatment also should only be given in a hospital. Some patients show great improvement after three or four injections of metrazol, but if improvement is not noted after twenty treatments, further injections are not given.

ELECTROSHOCK

Electroshock (ECT) was an outgrowth of the above drug inductions of convulsive therapy. The theoretical basis for an introduction of convulsive treatment was the assumption that epilepsy and schizophrenia are antagonistic to each other. The earlier workers concluded that the two disorders rarely occur together, but further work has not proved this point. It has been observed for years that persons accidentally shocked by electricity sometimes experience convulsions, and in 1938 an Italian physician experimenting with animals found that he could pass an electric current through the head of a dog and cause a typical epileptic fit. Following this work in Europe, the electrical-convulsive treatment of mental illnesses was introduced into this country in 1940 and has since found wide use.

This method of electric shock is used to jolt a mental patient out of his dream world back into sanity. Many theories have been proposed as to how it works, but none of these has been definitely proved. The theorists are divided amongst themselves into those who claim an or-

ganic basis for the therapeutic action, and those who argue that the effect is essentially psychogenic.

There is no doubt that during the treatment the oxygen consumption of the brain drops, and the basal metabolism is reduced. This condition is supplemented by compensatory hyperactivity.

From the psychological standpoint there are theories that point out that the patient experiences a sensation of death, followed by a feeling of rebirth. Rendering the patient unconscious by means of the shock results in a loss of ego, which parallels an actual experience of death. While coming out of the treatment, there is a subsequent experience of rebirth, which reduces the patient's feelings and permits him to reappraise reality in a more favorable light and to accept it. In other words, the shock disintegrates the patient's emotional life, and during the period of recovery from the shock, the patient reintegrates himself.

In most cases there is an amnesia, which is a sign of the disintegration of the personality. The shock which creates this amnesia disintegrates the personality, and this is followed by a process of reintegration, during which factors in the makeup and background assume their proper proportions. In regaining normal memory, the patient regains normal stability.

Others feel that the fear of the shock makes the patient feel that it is necessary to avoid further exposure to the fear-invoking punitive agent of shock. This feeling leads to the appraisal and acceptance of the previously shunned reality. This is not a valid theory, as statistics indicate that many patients who display fear do not improve, while many who display no fear are aided by the shock. One thing is certain: that many patients feel that shock is punishment for their sins, a form of penance. After the expiation of those sins, the patient's conscience lightens, and he returns to a life that he was unable to accept before. This is especially true of patients who suffer feelings of depression and guilt.

If, after a careful physical examination, treatment is

determined as warranted, the procedure and application are standardized. The bladder is emptied and all restricting clothes loosened. If there are false teeth, they are removed, and then the patient lies down on a firm bed with a pillow under the small of his back. Small round electrodes are placed one on either temple, just back of and above the eyeline, and held in position by a rubber strap. A mouth guard, made of some soft, firm material, is placed between the jaws, and the doctor applies the current, which is repeated until the desired convulsion is obtained. After a convulsion is obtained, the patient emerges from the coma in about fifteen minutes in a state of deep amnesia, and may become startled and sometimes assaultive, especially if someone whom he does not recognize at this stage is near him. Some will simply look about, turn on one side and go to sleep. Others thrash about, manifesting their bewilderment and confusion by excitement, agitation, restlessness, shouting and combativeness. The patient is not restrained unless necessary, and is simply kept from harming himself. After about ten more minutes, he is sufficiently clear to recognize the physician, and to accept suggestions. During this stage, psychotherapy is used. After about thirty to sixty minutes, although he may still have amnesia, he is able to go home, accompanied by relatives. He usually feels like sleeping when he gets home and may sleep the clock around.

Nourishment is best given in a highly caloric liquid form so that the patient does not have to chew his food or make any effort to feed himself. Patients who need shock treatment are frequently dehydrated and undernourished, and taking a nourishing drink, such as an eggnog or milk shake, every three hours will expedite the recovery.

Shock machines deliver an alternating current, with a range of 200 to 1000 milliamperes, with the machine marked to deliver 0 to 140 volts at an 0.1 to 0.6 second rate. Usually 100 to 140 volts are required to set off a convulsion, with a sudden jack-knife contraction. Of 1,166 treatments given,

only three patients (0.25%) suffered spinal fractures, and only one required a cast. There were no fractures of long bones, but frequent complaint of post-treatment muscular soreness. When glissando, or gradual turning on of current, was used prior to the convulsive shock, the convulsion came on more smoothly, and the soreness and possibility of fracture was reduced. Glissando was used in 1,759 ECT treatments, and no fractures resulted. One woman of 58, in profound depression, and known to be a poor risk, died during her first shock.

Each patient for whom electric shock treatment is considered must be evaluated individually, and the advantages to be gained by a possible psychiatric recovery must be weighed against the risks imposed by existing physical disease. Absolute contraindications to convulsive therapy are aneurysm of the aorta, coronary disease, true angina pectoris, and active tuberculosis in patients with a history of recent hemorrhage. Recent fractures of bones are important contraindications, but the psychiatrist may consult with a bone specialist to decide if convulsive treatment can safely be given. Glaucoma and threatening detachment of the retina, cerebral aneurysm, brain tumor, and increased intracranial pressure, toxic goiter, acute infections, and thrombophlebitis are absolute contraindications. Convulsive treatment should be avoided if possible in peptic ulcer and intestinal diverticula. Among the relative contraindications are generalized arteriosclerosis, fixed hypertension, myocardial disease, non-active tuberculosis, diseases of the joints and bones, organic brain disease, and mild infection of any sort, but the seriousness of the physical illness and of the mental condition must always be carefully weighed against each other. The decision to use this type of treatment must, of course, be left to the psychiatrist, whose main interest is to get the patient well. Taking everything into consideration, there is relatively little risk in shock treatment.

The depressions generally required between 4 and 10 shock treatments, while the schizophrenics and conversion

hysterias required between 10 and 20 treatments. These may be given every other day. Some psychiatrists give the first four on consecutive days, and some spread the treatments out to once a week. This is, of course, determined by the type of patient treated. Mechanical restraint is not necessary with most patients and, if possible, is better not used. The schizophrenics may become excited in the 15-minute post-shock period and may be handled by prior sedation with Sodium Pentothal injected into a vein. The depressions and neuroses do better without prior sedation unless there is acute anxiety, extreme tenseness and excessive musculature. Higher voltage is necessary to set off the convulsion if sedation is used. Where the patient complains of nausea following the first shock treatment, 100 mg. of Dramamine given before the treatment will prevent this symptom.

SUB-CONVULSIVE THERAPY

As with insulin treatment, some psychiatric conditions seem to be helped by passing an electric current through the brain at such low voltage that it does not cause a convulsion. Most psychiatrists, nevertheless, feel that the convulsion is necessary in order to obtain a cure.

ELECTRONARCOSIS

If the schizophrenic does not respond to shock (ECT), then electronarcosis (ENT) may yield the desired results, but the risk is much greater. Here, up to 500 milliamperes are used and continued for minutes, instead of a fraction of a second. The current is introduced by glissando, and usually at least 200 milliamperes are needed to put the patient to sleep. Generally, ten or more treatments are needed under ENT after the prior ECT series. This technic seems to be a good substitute for insulin coma, which cannot be administered as an ambulatory procedure. Only four cases

in seven hundred and seventy patients did not respond to one or another form of electric shock treatment and were given insulin shock after commitment to a hospital. Ten required ENT.

MINIMUM STIMULUS

Since 1950, another technic has been available. This is known as Minimum Stimulus (MST), which is given by the Reiter Electrostimulator. A small amount of current, 2 to 4 volts, is passed through the mid-brain, rather than through the temporal lobes. This technic has many advantages over the higher voltage. A convulsion may be set off at 15 to 20 milliamperes, but there is less post-treatment amnesia and confusion than with ECT. There is also less danger of fracture or muscle soreness. Immediately after the convulsion, the current is turned down to 1.5 to 2.5 milliamperes, and the vital centers are rhythmically stimulated. At first it was thought best prior to treatment to give an intravenous barbiturate, but this does not appear necessary, except as indicated for ECT. This therapy was given 3,297 times, of which 403 were with prior sedation, and 2,894 without sedation. During the same period that these 3,297 MST treatments were given, ECT with glissando was given 336 times. One upper arm and three evident vertebral fractures, (0.12%), and two deaths (0.06%) resulted from these 3,230 treatments. The oldest person in this series was 87 years old, and the youngest, 9 years old.

If a muscular relaxant is necessary in electroshock treatment, there are various drugs available: curare, the drug used by savages on their poison arrows; or the purified drugs, d-tubocurarine, syncurine, or succinylcholine chloride, which has been given the trade name "Anectine." This last drug seems to be the safest to use, but they all increase the hazard to life and have to be administered with extreme caution. They may delay respiratory recovery, cause cyanosis, lower blood pressure, and add to the time re-

quired for the treatment, and to the expense to the patient. Thus, this additional technic is not indicated unless there is already a fracture, definite danger of a fracture, or unless the patient has suffered a recent coronary disease and is considered a poor risk for shock treatment.

When Anectine is used, atropine or scopolamine is administered sixty minutes before treatment. Then an intravenous barbiturate is injected, and two minutes later a carefully figured dose of Anectine is injected through the same needle. After the injection, the lungs are inflated with oxygen for a minute, and then the shock treatment is administered as before described. If the patient stops breathing, then oxygen is again administered, and artificial respiration started. Obviously, if this technic is to be used, the patient should be in a hospital. The intravenous administration of barbiturates also increases the hazard of the treatment, as it induces respiratory depression.

AVERAGE NUMBER OF ELECTROSHOCK TREATMENTS REQUIRED FOR RECOVERY

Condition	Number of Treatments
Affective reactions	11
Schizophrenic reactions	13
Cerebral arteriosclerotic psychosis	9
Senile psychosis	7
Anxiety reaction	6
Conversion reaction	5
Obsessive-compulsive reaction	4
Depressive reaction	6

Very few patients showed improvement until after the 4th treatment.

Minimum Stimulus has the advantage that in this technic the respiration and cardiac centers are stimulated, and so apnea (cessation of breathing) and circulatory embarrassment usually can be remedied. Also, this technic may be used with or without oxygen to treat suffocation or barbital poisoning. On two occasions of sleeping pill poisoning, and one of hanging, it was used with success in these suicidal attempts.

Although shock therapy is the greatest advance in psychiatric treatment since the introduction of psychoanalysis, and almost miraculous results are at times obtained from its application, certain precautions need to be observed to prevent complications. The most common complication in electroshock therapy is vertebral fractures, or fractures of the long bones, but these cannot be prevented on occasion regardless of what technics are used. Often the psychiatrist who uses no restraint is blamed for failure to protect the patient; or, if he does use restraint, then it is stated that the use of the restraint contributed to the fracture. This also applies to the use or non-use of hyperextension, or having the patient bent backwards. Fractures are unpredictable in either sex and at any age, regardless of technics used, and have happened with all the different methods of applying the electric current. No matter what technic is used, the patient does not suffer, as he does not feel the passage of current if it is properly applied. If there is a fracture, he does not feel it until he awakens. Fortunately, the vertebral fractures that do occur generally heal without difficulty and without any special orthopedic treatment. When such fractures occur, and it is thought necessary to continue giving shock, then it is desirable to continue the patient's treatment with one of the many relaxant drugs.

The American Psychiatric Association has formulated certain rules for electroshock therapy:

1. Electroshock treatment should be administered only by a qualified psychiatrist who has undergone training for several months in the technic of electroshock treatment.
2. Many kinds of equipment are on the market and may be used if they are manufactured by a reliable firm. The unit should be clearly marked with the manufacturer's name, the serial number, and type.
3. The room where the treatment is given should be equipped with a bed or table on which the patient lies during treatment. No special way of constructing beds or tables has been discovered which would in itself prevent

the occurrence of fractures. Nevertheless, most psychiatrists use a firm surface.

4. A mouth guard which allows an airway should be used. It should be made of a moderately resistant, unbreakable, substance which cannot be swallowed. A circle of firmly rolled gauze or V-pad is frequently used. The attendant should hold the jaw shut against this guard.

5. Medical supplies, such as oxygen equipment, mechanical airway and tongue forceps, and necessary respiratory and cardiac stimulants, should be available and in readiness.

6. In addition to the psychiatrist applying the treatment, at least one other person should be present who is a trained attendant experienced in assisting in the application of electroshock treatment. If women are treated, then this additional person is best a woman.

7. The patient should not receive solid food for at least two hours prior to the application of treatment.

8. Patient's shoes, dentures, and metal hairpins around the electrodes, should be removed.

9. The patient should, if possible, evacuate his bladder just before treatment. Otherwise, when he relaxes, he will wet himself.

10. Extensive movements of the arms and legs should be prevented by having an attendant hold the patient's limbs gently in place when necessary. No force or mechanical restraint should be applied. When the patient thrashes about, he should be prevented, if possible, from injuring himself.

11. A patient in good physical health may be treated on an ambulatory basis, in the psychiatrist's office, provided his mental condition permits. However, patients should be treated in a hospital if their physical condition, although not precluding the application of electroshock, will increase the hazards of treatment. The same rule applies if the individual is too excited or suicidal to be treated as an ambulatory patient. In patients who receive electroshock treatment outside of the hospital, special precaution has to

be used in giving intravenous sedation or muscle relaxing drugs.

12. The patient's family should be told of the hazards of electroshock treatment, and a written statement consenting to the treatment should be obtained from the patient if possible, or from the family. Specifically, attention should be called to the fact that fractures sometimes occur in this treatment which are unpreventable, irrespective of the skill and technic used. Further, the patient's family should be instructed that many patients undergoing electroshock develop a temporary memory impairment, and that ambulatory patients should be kept under constant surveillance during the course of treatment. If the family is not able to provide proper supervision, then the patient should be treated in a hospital. This may require court commitment.

13. An ambulatory patient receiving shock treatments should be accompanied to and from the psychiatrist's office by a responsible person and should not be allowed to drive home. If his reactions are known after ten treatments, he may come and leave the physician's office alone. The patient, if alone, however, should always remain in the physician's office until he has completely recovered from the treatment, has no evident amnesia or confusion, and can leave without any untoward effects.

14. If the patient should complain of pain or impairment of function, he should receive a physical examination to ascertain if he has suffered accidental damage, and, if indicated, an X-ray examination should be done.

MUSIC THERAPY

Music is used in association with many of the shock treatments, especially if the patient expresses an interest in music. It has been evident that with most patients the playing of symphonies and lullaby music has helped them to relax and to reintegrate themselves following the convulsion. Long-playing records without words are most acceptable.

Music is also used in conjunction with other forms of psychiatric treatment, and many patients find that they can express their moods through music. In the last chapter music in its various forms was listed as occupational or avocational therapy.

FOLLOW UP

Whenever possible, after the shock treatments are completed, each patient is followed up with psychotherapy for at least two weeks. In the hour following the administration of the current which disintegrated the personality, the patient reintegrates himself, and during this period he is especially susceptible to constructive suggestion and other forms of psychotherapy. This treatment is usually overlooked in the hospital routine because of insufficient personnel, as the therapist needs to sit by the patient during the recovery period and seize every opportunity to direct the patient's reintegration.

Most patients require at least four hours to become adequately integrated after a shock treatment, which means that the patient should not be allowed to remain alone during this period, nor should he be allowed to drive or go on a trip, as his amnesia may prevent proper decisions. Also, during the period a patient is receiving shock treatments, if there is a desire for suicide, the treatments may release the patient's aggression, and so he may make a sincere attempt to kill himself. Thus, the family should always be aware of this hazard. If there is no relapse during the two weeks following the last shock treatment, then there is every probability that the patient will not have a return of symptoms for some time. In other words, he is "cured." Several months or several years later he may again have symptoms, as he might with a physical illness, but if he immediately returns to the psychiatrist, likely a smaller number of shock treatments will be necessary to bring him back into his normal line again.

CARBON DIOXIDE THERAPY

In 1918 it was found that intravenous sodium cyanide caused stuporous psychotic patients to become mentally alert for brief periods. In 1929 it was found that inhalation of 40% CO_2 in oxygen was more effective than sodium cyanide, and caused "cerebral stimulation" in mute or catatonic patients that lasted 2 to 25 minutes. In 1946 this treatment was first used in psychoneurotics. These CO_2–O_2 inhalations were known as carbon dioxide therapy (CDT).

Exponents of this therapy state that comparison of patients receiving CDT with and without concurrent psychotherapy give an identical improvement rate of about 60%, and that only 5% of the patients became worse during CDT.

Most reports agree that CDT is physically harmless, causes no lasting unpleasant after-effects, is time-saving to both patient and therapist, simple to administer, requires little equipment, and is suitable for office or clinic use. CDT is recommended in conversion reactions, anxiety reactions, and certain personality disorders. It is ineffective in psychoses, obsessive-compulsive reactions, and hypochondriasis. Some psychiatrists have found no lasting improvement in patients treated with one hundred coma CDT treatments.

No fatalities or serious complications from CDT have been reported. Epileptiform seizures and transient decerebrate rigidity may occur if CDT is carried far beyond the state of transient coma. However, these motor manifestations do not resemble those seen with ECT and require little or no restraint.

Frequently, patients describe unpleasant sensations during CDT, including fear of suffocation, choking sensations, unpleasant dreams, severe dyspnea (difficulty in breathing), feelings of disintegration, and fear of impending death, which may cause them to stop treatment.

The contraindications to CDT are few: severe hyper-

consider a group of related factors and come to a well-thought-out conclusion. Abstract reasoning and the ability to synthesize are impaired. Ability to plan activity beyond simple habitual routine suffers. Initiative is depressed. To some degree the patient becomes an automaton.

The mortality rate from the operative procedure is about 6%, and post-operative convulsive disorders occur in about 12% of the patients. If a second lobotomy is performed, the incidence of convulsions is increased. Causes of death have been cerebral hemorrhage, abscess, meningitis, atelectasis, and pneumonia.

Prefrontal lobotomy promises return to the community of a greater number of patients with chronic mental disease who have been hospitalized for more than two years than does any other therapeutic procedure. Relapse, with full recurrence of the symptoms of the original mental illness, may occur after the operation. Although there is evidence that patients who have undergone lobotomy are more sensitive to environmental stress after the operation than before, and although most patients show evidence of emotional deficiency, this defect often is not as disturbing as the emotional illness that they had prior to the operation. On the other hand, it cannot be overlooked that once the brain tissue has been cut, it is destroyed forever, as these cells cannot be regrown.

HYDROTHERAPY

One of the earliest methods devised for the treatment of "mental patients" was known as hydrotherapy, in which continuous baths, contrast baths, needle showers, Scotch douches, massages, and wet and dry packs are used.

Many disturbed patients are helped by being placed in a pack. The patient, in light underclothes, or in the nude, is wrapped in a sheet, head to toe, with the ends of the sheet tucked around each arm and leg. Then another sheet is wrapped around the patient, round and round, and about

the whole a blanket is wrapped. The sheets can be wrung out of cold or warm water. The patient is restained but does not feel so, and, therefore, does not struggle to get free. While lying on the couch or table, wrapped up, the patient is given citrus drinks, and an ice cap or cold cloth is placed on his forehead. Frequently a very restless patient will relax and go to sleep.

After spending an hour or two in the pack, the patient is taken out of the wrappings and given a contrast needle shower, warm and then cold. It may be ended up by a Scotch douche, in which a direct, forceful stream of water is played up and down the spine from a hose across the room.

In distressed patients, gentle massage may help them to relax tired and sore muscles. This allows them to sleep and to gain much needed rest.

Many patients who are not helped by the pack method of treatment may be helped by the continuous bath. The patient is placed in a tub, which is long enough to stretch out in. A canvas hammock is hung in the tub, and on this the patient lies. Over the tub is stretched a canvas cover, which allows the patient's head to pass through and rest on a pillow. The canvas acts as a restraint. Water is continually allowed to flow in and out of the tub, and the water is kept at body temperature. The patient is allowed to remain in the bath at least an hour, or until he is relaxed.

Psychologically, the continuous bath represents a return to the mother's womb, and the patient feels secure and content. It frequently makes the patient more receptive to psychotherapy.

DRUG THERAPY

Many drugs are given, both by mouth and by injection, which may be helpful in the treatment of the psychiatric patient.

Numerous sedative and hypnotic drugs have been pro-

duced, but care has to be taken that they are fitted to the patient, and not the patient fitted to the drug. Some drugs intended to quiet the patient and put him to sleep actually may excite him. Other drugs, when given in small doses, will put the patient to sleep, but when given in larger doses, will throw him into a delirium. If a sedative drug does not help the patient within a week, there is no use in continuing it. If these persons do not become addicted to the barbiturates, they may become alcoholics or addicts of marijuana, cocaine, or one of the opium derivatives. In fact, combined abuse of alcohol and barbiturates is not uncommon.

WONDER DRUGS

During the last three or four years there has been an increased interest in the chemistry of the brain, and many "wonder" drugs have been tried. Several of these drugs have been proven effective, and great hopes have arisen that with the use of these new preparations psychiatric treatment will be facilitated, and the mental hospitals hereafter will be less crowded.

Brain stimulants, such as amphetamine or "Benzedrine" may wake up the patient or relieve a depression, but, if continued, they may become an addiction, or even cause the person to become more mentally disturbed.

Although phenobarbital, a barbiturate derivative, was found effective in controlling the convulsions of the epileptic, it also caused sleepiness, so a search was made for drugs which would control the convulsions without sleepiness. Hydantoin, with its derivatives "Dilantin" and "Tridione," is a drug of this type.

Recently brain stimulants and brain depressants have been combined. One of the barbiturates is combined with a chemical such as amphetamine, or a similar drug. Such a combination is known as "Dexamyl." In depressed cases this combination sometimes alleviates the patient's state of mind, but, unfortunately, he does not usually realize that

his emotional reaction may not be on a physical basis. Unless the underlying psychological conflict is corrected, the symptoms will continue in spite of stimulation. An everyday example of this situation is found in individuals who resort to alcohol as a "pick up." These people frequently say that they feel they have to have a drink, and, after the drink, they feel "much better." True, they may be able to carry on a cheerful conversation, and go through a boring evening without difficulty, but they wake up from the effect of the alcohol with a stronger realization than ever that the underlying problem has not been solved. In other words, these brain stimulants build you up and then let you down.

Centuries ago the native medicine men of India found that an infusion of the root *Rauwolfia serpentina* helped to control the actions of mentally disturbed patients. The *Rauwolfia serpentina* is a small, erect, glabrous shrub growing wild in India and other tropical and subtropical regions, and has a root the shape of a serpent. The name *Rauwolfia* comes from Leonhard Rauwolf, a German doctor who made a trip to Asia in 1573 to study medicinal plants.

The drug received little attention in medical literature until 1933, when Indian scientists reported its use in the treatment of high blood pressure. Although chemical investigations of *Rauwolfia* were made as early as 1880, little progress was made until 1931, when five different alkaloids were isolated. Later other alkaloids were isolated, until now between 15 and 20 different alkaloids have been derived from various *Rauwolfia* species. In 1952 the most effective crystalline alkaloid was given the name of *reserpine,* and the first brand name was "Serpasil."

Oddly, one of the last applications of reserpine to be tested by modern investigators was in the control of severe mental disease, in spite of the fact that *Rauwolfia* had been used in India for at least five centuries to treat psychoses. The Indian physicians had routinely administered a concoction made from the snake-root plant for their mentally disturbed patients, noting that it seemed more effective in those afflicted with a mania than those with depression.

Rauwolfia was the main ingredient of a secret mental-disease "cure" which was publicly advertised in Indian newspapers. Moreover, the accepted Indian name for the drug is *pagal-ka-dawa,* or "insanity remedy."

The tranquilizing effect of reserpine is useful for many conditions in which the barbiturates are commonly prescribed. The drug has been used in anxiety reactions, feeling of tension due to high blood pressure, general nervousness, irritability, emotional tension, apprehension, excitability, insomnia, and depression. The calming influence of reserpine appears to allay worries, and to bring about a feeling of relaxation and well-being, even though the basic psychological problem has not been corrected. Also, mental illnesses such as schizophrenic reactions, paranoia, and manic reactions, may be helped by reserpine. The effects of reserpine treatment are sedation, improved sociability, fewer assaultive episodes, and less need for restraint.

A synthetic chemical known as *chlorpromazine* was introduced in America under the trade name "Thorazine" in May 1954, after extensive use in Europe for about three years. It was estimated that Thorazine was administered to nearly four million patients in America during the first year. Its value has been established in the treatment of mental and emotional disturbances, alcoholism, and withdrawal symptoms from drug addiction.

The doctor increases the dose of Thorazine until the symptoms are controlled, or until the effects of the drug prove troublesome. Very large doses may have to be administered to get the desired result. In resistant illnesses, the medication may have to be continued for a considerable period. In certain mental and emotional disturbances, maximum improvement may not be seen until after several weeks of treatment. But, when the symptoms have been controlled, it is almost always possible to reduce the dosage gradually to a maintenance level.

A constant search has been and is being conducted for a chemical agent capable of helping schizophrenic reactions, but experience to date has not shown that chlorpromazine

is as effective as reserpine in these conditions. There is no evidence that these drugs alter in any way the underlying pathologic thought processes. In the psychoneuroses some beneficial results are obtained when tension is pronounced, but such cases may relapse when the drug is withdrawn. In addition, many patients may become alarmed by the dizziness and palpitations which frequently occur during the first few days of treatment with Thorazine, and either will not go on with the medication, or feel they are being made worse. However, this chemical may be useful in the early stages of treatment in extremely tense and agitated neurotic patients as a means of assisting the doctor in gaining co-operation in psychotherapy.

Thorazine does not appear to have much value in the treatment of depressive reactions. Psychotherapy with or without electroshock treatment must still be relied upon. The drug is also of no value in the treatment of the psychopathic personality.

A combination of chlorpromazine and reserpine has been found effective in severe mental disturbances, and smaller doses of each drug evidently give the desired result. But it has to be remembered that with the extensive use of any potent drug, untoward reactions, and even fatalities, are bound to result. Therefore, these drugs should never be taken except under the supervision of a doctor.

As stated before, speculation as to the cause of schizophrenic reactions has led to the use of many new drugs for the treatment of these psychoses. *Azacyclonol hydrochloride*, given the trade name of "Frenquel," is the first American synthetic drug to favorably influence the course of these dissociation illnesses. Frenquel is different from the other drugs now used to treat schizophrenic reactions. In contrast to reserpine and chlorpromazine, Frenquel shows prompt action and specifically abolishes acute hallucinatory phenomena. It also is without depressant action.

In the treatment of the neurotic patient there has been a constant search for a medicine with sedative and relaxing effect. The earlier drugs used included paraldehyde, chloral

hydrate, and the bromides. In 1903 the use of the barbiturates was a significant advance in this field, but these drugs were accompanied by the hazards of addiction, overdosage, and poisoning. While the barbiturates are still the most widely used sedatives, the antihistamines are also used for this purpose.

In recent years a drug known as *mephenesin* has been experimented with. Partial success was obtained with its use in certain anxiety states, in certain neurological and muscular disorders, and in alcoholism. The relative success of this preparation suggested the possibility of other synthetic compounds having potential relaxing qualities, although it is entirely unrelated to anything heretofore used. One of these is 2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate, which is known as "Miltown." It is an interneuronal blocking agent and muscle relaxant and has an anticonvulsant effect. It seems most effective in patients with anxiety reactions.

With all the drugs that are now available, nevertheless, it cannot be over-emphasized that drugs or drinks of themselves are not "cures" of emotional or mental problems, and their prolonged use may only aggravate the illness, rather than alleviate it. If a patient does not show some improvement from either a sedative or a stimulant within a week or two, it is better not to continue the preparation without the advice of a physician. It is well to remember that the barbiturates and the so-called "wonder" drugs and alcohol are all somewhat similar in action and, therefore, should not be used together. To take one or the other after either has taken effect only aggravates the distressing feeling that has been created. Also, just as he comes to depend on alcohol, the patient can develop a dependency on these drugs.

TREATMENT OF ALCOHOLISM

Alcoholism is a major world health problem, and many disturbed minds use it as a means of escaping from reality.

Once a person has discovered that alcohol gives him even temporary surcease from his misery, he is apt to continue it, and many methods have been used to try to combat the habit. One of the most recent is the use of "Antabuse."

The reason for using Antabuse is to create in the person an overpowering fear of the effects of alcohol. When a person takes Antabuse and then imbibes an alcoholic drink, no matter how small, he gets a very severe reaction which threatens him with death. He becomes extremely miserable. His blood pressure falls, he becomes flushed and anxious, and he has a sense of impending death. It is the fear of this reaction while taking Antabuse that keeps the patient from repeating the use of alcohol. Obviously, therefore, it has to be given under supervision, and some member of the family has to see that the patient takes the Antabuse each morning. The patient realizes, therefore, that after taking the tablet he cannot possibly take any alcohol for the next day or so. The converse is also true that a person cannot take Antabuse until the system is free of alcohol, which is usually at least twenty-four to forty-eight hours.

Like any emotional illness, alcoholism cannot be "cured" by a drug. The patient has to be given insight through psychotherapy if he is to stay away from alcohol. Once he has decided to fight the habit, he can be greatly helped by group psychotherapy, as carried out by Alcoholics Anonymous.

GLANDULAR THERAPY

As has been pointed out before, many a psychiatric patient, having a lack of glandular secretion, needs to be administered the indicated glandular preparation, and this may assist greatly in helping the patient readjust his emotional life. It is a well known fact that thyroid and sex gland extracts may relieve some of the physical symptoms and give the patient a more stable emotional reaction.

FEEDING THERAPY

Most emotionally disturbed patients are in poor nutritional balance—either too thin or too fat. Getting them in physical balance may be a big factor in getting them in emotional balance.

Perhaps it is vitamins which are needed, or again it may be an amino acid, or just food. Perhaps he needs to be fed smaller quantities more often, six times daily rather than the usual three. If the patient won't eat by himself, or won't accept spoon feeding, he may have to be tube-fed.

Recently it has been found that the amino acids, combined with the vitamins and certain minerals, will help brain metabolism. One such combination is known as "L-Glutavite."

In tube feeding, a rubber stomach tube, well lubricated with K-Y jelly, is passed down through the nose into the stomach. This should only be passed by a physician. After the tube is in the stomach, a nourishing, high caloric liquid, reinforced with vitamins, is poured into the tube, and then the tube withdrawn.

This technic is sometimes essential to life, as the patient may want to die, and starving is one way to die.

FEVER THERAPY

In the past, syphilis of the brain or "paresis" was found to be cured by fever therapy. The spirochete of syphilis cannot withstand heat, and by giving the patient malaria, he has repeated bouts of fever, which eventually kill off the infection. Even fever induced by electricity may have the same results.

With the introduction of the biotic drugs such as penicillin, the problem of syphilis is now under control, although the basic sociological problem of this age-long infection is not yet solved. The introduction of the premarital and preg-

nancy blood tests has also done much to reduce paresis as a cause for hospital commitment from about fifteen per cent to less than five per cent in one generation.

HOSPITALIZATION

In New York State about one person out of every ten sometime during his life is admitted to a psychiatric hospital, although of over three thousand patients referred during seven years in private practice, only three out of a hundred had to be treated in a hospital. These individuals could not be properly supervised at home or refused to co-operate with the psychiatrist in receiving the treatment necessary.

A patient may voluntarily admit himself to a psychiatric hospital and sign himself in, but since most patients who need hospitalization are unco-operative, they usually have to be committed or certified to the hospital by court order, so that they may be held in the hospital against their will and given treatment whether they consent or not. In such cases, a responsible member of the family requests examination of the patient by signing a specified form. Two licensed physicians then examine the patient. If these physicians think the patient needs to be treated in a hospital, they so sign the form, which is then forwarded to the county judge. He may have a hearing of the case, or the patient may demand a hearing as is his right by law, or the judge may take the responsibility and sign the commitment form. Once this form is signed by the judge, the patient may be held in the hospital as long as the hospital authorities think it is necessary, and the patient cannot go home without their consent unless a court order or habeas corpus is obtained.

If the patient is very disturbed, once he has been examined by the physicians he may be admitted to the hospital with a duplicate copy of the commitment form, while the original copy is given to the county judge, who considers the case and, after signing the form, must forward it to the

hospital within ten days. The hospital cannot legally hold the patient beyond this period unless the certification or commitment form is in hand.

The hospital may have to lock the patient in an unfurnished room to keep him from harming himself or others. At times he may be violent, and then he may be placed in a room which has padded walls so that he cannot hurt himself. Most hospitals do not now find it necessary to keep the patient in restraint, such as a straitjacket, camisole, or padded cuffs. Packs or continuous baths described before, usually will relax the patient and quiet him down. Occasionally a sedative may have to be given for a few days, either by mouth or intramuscular or intravenous injection. Electroshock may also be used for its quieting effect. Now with the "wonder" drugs these unruly patients can more easily be quieted.

In the hospitals, treatments such as shock or lobotomy will not be applied without the consent of the family. Thus, the patient may be held in the hospital for some time before specific treatment can be started.

Unfortunately, most psychiatric hospitals are overcrowded, and, therefore, patients may have to spend long hours in rooms surrounded by many disturbed patients. This may be distressing but not harmful, as the patient has to learn to face reality, even though it is unpleasant. As the patient learns to get on with his fellow patients, he is given more privileges, moved to more pleasant wards, given occupational therapy, allowed to roam about the grounds of the hospital, and finally allowed to visit his home, and then he may be discharged from the hospital. He may be continued on the rolls of the hospital for a year or more so that he may return without formalities if he has a relapse.

The trip back from the depths of despair that so many patients experience when they are committed to a hospital, may be long and tedious, but with the help of the psychiatrists, the family, and friends, the trip can be successful. A full, and happy life can be regained.

CHAPTER X

A Philosophy for Living

All normal persons go forward. They cannot stand still. If they attempt to stop nature's progress, they slip back and regress to an earlier stage of development. From the time of conception until the period of senescence, the normal personality grows and builds up, constantly adjusting to the ever-changing environment. As long as an individual keeps pace with the times, progress keeps ahead of decay, but when the struggle for advance is despaired of, and retirement and retreat are accepted, then old age and senescence set in, no matter what the age. Then, regression overshadows progress.

In the remote past, the instincts came into being. Immediately after birth, society tries to curb the instincts and forces the personality to conform. The aim of the instincts is to preserve life, to enjoy existence, to perpetuate the species, and to help the individual adjust to his environment. Human urges in general separate themselves into two groups: the life-preserving, self-satisfying instincts; and the society-adjusting, self-denying, death-demanding urges. One group acts against the other. The denial of the former leads to frustration, while ignoring the latter leads to guilt. From beginning to end the battle goes on within the personality, and society only increases the sense of guilt.

Through the ages man has tried to come to some satisfactory peace in this battle within himself, and to find both comfort and courage in his religion by creating immortality in a variety of ways. Immortality gives him a chance to

make up for his frustrations on earth. He gains hope by creating a heaven which is beautiful and desirable, as contrasted to the ugly guilt and frustration of his earthly life. This is all a reward for being good. But, on the other hand, he is threatened that not being good is a sin, which leads to a sense of guilt and to eternal suffering, which he names a hell. But when religion goes to this extreme, and deprecates life by magnifying its imperfections, it implicitly encourages morbidity and pessimism. Thus, the life-preserving and self-satisfying instincts are diminished, and the death urge gets the upper hand. Religion itself becomes an ally of death and the death wish, tending to transform man from healthy-mindedness to sick-mindedness; an escape from reality.

Some of the churches take issue with psychiatry, stating that there are gross inconsistencies between the teachings of the church and the concepts of modern psychiatry, particularly those of psychoanalysis. On the other hand, there is nothing inconsistent in the attempt of socially-minded individuals, whether in the church or in psychiatry, to help troubled minds gain a direction in their lives. Psychiatry has no battle with straight thinking and scientific reasoning, but when dogma replaces reality, then psychiatry urges the individual to think it through and to establish a workable philosophy, fitted to himself rather than to the masses. Each person must formulate a philosophy by which he may live. From the beginning men have tried to form a philosophy for others, but these attempts have sometimes caused confusion rather than stability. A philosophy to live by should be positive and constructive, not one of denial and threat.

Centuries ago, when man began to think and reason, he observed the sun rise each morning and set each evening. He heard the winds rustle through the trees and saw the clouds gather in the sky. He did not understand the scientific phenomena taking place. He observed season follow season, as the night followed the day and the day the night, and, out of all this, he drew certain conclusions. He asked

questions about all the forces of nature which surrounded him, and because he did not understand, he called these forces of nature "spirits," and he classified them as good and evil.

This early man, many thousands of years ago, did not know the difference between animate and inanimate things. To him the trees, the flowers, the rivers, the oceans, the stones, the mountains, were all alive. They each had spirits, as did the elements about him. Man at that time was beset by the spirits. The sun and the moon, and even the stars, the rain, the wind, the storms, thunder and lightning, all were visitations of the spirits, and because man did not understand these phenomena, he held them in awe and worshiped them. This was the beginning of religion in mankind. These ancient peoples, as time went by, systematized their simple religion into dogmatic rituals.

While today there are still some peoples in the world who worship these spirits, over the centuries man has passed from nature worship to idol worship. Although most people in America consider idolatry contemptuously, there are even in this country many individuals who set up idols and statues which they adore and worship, either figuratively or actually. This brings their god a little closer to them, and throughout the world there are even today many millions who set up their idols to represent their gods.

With the development of idolatry, the number of things and beings worshiped multiplied rapidly. Images were made, not only for all existing nature gods, animals and ancestors, but also for newly conceived gods, such as the gods of the various families, gods of tribes, gods presiding over boundary lines, and so on; and with the multiplication of these gods, came a multiplication of hatred and struggles between tribes, families and individuals. The thinkers of that time came to realize that at the root of all evils was loyalty to the gods, and they began to preach against it. There were attempts made to establish other religions, and from time to time individual thinkers formulated dogmas which they

felt could replace the need for idol worship. The belief in many gods gave way to the belief in one god.

Over the centuries there have been many thinkers who have attempted to formulate a dogmatic religion to satisfy the masses. Such religions are Buddhism, Jainism, Hinduism, Confucianism, Taoism, Shintoism, Zoroastrianism, Judaism, Mohammedanism, and Christianity and all its many subdivisions. In recent years there has been an attempt to try to bring a clearer understanding of these religions, and to try to unify them into a common effort. Unfortunately, there are those in the individual churches who are jealous of their specific dogmas, and, who, therefore, refuse to consider working out a common philosophy. Such persons as Saint Paul, Martin Luther, John Calvin, John Knox, John Wesley, Joseph Smith, Mary Baker Eddy, down to Father Divine, have maintained that their special dogmatic philosophy is the only correct one.

These different dogmas overlook the fact that the belief in one god should lead to the belief in the unity of the world, and this, in turn, to the belief in the unity of mankind. The believers in one god need to realize that all mankind must be regarded as one large family, different as may be the color of their skin, their dress, their speech, or the manner of their daily lives. They must realize that whatever one race does affects all other races, and whatever one nation does affects all other nations. This, of course, leads to the conclusion that whatever one person does for good or for evil affects all other people. What is good for mankind at large is good for the individual. What is bad for mankind is bad for the individual.

Unless man can live in a healthy state of mind, he obviously cannot live with those about him, for the normal individual is a social individual, and this sociability cannot be attained through hatred, but through love; not through strife, but through co-operation; not through war, but through peace. Unfortunately, the world is full of pain, confusion, and bitterness, and the world's religions and dogmas are

lined up against each other as its peoples are lined up against each other. Until such time as the religions of the world shall unite and preach peace and good will, there will be disharmony and unhappiness. Regardless of the differences between dogma and dogma, religion and religion, or creed and creed, the members of each society must come to understanding between themselves, and mankind must work out a philosophy which has basic human understanding.

On September 26, 1953, Pope Pius XII addressed his twenty-fifth encyclical letter to the Roman Catholic world and said: "There must be a return to the straight path. If the darkness of error has clouded minds, it must be dispersed immediately by the light of truth. If death has seized upon souls, life must be taken hold of eagerly and energetically." No doubt the early fathers of the Roman Catholic Church realized the strength of the death urge, for they made the seeking of death an unpardonable sin; suicide an assurance of perpetual hell-fire. This is a philosophy of fear. Perhaps in Pope Pius' words there is new hope for joyous living.

If the individual is to overcome frustrations and find personal happiness, he must first come to terms with his society. He must do this by being the sort of person and doing the sort of things that will make him an acceptable and co-operating member of his social group, whether it is his family, his school, his neighborhood, his business association, or his church. He should learn to accept his social unit, contribute to it amiably, cooperate with it as fully as he can, and, if he feels a change is necessary, he should effect it by example rather than by force. He should have respect for the opinions of others. But if he is to find personal happiness, he must also come to terms with himself, which means that he must respect his own opinion. He must learn to live with himself, not as someone to be coddled and protected, but as a person who is not afraid to attempt every adaptation and achievement that is presented.

On the other hand, he must accept his limitations, choose the course which seems best, find the reasons for his failures, and then use these reasons as lessons and as guides for more effective living. He must be willing to accept the inevitability of heartbreaks and bereavements. He should not try to think them away, but to talk them out and express his emotions. He should not bury himself with his buried hopes and disillusionments. He should be realistic, and not despair. If he is to prevent a sense of guilt, he should stop to think before he acts. He may do what he wants as long as no one is harmed by the action. Thus, there will be no frustration and no feeling of guilt.

GROWING TO MATURITY

Human personality follows a definite sequence which exhibits an unfolding and progressive development of the individual from birth to full-blown maturity, followed by later maturity, and finally involution. Science has added years to human existence, but this has not always led to emotional maturity. It may be difficult to define maturity, yet there are certain manifestations which can be accepted for practical purposes. Physical maturity can certainly be recognized. Likewise, intellectual maturity can be estimated by performance. As the individual grows to understand and respect his own uniqueness and personality, and yet respects others, as he develops the ability to accept disappointments and defeat, and as he finds satisfaction in working and in friendly associations with his fellowmen, these are signs of social balance and emotional maturity.

It is obvious that if the individual is to reach emotional maturity, then his parents, teachers, and ministers need to know as much about developing emotional adjustment as they do about teaching dogmatism. They should accept the idea that all behavior is conditioned, and that the most common needs of children are the need for love and affection, the need to belong, the need for success, and the need

for a feeling of personal worth. From the well-adjusted child comes the well-adjusted adult.

Good citizenship depends on the quality of the relationships among people. Parents and teachers often minimize the tremendous influence which they personally have on the character formation of the child. Parents and teachers must help to give children the love and affection which they need, for children develop their moral standards through imitation of adults, and, if they cannot identify themselves with adults because they feel no affection for them, then they will have difficulty in developing a moral way of life.

Adults dealing with children must help to make them feel that they are important. To be effective citizens, individuals must feel that they are capable of contributing to others, that they are worth something to themselves and to others. The adult world must find ways in which all children can experience success, whether great or small. Variations in abilities are normal, yet schools and classes are too frequently organized as though all children of a certain age level had the same intellectual capacity. Parents frequently demand more than the child can achieve.

All adults need to give attention to their own mental health and not be ashamed to admit that they need psychiatric help when such is evident. School systems, whether grade school, high school, or college, should provide psychological and psychiatric consultative services for teachers, administrators, parents and students. There should be no stigma attached to seeking such help.

The training of teachers should emphasize the relationship of good mental health to good citizenship. Teacher-training schools and educational leaders within the schools need to put more emphasis on understanding child growth and development and the significance of behavior. The home and the school should permit more opportunities for children to satisfy their fundamental needs and to work out their normal emotional disturbances. The most hopeful

period for mental hygiene is during the school years. But what is even more important, is that mental hygiene should start in the home even before the child gets to school. If the child has mentally and emotionally well-adjusted parents, then that child has a good chance to grow up to be a mature, well-rounded adult, able to face the realities of life.

Administrators, whether in school, business, club, or church, need to be more concerned about the mental health of the teachers and workers. These administrators are so often busy with their efforts to have a smooth-running organization they have little time to be real leaders of mankind.

If the years being added to human existence result in a large number of tired and worn-out citizens, then a heavy burden will be created for society. Worn-out citizens are not only a nuisance to themselves, but they may threaten the very society in which they exist. A generation ago a man of fifty was considered ready for retirement. But today there are many individuals who are young in the seventies and eighties. Yet, for too many of these people, there is no useful place in the social scheme of things, and they have lost their direction. The great gains in material power have come to mankind but have not been accompanied by gains of social balance and emotional stability.

With added years man is having more time to think. The mental processes and social behavior of individuals are now making up more of the content of psychiatric research and social science. As human behavior is becoming more amenable to alteration and adaptation in accordance with social needs, a more stable social order may be established. Yet today there is still a vast amount of unexplored territory within the human personality. Scientific methods are becoming more accurate in the realm of physics, chemistry, and biology. Now there is the promise of further understanding of the darkness within the recesses of the human mind. Nature plants in the spring and reaps in the fall. With human life the early years are preparatory to the years

of accomplishment and arrival. Social progress largely depends on the utilization of the powers of mature minds when individuals have lived long enough to acquire knowledge, experience, and understanding.

Some years ago a great psychiatrist wrote an article on the subject of "the third phase of growth." In it he summed up the attributes of emotional maturity. These were classified as independence, pride in accomplishment, the recognition of the rights of others, the ability to adapt to rejection and defeat, and an appreciation of one's social obligations as a citizen. A great deal of the tragedy and suffering in the world is due to the fact that antisocial individuals with immature minds cause much needless social unrest. In the development of mature minds lies the hope of social balance and justice.

Glossary and Index

A-, An-: prefix meaning *without,* 133

Aberration: deviation from normal, 160

Abreaction: reliving of emotional experiences, 73

Acute brain disorders: recently acquired brain disease, 100, 108

Addict: one dependent on chemical substances, 218

Addiction: emotional and physiological dependence on a chemical substance, 106, 218

Adiposogenital dystrophy: underdeveloped genitals and excessively fatty body, 24

Adjustment: state of harmony of the personality, 185

Adjustment reaction: emotional inability to get along in one's environment, 107, 135

Adler, Alfred: (1870-1937), Austrian psychiatrist, 62

Adolescence: the period between childhood and adult life, usually the early teens, 29, 45, 135

Adrenal glands: the endocrine glands above the kidneys, 28

Adrenalin: emergency hormone produced by the adrenal glands, 28

Affect: emotional feeling, 190

Affective psychosis: a severe disorder of mood or feeling, 114

Aggressive instinct: the urge to get what one wants, 34, 56

Aggressiveness: self-assertion, 131

Aggressive type. a self-assertive individual, 131

Alcoholism: a diseased condition caused by excessive use of alcoholic liquors, 100, 102, 112, 142, 222

Alienist: a psychiatrist dealing with the legal aspect of mental disorders, 139

Alpha waves. brain waves induced by electrical impulses, 78

Ambivalence: simultaneous existence of contradictory and contrasting emotions, 128

Amentia: mental deficiency, 113

Amino acid: the chief structure of proteins, 224

Amnesia: loss of memory, 110, 124, 211

Amphetamine: a chemical that stimulates the brain, 218

Anal eroticism: pleasure in manipulating the anus, 154

Anal period the second stage of childhood, 40, 154

Analytic group: psychoanalytic treatment in a group, 189