BULLETIN of the MENNINGER CLINIC

Vol. 26, No. 1 January, 1962

Contents:

Topeka
Kansas

THE BULLETIN OF THE MENNINGER CLINIC

Published by The Menninger Foundation, a nonprofit psychiatric center for research, education, treatment, and prevention.

The **Bulletin** is a bimonthly, scientific journal which publishes original articles on psychiatry, neurology, psychology, psychoanalysis, child psychiatry, and related subjects.

The annual subscription rate is $4, single copies are 75 cents. Manuscripts, orders, changes of address and books for review should be sent to the **Bulletin of the Menninger Clinic**, Box 829, Topeka, Kansas.

Second class postage paid at Lawrence, Kansas, U.S.A.

VOLUME 26, 1962

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VOLUME 26 JANUARY, 1962 NUMBER 1

ACTIVITIES OF THE MENNINGER FOUNDATION

Twenty-First Annual Meeting, 1961

Forty-two members of the Board of Trustees and Governors and more than 200 special guests attended the 21st Annual Meeting of The Menninger Foundation in Topeka October 6–8, 1961.

Major decisions approved at the meeting were the future acquisition of the Hilltop property—340 acres of land and seven major buildings which the Foundation now leases—and the adoption of a new five-year development program to raise $12 million in contributions and grants to finance operations and to acquire land and capital investments.

Dr. Joseph Satten, chairman of the Foundation's long-range planning committee, presented tentative plans for the development of Hilltop. These include the remodeling of buildings for research activities currently housed in three former residences, for a faculty-student center, and for the Adult Outpatient and Psychotherapy Services.

Of the $12 million to be raised under the new development plan, $8 million will be for operations and $4 million for land and buildings. A supplemental fund-raising committee of the Board of Governors was organized to assist with the development program.

The Board of Governors also authorized consultation with architects about plans for an outpatient office building for the Children's Service. The library in the new Southard School Building was named the Dr. Donald J. Cowling Library in honor of the longtime Board member who is president emeritus of Carleton College.

Three Governors were elected to the Board of Trustees. They are R. M. Bunten and R. C. Clevenger of Topeka and M. J. Murdock of Vancouver, Wash. All officers of the Foundation were re-elected.

A highlight of the meeting was the program presented for members of the Foundation. Students in each of the professional training programs affiliated with the Foundation were massed on the stage of the Topeka

High School Auditorium. Representatives of each of the programs spoke, as did Doctor Karl and Doctor Will, Dr. Paul Pruyser, Dr. Ronald Filippi, and two Sloan Visiting Professors, Judge David Bazelon and Dr. Maxwell Gitelson.

Among the highlights in the annual report of the activities and developments at the Foundation during the fiscal year of 1960–61 were the following:

The Menninger Clinic: There were 1,134 inquiries for hospitalization during the year, far more than the number of patients we were able to admit—266. The average daily census in the C. F. Menninger Memorial Hospital was 115 patients (the occupancy rate increased slightly to 97 per cent). The median length of stay of patients discharged was 74 days. The average daily census in the Day Hospital was 57 patients. Again this year, slightly more than one-third of the patients discharged from the Hospital continued treatment in the Day Hospital. The median length of stay of patients discharged was 164 days.

The residential treatment program for children continued to operate at its capacity, with an average daily census of 27 patients. The new Children's Hospital, opened in November, has a capacity of 50 children. The number of psychotherapy hours with children, both inpatients and outpatients, totalled 6,548 with 64 patients. There were 66 outpatient examinations for a total of 1,775 hours, and 48 consultations for a total of 73 hours.

The number of adult patients seen in psychotherapy increased slightly from 302 to 313 this year, as did the number of treatment hours, from 23,017 to 24,266. A total of 758 persons were seen for outpatient examinations or consultations, an increase of 81 over the previous year.

Over the past few years, there has been a continuing increase in the case load of neurology and neurosurgery. This year, a total of 1,691 patients was seen, compared with 1,554 the year before. The number of electroencephalograms recorded was 1,111. There were 525 consultations with city, state, and federal hospitals in Kansas.

Clinical services were provided for 527 adults and children who were charged less than it cost the Foundation to provide them. The difference between fees paid for these services and the cost to the Foundation of providing them was $167,226. Of this total, $51,547 was financed by contributions for this purpose, while the remainder came from the unrestricted contributions of Foundation members and from other clinical income.

Professional Education: Graduation ceremonies for 23 physicians who had completed training in the Menninger School of Psychiatry were held in June. Twenty of the graduates went into fields of public service, research, and education, and three are in private practice. At the beginning of the school year on July 1, 1961, 40 new Fellows were enrolled in the School. They came from 15 states and 12 foreign countries. This number brings to 735 the number of physicians who have entered the three-year psychiatric training program of The Menninger Foundation.

During the year, six persons held Alfred P. Sloan Visiting Professorships in the Menninger School of Psychiatry. They were Dr. Frederick Hacker, psychiatrist and psychoanalyst from California; Dr. Konrad Lorenz, ethologist from Bavaria; Dr. S. I. Hayakawa, semanticist from California; Dr. Jean Piaget, Swiss child psychologist; the Honorable David L. Bazelon, judge of the United States Court of Appeals for the District of Columbia; and Dr. Erwin Stengel, psychiatrist and psychoanalyst from England.

Six Fellows were enrolled in the postdoctoral training program in clinical psychology. Two were graduated in September, 1961, and four entered the program. Four social workers completed training in the postgraduate program for psychiatric social workers.

In the Religion and Psychiatry programs, three doctor Fellows enrolled in Theology and Psychiatric Theory completed their year's studies, and four clergymen completed the year-long program in Pastoral Care and Counseling.

Research: One new research project was begun during the year. Entitled: A Principle of Personality Organization, the aim of this new project is to attempt to identify an underlying psychological principle of personality that may account for individual differences in personality.

The Psychotherapy Research Project, now in its eighth year, is concerned with the systematic study of changes that take place in the patient during and after his therapy in relation to three main kinds of factors—those in the patient, those in the therapy and therapist, and those in the patient's life situation. In accord with the project design, initial studies of 42 patients entering psychotherapy were completed by 1958. Thus far 28 of these have come to the termination study point, and 23 of them to the prescribed two-year follow-up study point.

The Perceptual Learning Project which has been under way at the Foundation since 1952 was expanded recently into a more broadly conceived Program in Reality Testing. Under the new project, investigations will be

carried out not only on the perceptual learning process, but also on the means by which "realistic" contacts with the environment may best be used in learning to overcome cognitive as well as perceptual distortions and difficulties.

Social Psychiatry: A series of exploratory studies on work and mental health begun five years ago by the Division of Industrial Mental Health have culminated in the publication of a manual entitled *Interdisciplinary Research in Work and Mental Health: A Point of View and a Method.* It is the beginning step of developing a case study method applicable to industry. The manuscript of *Work and Mental Health,* a book-length report based on an extended study in the first of the five organizations, is ready for publication.

As a result of a grant received during the year, it has been possible to formally organize a Division of Law and Psychiatry. Its objectives are to learn how current psychiatric techniques can be best applied to the handling of offenders, to advance new techniques, and to train psychiatrists interested in criminology.

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The 1961 Charles Frederick Menninger Award for outstanding contributions to the theory and practice of psychoanalysis was made to Drs. Merton Gill and Margaret Brenman of Berkeley, Calif., for their joint work *Hypnosis and Related States: Psychoanalytic Studies in Regression.* Both Doctors Gill and Brenman are former Foundation staff members. The award was established by Doctor Karl and Doctor Will in honor of their father. The American Psychoanalytic Association selects the recipient of the honor.

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Word has been received from Dr. Rudolf Ekstein of the death October 12, 1961, of Dr. Hellmuth Kaiser in Los Angeles, Calif. Doctor Kaiser served as a training analyst and a member of the Education Committee for the Topeka Institute of Psychoanalysis from 1950 to 1954.

SELF-DESTRUCTIVENESS AND SELF-PRESERVATION*

ERWIN STENGEL, M.D.†

I should like to express my sincere appreciation of the great honor you have bestowed on me by inviting me to deliver the second C. F. Menninger Memorial Lecture. To be asked to lecture in this Society, which plays such an important part in this great school of psychiatry, is by itself a privilege. But to be entrusted with this particular lecture means much more. There is something special about a memorial lecture. It makes it encumbent on the speaker to enter into a kind of communion with the person whose memory is to be honored. Thus, by a process of posthumous identification, he is to bring him back into the presence and to rekindle not only his memory but also some of the influence he had on his contemporaries.

I know Dr. C. F. Menninger only from what I have read and heard about him. He was a man of many outstanding qualities, but those which impressed me most, because they are so rare today as they must have been in his lifetime, were his unremitting search for knowledge, the catholicity of his interests, his open-mindedness, and his practical idealism which found such rich fulfillment.

We can be sure that the choice of the subject for this lecture would have had his full approval. The title may sound a bit grandiose, but I shall try no more than to present some clinical observations and to discuss their significance. I shall concern myself with suicidal behavior, to the study of which Dr. Karl Menninger[1] has made substantial contributions.

Considering the ubiquity of the threat of suicide and the role it plays in the work of the clinical psychiatrist and psychoanalyst, it is surprising how few special studies about this subject exist in the psychoanalytic literature. To realize the magnitude of the problem, we need only try to imagine how profoundly our work and our lives would change if the possibility of suicide of one of our patients, our relatives and friends, and indeed of ourselves, should cease to exist. And yet, Dr. Karl Menninger's book *Man Against Himself*[1] is the only psychoanalytic monograph on this subject, and there are only a few articles on suicide, most of them in

*C. F. Menninger Memorial Lecture to the Topeka Psychoanalytic Society, May 25, 1961.

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the early psychoanalytic literature. There are, of course, good reasons for this. The psychoanalyst views suicide and attempted suicide as incidents in the continuum of his patients' behavior and as extreme manifestations of mental forces with which he concerns himself all the time. To single them out for special study would not be in keeping with this approach.

Psychoanalytically speaking, suicide is as much a way of life as a way of death, and those two functions merge into each other. This approach has been productive of new insights. But the problem is so complex that it must be viewed from many aspects and be explored with a variety of methods. Any new insight concerning suicidal behavior should be of interest to the psychoanalyst. The observations I am about to report have been made not from the psychoanalytic viewpoint, but from the viewpoint of a psychoanalyst practicing clinical psychiatry. My observations about suicidal behavior could be regarded as a feedback from clinical psychiatry into psychoanalysis, because without my psychoanalytic training I should not have been able to make them.

First I shall survey briefly the psychoanalytic literature on suicide, by which I mean the act of actually killing oneself with the conscious intent to do so, however vague this intent may be. In 1929 the *Zeitschrift für psychoanalytische Paedagogik* published a special number with a series of articles exclusively devoted to the subject of suicide. That same year Paul Federn[2] published a belated report on a discussion of suicide among school children which came from a meeting that took place under Freud's chairmanship in 1910. In that discussion, the revenge motive was stressed and the aggressive nature of suicide was pointed out. Freud was reluctant to express a definite opinion on suicide on that occasion. "We should like to know," he said, "how it could be possible to overcome the strong urge to live." He thought that one could arrive at an understanding of suicide only through the study of melancholia and of the affect of mourning. This remark foreshadowed "Mourning and Melancholia."[4]

In another paper, Federn[3] discussed suicide prophylaxis in psychoanalytic treatment. He regarded suicide as one of the risks of treatment. Neurosis, in his view, was not only a flight into illness, but also a refuge from suicide. Removal of neurotic anxiety may lead to suicidal tendencies unless the patient had strong libidinal ties. Only he whose death was wished by somebody else killed himself. Ernst Schneider[7] commented on Tom Sawyer's fantasies of death and suicide. They were viewed as reactions to libidinal frustrations. Mary Chadwick[8] also contributed an

article on suicide fantasies. She interpreted them as manifestations of a compromise between the life and the death instinct, whereby reality was modified according to the individual's wishes.

Reading these articles published 32 years ago, one notes that several authors concerned themselves with the role of interpersonal relations in the causation of suicide, while Freud,[5] since the publication of "Mourning and Melancholia," had focused attention exclusively on intrapsychic processes. The external object played a part in suicide only if it had become introjected. Bernfeld,[9] who also contributed an article to that series, summarized the state of the theory of suicide based on the studies of Freud[5] and Abraham,[10] in stating that suicide was, on the unconscious level, an act of murder directed against a hated, previously loved, object with whom the person had identified himself. It also was an act of self-punishment. One wonders in what direction psychoanalytic research into suicide would have developed, if Freud had not chosen the most severe type of depression as his starting point.

The next stage in the psychoanalytic exploration of suicide was Dr. Karl Menninger's book *Man Against Himself*,[1] which has remained the most comprehensive exposition of the various manifestations of the death instinct directed against the self and its partial neutralization by the self-preserving tendencies. In committing suicide, according to Karl Menninger, the individual kills himself, murders somebody else, and also fulfills his wish to die.

Schilder's observations on suicide[11] are worthy of note. He considered suicide as a means of forcing others to express their love in their grief reactions. Suicide, therefore, was a manifestation of the desire for love. The human mind was incapable of conceiving total extinction. Schilder did not accept the theory of the death instinct, nor did Zilboorg[12] who made important contributions to the subject. He was always stimulating and provocative, but he sometimes tended to overstate his case. He dismissed suicide statistics as totally misleading and useless, because they were incomplete and unreliable. Having condemned statistics, he proceeded to make a statistical statement of far-reaching importance, namely that suicide was at least as common among primitive societies as in urban western communities. He was, of course, right in refuting the myth of the absence of suicide in primitive societies. But he was probably wrong in going to the other extreme. The ubiquity of suicide suggested to him that it must have a positive biological function. Suicide was the only way of avoiding

natural death. It was a paradoxical self-assertion of immortality. Massermann[13] has expressed similar ideas. Schilder, Zilboorg, and Massermann tried to understand the suicidal urge and motivations through the study of suicide fantasies and of attitudes toward death. In doing so they saw suicide as an act of self-perpetuation rather than of self-destruction. It is surprising that it did not occur to them that the two motivations could coexist.

Zilboorg was the first to draw attention to the frequency with which a history of a broken home in childhood could be found in cases of suicide. This observation has since been confirmed by others and it is now assumed that early loss of or prolonged separation from the parents plays some part in the etiology of suicide proneness. However, the so-called broken home in childhood has been blamed for practically every psychological disorder. Early parental loss can hardly be regarded as a specific etiological factor in suicide proneness, but together with other factors, it might play an important part. I should like to give an example of the way in which such a hypothesis can be tested.

Every patient suffering from abnormal depression presents a suicidal risk, and every such patient wishes at times to die. But not every such patient attempts or commits suicide. Walton[14] tested the hypothesis that there was a significantly higher incidence of broken homes in the histories of depressed patients who had committed suicidal acts, than of those who had not done so. In speaking of suicidal acts, I mean suicide and attempted suicide. The relevant data were examined in 200 cases of pathological depression, and the hypothesis was confirmed. It sounds almost too good to be true and I hope that this hypothesis will be tested elsewhere. If it should be confirmed, it would be of considerable interest. This is an example of the way in which hypotheses arising from genetic psychoanalytic propositions can be tested by methods used in clinical psychiatry.

My survey of the psychoanalytic literature, though incomplete, has covered the areas of the suicide problem which have been explored by psychoanalysts. They have contributed valuable dynamic and genetic propositions concerning the etiology of suicidal acts. I am using the concept of psychoanalytic propositions proposed by Hartmann and Kris.[15] The concept of suicide being an act of aggression against an introjected love object falls into the dynamic category, while the hypothesis of the role of a broken home in childhood in the etiology of suicide proneness is a genetic proposition.

Throughout the psychoanalytic literature the problem investigated has been suicide, *i.e.*, self-injury with a fatal outcome. Karl Menninger alone speaks of incomplete, partial or focal suicides. He does not expressly include suicidal attempts among incomplete suicides, although they would fit into this category. Suicidal attempts have, in the psychoanalytic as well as in the psychiatric literature, been treated as bungled or abortive suicides. It is more or less taken for granted that what applies to suicide also applies to suicidal attempts, and the same questions have been posed concerning suicidal attempts as about suicide. Many writers even use the terms interchangeably. Now this would be permissible if people who make suicidal attempts committed suicide soon afterward and if the attempt could be regarded as the first step to suicide. But is it? In common with clinical psychiatrists, psychoanalysts have studied suicide mainly retrospectively which is in keeping with their fundamentally historical approach.

It is surprising that until recently follow-up studies of people who made suicidal attempts have not been carried out. It was quite unknown how many of those who made so-called unsuccessful suicidal attempts proceeded to suicide, and how soon after the attempt they did this. Unless we know the approximate answer to this question, we cannot make any statement about the clinical relationship between suicide and suicidal attempts. But psychologically, one may say, they are the same. It depends on what is meant by "psychologically." Suicide and attempted suicide are both aggressive acts, but otherwise they are as different from the psychological and biological point of view as a slap in the face differs from murder, both of which are also acts of aggression. There has been a tendency in psychoanalysis and in clinical psychiatry to overlook the differences.

I have carried out systematic follow-up studies[16–18] of attempted suicides, and more recently reports of similar investigations have been published, the last from the Suicide Research Center at Los Angeles. The results of these studies, which covered periods of up to 18 years after the first suicidal attempt were as follows:

The number of people who commit nonfatal suicidal acts, *i.e.*, who attempt suicide, is about seven to eight times as high as the number of those who commit fatal suicidal acts, *i.e.*, suicide.[19] This means in actual figures that if a town with 110,000 inhabitants has a suicide rate slightly above the national average, say of 14, about 15 or 16 would commit suicide

within a year on the average, and there would be 100 to 120 suicidal attempts in the same period, surely a conservative estimate.

When the two groups, the fatal and nonfatal suicide acts, were compared, they were found to differ with regard to age, sex and mental state. Suicide has been found to be relatively more frequent among men than among women, while more women than men attempt suicide. The average age of the people who attempt suicide is lower than that of the suicides. It was found that only a small minority, between one to ten per cent, had killed themselves by the end of the follow-up period which ranged from between two to eighteen years. Although this was only a small fraction of the total, the expectation of suicide among this group was much higher than in comparable groups of people who had not made suicidal attempts. This confirmed the impression that a history of a suicidal attempt implies a higher risk of suicide.

While I shall not go into the question of how those figures were arrived at, I want to say that suicidal gestures were not included and only those acts of self-damage were regarded as suicidal attempts which had been carried out with the intention of self-destruction. The first conclusion to be drawn from those follow-up studies was that people who commit suicidal acts fall into two different though overlapping groups, or populations: the ones who kill themselves, and the others who commit nonfatal suicidal acts, *i.e.*, suicidal attempts. The latter group is very much bigger than the former. Some members of the larger group enter the smaller one in the course of time. Another interesting feature confirmed the thesis of the two different though overlapping populations: only a minority of those who killed themselves had made suicidal attempts previously. In the majority of them suicide, by which I mean self-inflicted death, was their first suicidal act.

To give you an idea of the size of the groups dealt with, I should like to point out that annually in the United States the number of people alive who will kill themselves has recently been about 18,000, and that the number of people alive who have at some time in their lives made one or more suicidal attempts cannot be below one million.

These statistical findings are of considerable interest to the psychoanalyst. Clearly, suicidal attempts cannot be looked upon as nothing but abortive suicides. There is a fundamental difference between suicide and suicidal attempts. In the latter cases, life goes on as a rule, and the suicidal

act becomes a meaningful event to the person who made the attempt and to those close to him.

I have endeavored to study the psychological effects of attempted suicide on the people who committed the act, on those close to them, and on society as a whole. Let us first recall the characteristic features of the normal grief reaction: an upsurge of love for the deceased, sometimes even a denial of the loss, at least in the fantasy; a tendency to identification with the lost object resulting in the wish to join him in death; guilt feelings with self-accusations of not having loved the dead more, and not having done enough for him; regret that it is now too late for making good, and all this colored by ambivalence. When the deceased has died not by natural causes but through suicide, these reactions are much more pronounced, especially if the bereaved feels, rightly or wrongly, that he could have prevented the death. When, as frequently happens, he had had conscious death wishes against the dead person, self-accusations are all the more violent. The reactions of society as a whole are similar to those of individuals. The anticipation of those reactions might be partly responsible for our dread of the suicide of anybody close to ourselves, and we feel the same, though less strongly, as members of society.

The reactions of individuals and of groups to a suicidal attempt are not unlike those to bereavement by suicide, but with some obvious differences. Those close to the person who almost died usually feel an upsurge of love, a feeling of guilt about not having loved him or her enough, or even of being responsible for the event. But while, in the case of a fatal outcome, it is too late to make amends, in the case of attempted suicide there is an urge for compensation and reparation. This urge will be the stronger the greater the guilt feelings are. In fact, people close to the person who has attempted suicide, and society, try to behave as they would have felt they ought to have behaved, had the outcome been fatal. Only exceptionally do individuals, and society, react to the aggressive component of the suicidal act directed against them by rejection, or by punitive measures. As a rule they come to the aid of the individual with all the means at their disposal. In fact, these reactions are so regular and universal that they have almost the character of an innate behavior pattern, with the suicidal attempt acting as a so-called "social releaser" as described by Lorenz.[20] But whether these reactions are innate or culturally determined remains to be explored. However, they are common to all cultures.

If we study the behavior of persons immediately before and during

suicidal acts, we frequently note certain features which do not serve the purpose of self-destruction. There is a tendency to give warning of the impending attempt and to give others a chance to intervene. Most people who attempt and many who commit suicide remain in close vicinity to others, or move toward them in the course of their self-damaging actions. The suicidal attempt acts as a powerful appeal for help, and frequently there are indications that the anticipation of helpful reactions from the environment plays a part in the motivations of suicidal acts, though not as a rule consciously so. The appeal character of the suicidal act is often exploited by hysterics, but this does not mean that it is by itself a hysterical manifestation. No, hysterics tend to resort to suicidal acts because they have an appeal character. The outcome of a suicidal act can be broadly predicted. It is either death, or survival followed by some helpful reactions from the environment. The awareness of these alternative outcomes is likely to play a part in the motivations of suicidal acts.

The appeal effect of the suicidal attempt makes it understandable that it is only very rarely repeated immediately and with increasing violence. As a rule it alters the person's circumstances temporarily or permanently, and may thus remove or modify its causes.

The outcome of most suicidal attempts is more or less uncertain because it depends on a variety of factors outside of, or not wholly under the control of, the individual, especially on the reactions of the environment in the suicidal situation. Only a small minority of suicidal acts are carried out in such a way that nothing is left to chance. Most suicidal acts are dangerous gambles with life, but survival is usually accepted without demur, at least for a time. The psychology of gambling has been studied by psychoanlysts. It has been interpreted as originating from the urge to test the balance between the libidinal and life-preserving tendencies on the one hand, and the destructive impulses on the other hand. The suicidal act can be compared to a special type of gamble, namely an ordeal in the original sense, *i.e.*, a trial in which the person submitted himself, or was subjected, to a dangerous test, the outcome of which was accepted as divine judgment.

The cathartic effect of a suicidal attempt has not received attention from psychoanalysts. One would expect the release of aggression against the self and others to have a profound effect on the dynamic and economic aspects of the patient's condition. It is bound to release and to mobilize anxieties in the attempter and in those close to him. The risk of a repetition of the suicidal act will depend upon the degree of change which has taken place as the result of it. Psychoanalysts should be in a better position to throw light on this problem than other observers and therapists.

If we look at attempted suicide not as an inferior version of suicide, but as a meaningful event in a person's life, many questions arise. What are the effects of the suicidal attempt on the person's inner conflicts and on his relationship to others? If we think in terms of the introjection theory, what happens to the introjected object? I have tried to study the effects of suicidal attempts on the patients concerned and their life situations, with special consideration of their human relations. Frequently the suicidal attempt proved a decisive turning point in their lives and sometimes in their relatives' lives also. At least it acted as an alarm signal.

Many patients would have never received treatment had it not been for a suicidal attempt. Though the attempt failed in its purpose of self-destruction, it did fulfill its function as an alarm signal and as an appeal for help. In this respect it was highly successful. This is why I do not like the division of suicidal attempts into the successful and the unsuccessful. The division regards death as the only mark of success and fails to do justice to the complexity of motivations. The message of every suicidal act reads like this: "I want to kill myself and should like to kill some others with myself; I want to be dead, but if I should not die, do something about me!" This ambiguity is a feature of most suicidal acts, including many with a fatal outcome. Both parts of the message have to be taken seriously, but the emphasis varies from case to case. Obviously, where it is mainly on the destructive part, survival is less likely, and vice versa.

Suicidal acts, then, are no exceptions from the rest of human behavior patterns. They, also, express the coexistence of the impulses springing from love and from hate. Even if the outcome is fatal, they achieve, though posthumously, a readjustment of the balance of these two drives in the persons close to the individual who has killed himself. But if we take all suicidal acts together, *i.e.*, the suicides and the suicidal attempts, only a small minority of them are fatal. The majority of those acts function as alarm signals and appeals for help and thus reinforce the urge for self-preservation. Whatever the outcome of a suicidal act, be it death or survival, it does not leave things as they were before. It either brings about death or new hopes. The suicidal act, then, reflects the human attitude toward death which has always been felt to be the end, as well as a new beginning.

Psychoanalysts have, of course, sometimes reported observations which are relevant to my thesis of the double function of suicidal acts. Freud,[6] in 1920, reported the case of a female homosexual who came for treatment as the result of a suicidal attempt which, according to Freud, had the effect of greatly improving her relationship to her parents and to her friend. On another occasion, in 1922, Freud[5] referred to a male patient who by a suicidal attempt had forced a woman to yield to his advances and to become his mistress. But in neither of those cases were the psychodynamics of these changes in the patients' relationships and of their effect on their symptoms discussed. The latter case illustrates what is often described as the use of the suicidal threat for the purpose of blackmail. Individuals and society have sometimes tried to reduce the incidence of suicide by resisting this purpose and by depriving suicidal acts of their appeal function by a show of indifference to suicidal threats. It is dangerous to adopt such an attitude. Threats of counteraggression, which in the case of society means threats of punishment by law, have failed to have a deterring effect. It almost seems as if the threat of suicide were one of those regulators of the precarious balance between love and hate on which human relations depend. A relationship between individuals, and between individuals and society, in which a suicidal act fails to function as an alarm signal and as an appeal for help, has to be regarded as highly abnormal. Such societies are exceptional. In the German concentration camps during the war, suicidal attempts hardly ever occurred, probably because they were deprived of their appeal function. Nor were there suicides through self-destruction. Death could be had by other means.

The concept of the appeal function of the suicidal act has been criticized in some quarters as an unwarranted generalization. That the suicidal act has this effect cannot be denied, but its role in the motivation cannot always be demonstrated although it can often be inferred from the patient's behavior before and during the suicidal act, *i.e.*, by previous warnings, contact-seeking behavior, by the patient's failure to leave the social field. But even if none of this can be demonstrated, it stands to reason that a predictable effect of an action, even if it is only an alternative effect, is likely to play a part in its motivations. Psychoanalysts could throw light on this and other problems of suicidal acts, and there are many other aspects which they could explore. In doing so, they would not only contribute to a deeper understanding of a common human behavior pattern, but also to a reduction of its incidence. Although I expressed the opinion that

suicidal threats, suicidal attempts and suicide are probably inevitable a the present state of the evolution of the drives and impulses which contro human relations, I could imagine that at some later stage of this evolu tionary process, when man will have attained a better control of intra psychic forces, they will cease entirely. In the meantime, we have to liv with them and do our best to understand their meaning and their message

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SEMINARS FOR EXECUTIVES AND OCCUPATIONAL PHYSICIANS

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In 1956, the Division of Industrial Mental Health of The Menninger Foundation undertook two one-week seminars, one for top-level executives and the other for occupational physicians. These seminars were an experimental effort to learn how some of the concepts of psychiatry, psychology and psychiatric social work which are crucial to psychiatric clinical work might be communicated to those people in business and industry who have an important responsibility for and influence upon the psychological well-being of employees, what particular concepts might be most useful and what value such seminars might have.[1]

The success of the initial seminars led to their becoming a regular part of the Division's program. The seminars continue to be directed toward top-level executives and to physicians because these groups are in the best position to make use of psychiatric information. Top executives establish the policies and practices under which people must work. Occupational physicians are responsible for the health of employees.

The focus for each group, however, is different. Executives are concerned about leadership, about doing a better job of directing their organizations. The physicians are concerned about discovering symptoms of mental illness, relieving the symptoms, and possibly alleviating the stresses which precipitate them. In short, the focus in the executives' seminar is on the executive himself; in the physicians' seminar it is on what the physician can do about the patient and the context in which he works.

Organization of Seminars: The seminar begins with a Sunday evening dinner and continues through lunch the following Friday.

The format of the seminars is lecture, discussion with the lecturer and small group discussions during the last part of each afternoon. Thus is presented the theory and the relationship of the theory to practice. Participants are stimulated to examine the theory itself as well as its implications for their own work. For some, such a presentation varies so much from their understanding that conflict is aroused. Others may reject the new ideas or be skeptical of them. Their questions make for a penetrating examination of the ideas presented formally and also lead the participant to understand the resistance of others to psychiatric information as he looks back upon his own reactions.

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The week is planned in detail. Each man is given a notebook which contains the schedule, biographies of seminar participants, biographies of the faculty, references and reprints. After each lecture has been given, a copy of it is provided to include in the notebook.

Seminar participants live together and take their meals together. The bus that takes them from the hotel to conference room, and to meals becomes an important instrument of group cohesion about which there is much joking. Considerable discussion goes on during the bus rides.

The evening meal is usually over by 8:30 p.m., at which time the men return to the hotel for informal discussion and socializing as they wish. Members of the staff are with them during this time.

Executives are given a personal interview during the week and the seminar ends with an evaluation by each participant. Before the last lecture, participants have an hour of discussion without the discussion leaders. A representative then reports what the group thinks it has learned during the week, particularly in the discussion groups. This report summarizes what has gone on in each discussion group and serves to consolidate the week's experience so that each participant has some way of conceptualizing what he gained from it, and some feeling for what his colleagues learned.

Results: There are perhaps two major results to come from the week. Most important is the way in which participants take an intensive look at themselves and their behavior in their families and at work. Some of them report that this is the first opportunity in many years, or even in a lifetime, to do so.

The second major experience is one of identification with the staff. Participants identify themselves, not with single persons, but with the seminar faculty as a whole, and feel that they would like to be able to consider other people with the same empathy as do members of the staff.

We believe these desirable effects occur because the men are brought to recognize their own personal feelings and discuss them, because of (a) the reassuring structure of the seminar which affords all necessary controls; and (b) exposure to a variety of interpersonal relationships in a supportive atmosphere (formal-informal, large and small groups, interview, evenings, meals).

Probably an examination would show that the men are not clear about the meanings of many of the terms used. Rather, they seem to get a feeling-tone about people, a general understanding about clinical con-

cepts and identification with the clinical point of view, and a desire to do more for their company's employees. We have yet to have a report that a participant psychologized or used jargon when he returned to his job.

Executive Seminars

One seminar for executives, "Toward Understanding Men," was held annually from 1956 through 1959. Participation was limited to 20 executives at the presidential and vice-presidential levels, people whose positions would have a significant impact on the morale or emotional climate of their company. In 1960 and 1961, three executive seminars were held each year because of the increasing demand for participation in them. The same number is planned for 1962.

Objectives: The seminars were designed to further the development of a psychiatric and psychological frame of reference applicable to the daily activities of the executive in business and industry. More specifically, they were intended to help executives further their understanding of and effectiveness in the supervision of others.

These objectives were based on the assumption that a major task of the executive is to be concerned with people: their growth and development within the organization, their morale and motivation, their efficiency on the job, their working relationships with each other and the complementary identification of employee and company with their mutual goals and purposes.

Formal Organization: The executive seminars are divided into four major units. The first unit, on *Psychodynamics* or the basic psychoanalytic theory of motivation, attempts to provide a general theoretical foundation within which the subsequent discussions of practical applications can have some systematic meaning. The unit consists of four lectures: "Principles of Psychiatry Applicable to Management," "Conscious and Unconscious Motivation," "Constructive and Destructive Trends," and "Personality Mechanisms."

The second unit is on *Psychological Factors in Leadership*, which stresses the father-figure concept of leadership and draws upon experimental studies in business and industry to illustrate what employees expect from authority. The second lecture of this unit takes up concepts of supervision drawn from psychiatric social work, emphasizing sensitivity to the feelings of subordinates and the process of identification with the superior. The two lectures are "The Role of the Leader" and "Developing Subordinates."

The third unit, on the *Psychological Dimensions of an Organization*, concerns ways the organization of the business may support the ego functioning of the people within it. A major distinction is made between problems which arise primarily for psychogenetic reasons and those which may be precipitated by the environment, differentiating the roles of the clinician and the executive. This is followed by a discussion about how psychological distance in the organization of a business may force people too close together psychologically or keep them too far apart. The two lectures in this unit are "The Meaning of Structure" and "Psychological Distance." The fourth unit is on *The Emotional Problems of Executives*, which examines the characteristic and typical stresses of executives. One lecture is devoted to this topic.

Each lecture is about fifty minutes long and is followed by an hour of discussion between the seminar participants and the lecturer. These lectures and the format of the seminar represent the present pattern which has evolved out of the six years of experience. Some of the lectures and notes on discussions from previous years are available in transcript form.[2]

On Tuesday and Thursday mornings, Dr. Karl Menninger has an informal discussion hour with the participants. This hour begins with answers to their questions about the material presented so far and then ranges over many psychiatric and related topics, providing the men with a broad range of phenomena to which psychiatric thinking can be related. These sessions serve to tie together and place in social context much of the discussion which has gone before and also act as an anxiety-relieving device.

On Wednesday morning an informal hour is devoted to a discussion of adolescence. A child psychiatrist makes a brief formal presentation followed by ten minutes of discussion. This session was introduced because the executives were frequently preoccupied with concerns about their adolescent children. These concerns were increased by the subject matter of the seminar and the discussion with the child psychiatrist proved to be a valuable and reassuring experience for all of them.

Interviews: Each executive has a personal hour-long interview during the week. The interviewer is someone other than the leader of the discussion group in which the man participates, and the focus is on the needs of the men so that the seminar may be reoriented from year to year. The interview, then, is for the purposes of the staff and this is clearly explained to the participants. The participants have come to feel, however, that this is an important part of the week and some have asked for a second inter-

view. The interview poses these questions: (1) Why did you come to this seminar? (2) What brought you to your present position? (3) What do you consider your biggest problem? (4) What does the future hold as you see it? (5) What would you like to ask me?

The interviews are confidential. Only one staff member sees them all. The staff discusses only a summary of the interviews to guide planning of subsequent seminars.

Occupational Physicians' Seminars

The seminar for occupational physicians, "Maintaining Emotional Health," is directed toward industrial physicians concerned with the health maintenance of a major segment of a company. It is expected that this seminar will be particularly helpful to physicians who recognize the need for orientation to the practical application of psychological knowledge and skills in their daily clinical activities.

Objectives: The objectives of this seminar are to help the occupational physician further his understanding of psychological motivation; improve his skills in assessing the emotional aspects of the medical problems; familiarize himself with techniques of psychotherapy; enlarge his knowledge of psychiatric treatment methods, criteria for referral, and processes of rehabilitation; and develop an organized point of view with respect to the emotional influence on health.

It is assumed that the major responsibility of the physician in industry is to maintain the health of people at work. It is further assumed that the occupational physician takes a holistic view and, therefore, is concerned with feelings and attitudes and their relationship to health, as well as with organic conditions, the plant environment, and physical stresses.

Formal Organization: The first unit of this seminar on *Psychodynamics*, is essentially the same as that for the executives, but at somewhat deeper levels. To it is added a sociological discussion of the "Work Environment," including an examination of the multiple roles of the occupational physician. The second major unit is on *Principles of Psychiatric Examination.* This includes "Psychiatric Aspects of the Medical Examination," and "Principles of the Psychiatric Examination," "Case Study," and "Traumatic Neuroses." The third unit, *Psychiatric Treatment,* is devoted to "Principles and Criteria for Psychotherapy," "Brief Psychotherapy," "Ambulatory Neurological Syndromes" and "Current Developments in Somatic Treatment Methods." One informal session is devoted on Thursday afternoon to a discussion with Dr. Karl Menninger, which serves much as the two informal discussions which he has with the executives.

Small Group Conferences: Each afternoon on the first three days, the physicians are divided into three small groups, each of which then takes part in a clinical conference, two days at the Topeka State Hospital and the third day at the Topeka Veterans Administration Hospital. Each clinical conference is directed to elaborating in case demonstration the concepts discussed in the previous lectures that day. The patients for the case conferences are chosen to approximate those whom the physician would see in his everyday work. Some cases are so familiar, in fact, that the physicians are often surprised that such a patient is hospitalized.

On Monday and Tuesday of the seminar week, there are five informal voluntary discussion groups on selected medical topics. In the 1961 Occupational Physicians' Seminar these topics were, "Neurological Syndromes Relevant to Industry," "Aspects of Medical Practice in a Psychiatric Setting," "Observations on Coronary Thrombosis Experience," "Psychological Testing," and "Hypnosis in Medical Practice and Research."

Some Psychological Aspects of Seminar Participation

Small Group Discussions: Each group of 20 is divided into three smaller discussion groups of six and seven men each, which meet for the final hour and one-half each afternoon with a professional leader. A representative of each discussion group keeps notes on each meeting and fifteen minutes before the end of each session feeds back to the group a report on its discussion. This report is built around four questions: (1) What were the main areas and topics in which the group seemed particularly interested? (2) What topics were dropped or seemed difficult to discuss? (3) Why? (4) How well did discussants communicate with each other?

These discussions serve three purposes. If questions have not been adequately answered by the lecturer, then the small groups provide another way to elaborate or extend the reply. Second, each executive is asked to submit in advance a case-problem from his own experience to be discussed in these small groups. This permits the theory to be related directly to the cases, as well as to help the presenter and the other participants examine the problem anew in the light of the seminar experience. Third, any communication of mental health concepts is bound to arouse anxiety and in the small groups much of it can be dealt with by the professional leader. The physicians were not required to submit cases because the

patients they saw in the clinical conferences served as the basis for discussions in the small groups.

Rhythm: There is a definite psychological rhythm in the week, particularly in the executive seminars. On the first day a considerable amount of unconscious hostility is displayed in the small group discussions. In the executive seminar this usually took the form of strong attack on the authority-figure in the case under discussion. The expression of this hostility is as if to say to the faculty: "Who are you, what are you up to, and what are you trying to do to us?" It is also as if to say: "What is all this about?" The feeling-tone at this point is one of being overwhelmed by the complexity of the material presented and questioning its applicability to concrete, everyday business or medical problems.

On the second day the dominant quality of the comments is one of self-doubt and amazement. As one participant said of the faculty, "They are looking in a dark closet for a black hat—and they are finding it." By this time all of the theory has been elaborated, its sequential relationship made clear and the men have begun to see the play of some of the mechanisms in their own discussion groups. This experience is a shaking one, particularly as participants look back on their relationships with their families as well as employees.

On the third day, as the theory begins to be translated into the everyday activities of the executives and physicians, the feeling-tone is "You have something there." What before had been somewhat nebulous and confusing now begins to take on structure and meaning in terms of their own experience.

On the fourth day, there is a resurgence of self-confidence. By this time the men have been able to relate some of the theory to some of the case problems and clinical conferences. They can understand some of the problems somewhat differently than they had before. They learn, too, that often their view of a given problem makes psychological sense. As a result, they feel, "You may have something there, but I have something too."

On the fifth day there is a feeling-tone that, "We have something here together." Throughout the week there is a movement from seeking specific answers to specific questions to an attempt to understand and make use of the more general frame of reference. As the week progresses, the participants come to recognize the greater importance of the broader frame of reference for its application to many different problems.

Reasons for Coming: Executives give a number of different reasons for coming. Some come because they have the responsibility for being up-to-date on developments concerning personnel. Some come because they have recognized their need for greater understanding of the subtlety and complexity of human behavior. Many have explicitly expressed dissatisfaction with earlier experiences in management seminars which emphasized gimmicks and manipulation. Some come because they feel they have not organized their businesses well enough to help people properly—they wish their businesses to be constructive rather than destructive to people. Some are sent by their superiors who have themselves participated, or who have heard about the seminars from colleagues, or other subordinates. Some come because a relative is in psychiatric treatment and they would like to know more about psychiatry. A few come because they themselves need psychiatric help and expect to find in the seminars avenues for getting it. All come with some degree of a question about, "How do I understand others and myself better?"

Perhaps another reason they come lies in typical case problems, submitted to the discussion groups. These tend to cluster around several topics: finding suitable men for top jobs, motivating men who lack self-motivation, helping people who cannot delegate responsibility or develop subordinates, supervising executives who cannot grow with the business. The problems cover the gamut from small to large in significance, and from individual problems to those of whole organizations. Most concern people whose behavior seems strange, inconsistent, and generally difficult to understand or change. In discussions there is a tendency to ask "What might we have done earlier so that this problem might not have developed?" or "How can we apply the insights gained in the discussion about this case to others?"

We have no way of knowing from the application which of the men comes for what reason. The men are selected from those who apply after mailings have gone to all companies which are members of The Menninger Foundation, those which employ a thousand or more people, and those who have heard about the seminars and written for information. There are no limits on the size of the company from which people may come and an effort is made to keep the seminar representative geographically and in size of organization.

Reasons for which the physicians come are more obscure. Some come for personal reasons as do executives. Others recognize the need for psy-

chiatric insights. Some are sent by their superiors. Physicians traditionally more frequently pursue continuing education in special courses and seminars. Announcements go to all members of the Industrial Medical Association.

The groups vary in spirit and in composition. Some are quite spirited. Others seem more serious. In some there is clearly a dominant leader, in others, none. The reasons for these differences are not clear.

Evaluation: During the week and afterward there is a built-in process of evaluation. Participants are given evaluation forms on which they are asked to rate each lecture and seminar activity anonymously on a five-point scale. Ample space is left to write spontaneous comments. These evaluations have been found to be constructively critical and highly useful as a basis for revising various aspects of the seminar. Despite the enthusiasm of the participants, they have remained relatively objective in their judgments about individual presentations and other aspects of the seminar.

From three to six months after a seminar, a letter is sent to the participants asking them to report on what they have done about what they have learned, what they think might be changed in the seminar, and how the seminar might be better directed to their needs. Most respond with detailed letters.

Members of the staff have occasionally visited in the offices and plants of former participants who then report verbally on their experiences. Sometimes subordinates have asked staff what went on during the seminar because they have noticed certain changes in their bosses who were participants. For example, one man asked, "What did you do to my boss in that seminar? He used to be a man who asked that everything be done yesterday. Now he still demands, but not that it be done yesterday."

Occasionally wives will ask what went on in the seminar about which their husbands have talked so much. There is a good deal of "repeat business" in the sense that while no one who has participated is permitted to participate again, other representatives of the same company often take part in the seminars. The participants themselves have asked for more advanced seminars and these are being considered.

Some participants have reported back that they seem more comfortable in their relationships with other people and in their work than before. One man said, "I find myself listening more and talking less." Another said he was not so quick to be angry with people who were having emotional difficulties.

Some seem not to have gained anything from the week except a pleasant experience. One man reported that three weeks after the seminar all he had learned had "rubbed off." Some subordinates have reported that the seminar had had no effect at all on how their bosses behaved.

By-Products: There seem to be several psychological by-products of these seminars. In some cases, seminar participants have engaged psychiatric or psychological consultants. One man now meets every other week with two of his vice-presidents and a consulting psychiatrist to discuss their business relations and business matters. Frequently seminar participants will call or write, asking for local clinical resources to help people who are troubled. Several have taken a more active part in local and state mental health associations. Others have started local seminars for people in their plants, as well as for others in the community, with the help of both local clinical people and occasionally members of our own staff. In some cases the participants have abolished "gimmick" programs which have previously been instituted to "motivate people." Several have employed staff psychologists and psychiatrists.

An important by-product was the development of a one-and-two-day seminar model under the auspices of the National Association for Mental Health. Following four demonstration seminars in New Haven, New Orleans, Portland, Oregon, and Milwaukee, the National Association for Mental Health published a manual[3] to guide local mental health associations in developing these seminars.

The seminar participants have a strong feeling of satisfaction and enthusiasm about the week. In contrast to various other kinds of seminars, many get a feeling from the consideration given them, that someone cares about them, that they and their problems are important. The point of view presented by the faculty becomes an important adjunct to the personal as well as the business lives of participants. Some have remarked that it was the most important experience in their lives. Others keep saying they wish they had had this experience twenty or thirty years ago.

The reactions of the occupational physicians are much the same as those of the executives. The evaluation process is the same. At least one of the former participants is now working part time on a volunteer basis in a mental health clinic in his local community. Another has undertaken a psychiatric residency. Several others have instituted various kinds of mental health programs as part of their health education efforts in their plants. Some have assumed leadership in the Industrial Medical Associa-

tion, working toward establishing closer relationships with the American Psychiatric Association and developing I. M. A. sponsored local seminars with psychiatrists in their home communities.

Many physicians were surprised that they were not "talked down to," were not overwhelmed with jargon and that there were aspects of psychiatry which they could put to good use in their daily practice. Some reported back that they were doing more psychotherapy than they had done before, that they were talking longer with their patients. Others have reported that they have more comfortable relationships with people who have emotional disturbances, that they are less ready to pass them off, and, further, that their relationships with psychiatrists in their home communities have improved. The physicians, too, have asked for more seminars.

Observations in Teaching

The original question of the staff about whether such a seminar would be of value has now given way to enthusiasm. They enjoy the seminars with the men. From their own experiences, the staff feels they have an important contribution to make to the solution of problems with which these men deal and, therefore, to the mental health of hundreds of thousands of people. They find that many of the points they are trying to make are quickly grasped by the executives, because of their broad experience, and that, where there are hostile individuals, these usually become the most interested participants before the week is out. While for some members of the staff the week has much the same emotional tension as conducting sixty straight hours of intensive psychotherapy, it is nonetheless a most gratifying and rewarding experience for them. Despite protests that mental health education has little value,[4, 5] we are convinced that this model of mental health education has important mental health effects.

After six years of experience with such seminars, we have come to certain conclusions about teaching methods. We do not permit discussions to wander randomly or repetitively. We try by interpretation and guidance to maintain a structure for the discussion groups, so that people do not feel their time has been wasted. This direction is not intended to limit or freeze discussion or to force the men to preconceived conclusions, but rather to help them understand some of the processes through which they are going in the course of thinking about mental health concepts and to keep the group focused on its joint task.

We have had little success in using films. Compared to the clinical conferences and the first-hand relationships with the staff, films seem pale. We tried a number of different films through the years before abandoning them altogether. We found also that the clinical conferences are much better than one-way vision room demonstrations.

Given the kinds of structure we maintain, we find little problem with anxiety. This kind of a seminar requires clinical skills. It cannot be handled mechanistically. When the seminar leader is sick for part of one seminar, or a discussion leader provides too little direction and understanding in his group, there is a great deal of turbulence during the week. Transference phenomena occur in such seminars and must be dealt with.

In discussing the rhythm of the seminar, it was pointed out that hostility tends to arise in discussion groups on the first day. If the hostility does not arise in the first day of the seminar and is not interpreted or dealt with early in the week, then it remains as a residual during the end of the week, dampening the excitement and enthusiasm of the participants. In future seminars this problem will increase because more and more participants come to the seminars prepared by an enthusiastic report from former participants and with some anticipation of what is to go on. Thus, there will tend to be less and less hostility the first day, leaving more to be overcome later.

The seminar model is a constantly evolving process. We expect to see many changes in it from year to year. At the same time, the present format seems to be a highly useful one. It appears to provide the perspective for which the seminars were established without at the same time merely providing jargon for psychologizing purposes. Both the executives and the physicians leave the seminars with a sense of humility about psychiatry and psychology, but at the same time with a clear definition of the areas which should best be left to the mental health professional and those in which they themselves might contribute to the mental health of others.

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THE SUBJECT'S APPROACH: IMPORTANT FACTOR IN EXPERIMENTAL ISOLATION?*

EDWIN Z. LEVY, M.D.

Isolation is a part of many human experiences. It has been a subject of special interest in recent years, partly because of the rich new ideas about mental functioning which have come from the first experimental studies,[1-8] and partly because of its pertinence to fields such as brainwashing and space flight.

Many of the reports of experimental studies have stressed remarkable effects of isolation, such as hallucinations and disorganization of thinking. But, because isolation in the laboratory is a complicated situation, it is not always easy to determine the cause of such effects. Causes may lie principally in the isolation itself or in the subject, or in the experimenters, or in some aspect of communication between the subject and the experimenters.[9]

As an experimenter and as a subject in experimental isolation, I became impressed with the possible causal importance of two (out of many) subject-related issues: The psychological approach of a person to being a subject; and the influence of the situation on his approach. These issues are the focus of the following discussion.

For background, certain aspects of some of the well-known studies in experimental isolation will be mentioned: Emphasis will be placed primarily on the circumstances which led up to the experiment, the kinds of subjects employed, and the way the subjects were introduced to the experimental situation.

Prompted by the suggestibility reported in brainwashing[10] and by the lapses of attention which occur when a man gives prolonged attention to a monotonous environment, Bexton and others,[2] working with Hebb, studied the "cognitive effects of decreased variation in the sensory environment." They described their procedure as follows:

> "The subjects, twenty-two male college students, were paid to lie on a comfortable bed in a lighted cubicle twenty-four hours a day with time out for eating and going to the toilet. During the whole experimental period they wore translucent goggles which transmitted diffuse light but prevented pattern vision. Except when eating or at the toilet, the subjects wore gloves and cardboard cuffs, the latter extending from below the elbow to beyond the fingertips. These permitted free joint movement but limited tactual perception. Communication between the subject and experimenters was provided by a small speaker system, and was kept to a minimum. Auditory stimulation was limited by the partially soundproof cubicle and by a U-shaped foam-rubber pillow in which the subject kept his head while in the cubicle. Moreover, the continuous hum provided by fans, air-conditioner, and the amplifier leading to earphones in the pillow produced fairly efficient masking noise."

* Written to meet a requirement of the Scientific Writing Course in the Menninger School of Psychiatry.

The work on which this paper is based was done in association with Dr. George Ruff and Capt. Victor H. Thaler at the Aerospace Medical Laboratory, Aeronautical Systems Division, Wright-Patterson Air Force Base, Ohio.

The effects of this procedure seemed remarkable: deterioration in the capacity to think systematically; emotional lability; a state of daze upon emerging from the cubicle; post-isolation disturbance in visual perception; and hallucination-like processes. These images varied from field color changes to complex integrated visions. One subject heard what his visions said. Four described kinesthetic and somesthetic phenomena. The authors concluded that the experiments "provide direct evidence of a kind of dependence on the environment that has not been previously recognized." The experiments lasted from a few hours to as long as six days.

Lilly[5] formulated the following questions:

> "We have been in pursuit of some answers to the question of what happens to a brain and its contained mind in the relative absence of physical stimulation. In neurophysiology, this is one form of the question: Freed of normal efferent and afferent activities, does the activity of the brain soon become that of coma or sleep, or is there some inherent mechanism which keeps it going, a pacemaker of the "awake" type of activity? In psychoanalysis, there is a similar but not identical problem. If the healthy ego is freed of reality stimuli, does it maintain the secondary process, or does primary process take over, *i.e.*, is the healthy ego independent of reality or dependent in some fashion, in some degree, on exchanges with the surroundings to maintain its structure?"

He described his experiments as follows:

> "In the Canadian experiments, the aim is to reduce the patterning of stimuli to the lowest level; in ours, the objective is to reduce the absolute intensity of all physical stimuli to the lowest possible level. . . . In our experiments, the subject is suspended in a tank containing slowly flowing water at 34.5° centigrade, wears a blacked-out head mask for breathing and wears nothing else. The water temperature is such that the subject feels neither hot or cold; the experience is such that one tactually feels the support and the mask, but not much else. The sound level is low—one hears only one's own breathing and some faint water sounds from

the piping. It is one of the most even and monotonous environments I have experienced. After the initial training period, no observer is present. Immediately after exposure, the subject writes personal notes on his experience."

While in this environment, Lilly noted in himself a "stimulus-action" hunger, highly personal and emotionally charged reveries and fantasies, and projection of visual imagery. He also described a great increase of energy which followed each exposure. The experiments lasted up to two and one-half hours.

Solomon, Mendelson, Leiderman and Wexler[6-8] observed psychotic-like states in polio patients confined to respirators. To investigate this, paid, volunteer subjects were placed in a respirator with the ports open but the motor on; their vision limited by white screens; their hearing limited by the respirator motor and the quietness of the room; tactile sensations, proprioception and body awareness by means of the mechanics of being in the respirator, and by cuffs. The effects of this situation included hallucinations, delusions, mood shifts, and other changes. The experiments lasted from a few to 36 hours.

Holt and Goldberger[11-13] used 14 male college freshmen who were told they had been chosen for their outstanding intellect and emotional stability for a series of experiments, of which this was but one, and that they would be paid one dollar an hour. Prior to beginning the experiment, the subjects were given the following information:

"Today's experiment is one in doing nothing . . . you will be asked to lie down on a comfortable couch. Your eyes will be covered by these eyecups. . . You will be wearing some gloves and cuffs, which to some extent will hamper your motions. . . Try not to move any part of your body unless you find it absolutely necessary. You will be all alone in the room, but I will be in attendance all the time. You can talk at any time you wish. . . I want you to talk about the thoughts that go through your mind, the feelings you are experiencing and anything else. . ." (The subjects were told that if they talked just for the sake of it, they would receive a signal to stop it. Another signal was used to instruct subjects to report their thoughts and feelings if they were remiss in doing so.) "If you want to go to the bathroom, just say the word 'bathroom' and I will take you there. If for some reason you want to stop the experiment, just let me know, but try to stick it out. . . I will bring you some lunch. . . Well, how do you feel about it? Do you have any questions?"[11]

The authors described the significance of personality variables in determining response to the isolation situation. They discriminated between isolation tolerance and isolation effects in reporting an "adaptive" and a "maladaptive" syndrome. Correlations were demonstrated between these "syndromes," personality attributes (as determined by meticulous analysis of various psychological tests), and effects such as hallucinations.

Cohen, Silverman, Bressler, and Shamvonian[14] describe their study as follows:

"Ten subjects were chosen randomly as far as economic status, occupation and education were concerned. . . Both males and females were used. . . The subjects were asked if they would like to participate in a pilot study for which they would be paid. They were given no clues as to the nature or duration of the study. . . When the subject appeared, his watch and cigarettes were removed, following which he was sealed in a four by seven foot acoustical chamber. He was asked not to move, speak or make noises. No mention was made of when he would be released. If he asked, he was told that the experimenter would be back for him later. If the subject specifically asked about the possibility of being released if he gets uncomfortable, he was told to tap on the window. . . The subject was then left in the chamber for two hours."

These authors mention several variables under three headings: those related to the subject—including his attitudes toward the situation as a whole, his private opinions, expectations, and anxieties—the experimenter, and the experimental situation. They emphasized the importance of how little their subjects knew ahead of time about the situation. Bizarre behavior, hallucinations, and emotional upsets—the latter extending into the post-isolation period—were reported.

Grunebaum, Freedman and Greenblatt[15,16] also screened and paid undergraduate students who had responded to a notice requesting volunteers for a research project. Subjects were confined in a room for eight hours with gloves, cuffs, goggles, and instructions not to move. "Before coming for their first interview, they had received a form briefly describing the experiment so that to some extent they all had the same information about it." At the start of the isolation sessions subjects were asked "to tell us, from time to time, about your mental processes, thoughts, images, daydreams, perceptions, feelings—just what it is like to be in this experiment. It is not expected that you will talk continuously."[15] Hallucinations and abnormal behavior were not uncommon. Distortion of perceptual function followed isolation.

A review of these studies emphasizes that there have been many kinds of experiments in which a wide variety of sensory limiting techniques

were employed on diverse types of subjects for longer or shorter periods associated with a broad range of effects for which explanations have been offered in accord with the theories of several disciplines.

Some examples will help to demonstrate the scope of these differences.

The variety of sense limiting techniques used is indicated by the following list: Visual input may be altered by a totally dark room,[9,17] light-proof goggles,[9,18] frosted goggles,[2,9] half Ping-pong balls,[11] or white screens.[7] Auditory input may be altered by a soundproof room,[9,14,17] earplugs,[18] or masking noise.[2] Proprioception and tactile sensation may be reduced by gloves and cuffs,[2,7,9,16] by cutting down on motility or by "water suspension."[4]

Subjects have included experimenters, paid and unpaid undergraduate and graduate students, hospital personnel; hospital patients; military personnel, and others. Some investigators have screened out candidates with manifest psychopathology,[11] others have used all comers.[14]

Effects have involved all aspects of mental functioning: A hallucination-like process is reported as well as distortion of visual and auditory perception as tested in the immediate post-isolation period. Thought may be restricted, flow more freely, or become illogical or discomfiting. Emotional shifts have included suspiciousness, blandness, bravado, elation, depression, despair, anxiety, and panic. Hyperactivity and hypoactivity occur. Profound disturbances of integrative functioning have been reported. Finally, in some situations subject intolerance is a principal feature, while in others the procedure is usually tolerated well. By no means do all people experience all effects.

Explanations have involved communication theory, brain function theories, various academic psychologies, psychoanalytic theory, and phenomenological psychology. Different investigators have written of the effects of sensory deprivation on the function of the brain, or of the effects of isolation on the function of the ego, or of combined effects of perceptual and social isolation on the organism. Several authors have stressed the importance of personality attributes in determining response to an experiment.[6,9,11-16,19,20] The possible importance of other sources of variance is implied in some experimental designs. For the water immersion procedure one must be very used to the procedure and have faith in the apparatus.[21] Solomon[7] and his group duplicated the polio-respirator patient's circumstances as closely as possible. Hebb and his group[1-3] imitated certain aspects of brainwashing.

Ruff, Thaler and I were engaged in isolation research at the Aerospace Medical Laboratory from 1957 to 1959. The experimentation was part of a program studying psychological aspects of space flight. We isolated well over 100 subjects for from three hours to seven days, under varying conditions of sensory deprivation with varying degrees of motility allowed. In some studies we used ourselves as subjects in repeated exposures to differing kinds of sensory depriving situations. In most of our work, volunteers for a "research study related to space flight" were used as subjects. Many were unpaid. Most of these were mature military officers. Subjects were confined in a 7×14-foot soundproof chamber which contained a bed, a chair, a chemical toilet and an icebox. The room was totally dark and silent for most experiments. In other studies, dim light, frosted goggles, and a masking noise were used. Subjects had psychological tests and psychiatric interviews for a day or two days prior to each experiment. Efforts were made to make subjects psychologically comfortable, though only what was necessary was said about the experiment, which was presented to the subjects as "going into isolation."

As reported elsewhere,[9,19,20] the effects of the Aerospace Medical Laboratory isolation studies were relatively benign. Only two subjects had hallucination-like experiences, and these were clearly hypnagogic. Subjects with good life adjustment by and large tolerated the experiment well. Much of the stress of the experience focused around "When is it going to end?" The most striking finding was the individualism and force of the subjects' descriptions of how it "felt" (or feels, if they talked during a study) to be in isolation.

Because of this individualness of each subject's approach, and because it did not seem possible to explain the relative absence of pathology-like effects in our studies solely on the basis of details of sensory depriving technique, like Silverman and Cohen, and Holt and Goldberger, our research became directed toward sources of variance other than sensory deprivation. The result was a description of eight groups of variables with a role in determining the nature of a specific isolation experience.[19,20] In addition to:

1. The modality, quantity, and pattern of sensory input; and,
2. Subject personality, background, motivation and set;

The following groups of variables were discussed:

3. The surrounding circumstances of the isolation;

4. The degree of aloneness achieved;
5. The amount of communication between subject and experimenter;
6. The kind of physical confinement;
7. The closeness to the subject of the sensory limiting barriers;
8. Several aspects of the duration of isolation.

We classed these groups of variables into four dimensions.[9] The first consists of all of the aspects of the barriers between the subject and the outside world—the means by which he is isolated. This is termed the microcosm. The second dimension refers to the individual who is isolated. The third includes the reality factors of the outside world—the conditions, circumstances, reasons, and attitudes under which the experiment or experience occurs. This dimension is termed the macrocosm. The fourth dimension refers to the communication between subject and macrocosm.

All of these factors point to the desirability of a further consideration of isolation as a human experience; something which a person must approach with personal preconceptions, undergo and react to as a whole. From this, insight may be gained concerning the psychological position of the subject with reference to his participation in the experiment; his "set"; that is, his knowledge, conscious attitudes, expectations and dispositions; what may be called the interaction between the subject and the macrocosm.

A subject will surely "look around" before beginning his experiment. His view of the situation depends upon what the experimenters wittingly and unwittingly show him and upon what he makes of it. Subjects in each of the researches previously described agreed on certain terms to undergo a specific experience which in turn resonated with or fed back to their agreements in a special fashion. What are some of the significant issues in the subject's approach? How might what he sees alter his approach and his concept of the situation's demand expectations? How may these issues affect his response to the experiment? Consideration of these questions may be facilitated by a generalized description of isolation research, which emphasizes prerequisities for experimentation, as follows:

> A person for some reason agrees to place himself, or be placed, for a time, into a unique situation. In this situation the range of perception and action open to him and his control over this is reduced. He agrees to be observed, perhaps to experience novel inner effects, and perhaps to reach the limit of his tolerance for the condition. He may be asked to reveal the effects or his intolerance by action or by voluntary communication. Disturbances in his functioning may be deduced by clinically sophisticated observers. For a time, his entire being is lifted from its ordinary state into this peculiar condition.

The first prerequisite is the subject's general agreement, which has a highly individualized quality. Two additional prerequisities are that the subject will specifically give up the control he ordinarily exercises over certain things, and that he will permit himself to be observed. The subject must have adopted a position with reference to these two factors, consciously or unconsciously, before the experiment can begin. Furthermore, throughout the experiment he must either maintain such a position, or change it.

Isolation research depends upon the willingness of the subject to participate, to be controlled, to be observed, etc. There are many styles of willingness of which the following are a few examples: a subject may:

agree to try it for a while;
agree to try it as long as he can;
assume that he will just plain "do it";
eagerly enter into this interesting new experience;
agree in order to humor the peculiar people who asked him;
etc.

In adopting a style of willingness it is as if the subject says singly or in combination:

"I want to do this, because . . ."
(Any number of things could be inserted.) or,
"I don't want to do it, but I will, because I must."
"I don't want to do it, but I will, because I ought to."
"I don't want to do it, but I will, because they want me to."
"I don't want to do it, but I will, to see if . . ."
"it will get me."
"I can do it."

Within the terms of his agreement, the subject may or may not be able to trust the experimenters. Even with trust he may see the situation as friendly or unfriendly; good, neutral or bad; interesting or dull; pleasant or unpleasant. He may feel safe, or he may feel himself in danger, frightened, and threatened. Such feelings may be influenced by the attitude of the experimenters. Since isolation research has been associated with awesome effects, it is not without trepidation that one man places another in a box and watches him. Indeed he is disposed to watch closely

and with concern for what may happen. So the experimenters may seem anxious. For other reasons they may appear as friendly, prying, cruel, lecherous, as potential sources of treatment, or as eminent scientists, or silly people doing silly things.

If the subject is an experimenter-subject, his convictions and prior exposures and those of his co-workers will color his expectations and tend to shape the situation into a personal challenge: to stay longer; to see more; to see less; not to reveal anxiety.

The subject no longer has the control he ordinarily exercises over his environment. How easily may he regain control from the experimenters? Does he know how to terminate the experiment? How does he view those who now control him? Can he surrender control to these experimenters? Does his perception of their spirit remain the same, or does it shift? Does his need to maintain control change? Does he expect and do the experimenters expect him to tolerate surrender of control well? And, finally, how does he actually tolerate loss of control?

In many experimental situations, the subject may be observed, though he is unable to see himself or the experimenters. He may be "pouring out data" through electroencephalograph, skin resistance, or electrocardiograph with no idea what he is communicating. An intercom may be operating. The subject may wonder about one-way vision screens and infrared viewing devices. The questions posed about control may be asked here. Does he suddenly shift in his willingness to be observed? Does something happen which he wants to hide? How well does he tolerate observation?

It is obvious that if a person will not participate because he does not want to be observed or controlled, there is no experiment. If he were forced, one would learn about his reactions purely to forcible deprivation of control rather than to deprivation of sensory input.

An anecdote will emphasize the importance of these issues for early tolerance of an experiment. A friend once visited the laboratory and said he wanted to try isolation for a "couple of minutes." He was relieved of his watch and matches and ushered into the chamber. I told him that I would be back in a "couple of minutes," closed the door and turned out the lights. I went out, left the antechamber for a moment, was delayed and did not come back until four minutes had passed. I heard shouts and pounding inside the chamber and released my friend who was in a state of profound psychological discomfort. He had experienced an enormous rush of anxiety. After calming he said that he might have been willing to stay for a few hours, but he wanted to know about it in advance. He had become panicky when he felt I was violating our "two-minute" agreement, and he didn't know how to get out by himself. This was not a claustrophobic reaction, nor a response to sensory deprivation, but rather a reaction to loss of control.

Similarly, as an experiment continues, it may not be the impairment of his vision or hearing that the subject is unable to tolerate, but the loss of active control, or being observed. When the subject himself terminates the experiment, we may assume that he has undergone a shift of set with reference to these issues.

What of approach, control, and observation in relation to the effects of isolation? Can the subject permit isolation effects under the given circumstances of control and observation, or would he rather give up his role as subject? Can he tell his experimenters about the effects? Was he warned about possible effects? About effects the experimenter would consider as interesting (desirable) results? Does he feel affected by the limitation of his perception or as having been dealt with in some mysterious manner by the experimenters?

It will be recalled that behaviors similar to those seen in the laboratory are seen at times in nonlaboratory "real-life" situations, which are considered to contain some elements of isolation. Brainwashing, the respirator, and space flight have been mentioned. Lilly noted that hallucinations, delusions, and other peculiar behavior occur in solitary sailors, those who live in the polar night, and others.[5] The desert wanderings of certain religious figures, other habits of religious figures and mystics, Weir Michell's rest cure, the Japanese psychiatric treatment for their nosologic entity "Shinkishitsu," solitary confinement, high altitude flying, submarine duty, being lost, shipwreck, blindness, deafness, being in a foreign land, and more situations can be thought of or have been written about as involving isolation.

How a person gets into these situations, his feeling about his remaining degree of control, the presence of possible observers, would seem to be important aspects of the "real-life" situations also. It is interesting to note that the "real-life" situations do not feature sensory deprivation quite like that obtained in the laboratory.

It may be asked then, if isolation effects are seen in real-life isolation which features monotony and is *without* laboratory-like sensory depriva-

tion, and are also seen in most of the experimental situations *with* different kinds of sensory deprivation, must one not consider the significance of the subject's approach and of such issues as control and observation in the production of isolation effects?

For example, these variables may help explain why so few of the subjects experienced hallucinations. First, pains were taken to make our subjects feel at ease and to feel positively toward the experimenters. Second, just before undergoing the experiment the subjects came to know us by means of a one- or two-day evaluation process which was calculated not to be disruptive. (Most other workers have made their evaluations separate from the experiments—either after, or well before the start of isolation. In certain instances, the evaluations have been made by other people than the experimenters.) Third, our research was associated with space flight, which has quite a different aura from an iron lung or thought control or pure research.

The rare subject who developed persecutory ideas or near panic clearly had never established a position of trust, or the usual position with reference to control and observation. Two of these subjects were schizoid or borderline, and such persons, of course, usually find it difficult to trust others.

The lack of absolute restriction of motility, and the fact that most of our subjects were in a totally dark room rather than with frosted goggles, have been considered by some the reasons that our subjects did not report hallucinations. Another possibility is that the subjects did not want to mention such things as hallucinations to superior or fellow military officers. Also, the subjects were by and large older and more broadly experienced than those of most other investigators. But, the subject's approach, the nature of the introduction to the experiment and the friendly macrocosm may have had a crucial role. Yet, if the subjects were comfortable, why, as was the experience of Holt and Goldberger,[12] did they not experience hallucinations? Certainly it was a different kind of "comfort," the surrounding atmosphere was quite different, the people had "adapted" to a different constellation of control and observation factors. This, however, along with many other questions, is not fully answered.

It may be that the macrocosm of an isolation experiment (the reality factors under which the experiment occurs—see above) is analogous to the milieu of a psychiatric ward, and that the operation of such variables as control and observation has an effect like milieu and attitude therapy. The effects of these variables may be as important and potentially overriding with reference to the sensory depriving variables as is the milieu in which the psychotic patient receives drugs, shock, psychotherapy, or nothing but milieu therapy. This in no way denies the importance of sensory deprivation per se.

Experiments become "real" for subjects because of issues like control, observation, and approach. It was very easy for one of our subjects to go into our dark chamber. During the war he had worked alone in a small room in a third subbasement without windows, and occasionally the electrical power would fail. Another subject, who had some question about his stability, looked upon "the pit" from quite a different point of view. "I can [cannot] handle this," and "Who else is [isn't] around?" are factors in experiments and in real life and may be quite important in determining how similar experimental isolation is to real-life isolation. Referring again to the generalized description which has been offered, the crucial issue for experiments may be whether a subject comes to feel that "his entire being is lifted from its ordinary state into this peculiar condition."

While a very promising research tool, isolation is no less complex than an interview. The subject's approach is of central importance and should be well understood before experimental results are utilized to formulate or support theories based on neurophysiological or computer concepts.

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READING NOTES

The most impressive single point that I get out of Toynbee's marvelous summary of Greek history, *Hellenism* (Oxford, 1959), is that the Christians introduced into Judaism what was essentially a Greek idea. It is Toynbee's point that the Greeks introduced two things—the worship of the city state and the worship of man, the latter becoming in later years Humanism. The idea that man could have elements of divinity was taken up by the Christians in another form. The Greeks turned more and more to their worship of the city state, with its consequent incessant warring with other city states, bringing about the self-destruction of Greece. "The modern world must exorcise this demon resolutely if it is to save itself from meeting with its Hellenic predecessor's fate." Toynbee is clearly referring to certain political trends in this country and elsewhere, the glorification of states' rights, some activities of Chambers of Commerce and, of course above all, chauvinistic patriotism.

° ° ° °

Read Homer's *Odyssey* this summer, as translated by Robert Fitzgerald, which the reviewers seem to regard as the best ever. "It is as good English as the Greek is wonderful Greek." says George Steiner (*The Atlantic Monthly*, August 1961, pp. 77–84). From reading Toynbee's *Hellenism* and Bertrand Russell's *History of Western Philosophy*, I realize better how the *Odyssey* and the *Iliad* were the *scriptures* of the Hellenes, and written down about the same time the Hebrew scriptures were being written down (8th to 6th centuries).

° ° ° °

At the time I wrote *Man Against Himself* I was unfortunately not well acquainted with Thucydides' account of the Peloponnesian War. I was not even well acquainted with Greek history as I should have been or I would have remembered that this great civilization—the pre-Christian Greeks—with the greatest collection of leaders and thinkers we have ever known was systematically destroyed in a continuous civil war of the most senseless nature. I have just read *Thucydides*, a new translation by Rex Warner (Penguin, 1954)—or as much of it as I could stand—and reflected again on the self-destructive determinations of mankind.

° ° ° °

In Kurt Eissler's magnificent monograph, *Leonardo da Vinci: Psychoanalytic Notes on the Enigma* (International Universities, 1961), there are many fine illustrations with clarifications of some of the problems long

posed by some of Leonardo's drawings and paintings. There are also many of the *profetie.* These were strange riddles, something like our conundrums, but couched in shocking terms. For example: "Men shall come forth out of the graves changed to winged creatures, and they shall attack other men, taking away their food even from their hands and tables."

Would you ever guess the answer? Flies!

Again: "Many Franciscans, Dominicans, and Benedictines will eat that which has recently been eaten by others, and they will remain many months before being able to speak." (Answer: Nurslings.)

Another: "It shall seem to men that they see new destructions in the sky, and flames descending therefrom shall seem to have taken flight and to flee away in terror; they shall hear creatures of every kind speaking human language; they shall run in a moment, in person, to diverse parts of the world without movement; amidst the darkness they shall see the most radiant splendors. O marvel of mankind! What frenzy has thus impelled you? You shall hold converse with animals of every species, and they with you in human language. You shall behold yourself falling from great heights without suffering any injury; the torrents will bear you with them as they mingle in their rapid course." (Answer: Dreaming.)

* * * *

Not all colleagues may have noticed the prize for the winning essay in the contest in honor of William James offered by the American Society for Psychical Research was won by our friend, Ian Stevenson, with a study "The Evidence for Survival from Claimed Memories of Former Incarnations," published in two parts in *The Journal of the American Society for Psychical Research* for April and July 1960.

* * * *

A scholarly article in the spring 1961 number of *Judaism,* by Harris H. Hirschberg whom the editor does not identify, implies that the dual instinct theory appeared 1800 years before Freud in Talmudic dogma. The *Yetzer ha-ra* was declared to develop in the child "from his mother's womb"; at the age of thirteen it begins to be opposed by the *Yetzer tov.* The *Yetzer ha-ra* is powerful and foolish but not evil in itself. The *Yetzer tov,* similarly, is not only good but intelligent and controlling. Thus, "*Yetzer*" is less representative of instinct theory than of the Id and the Ego topology. When the *Yetzer ha-ra* "tells a man" to profane the Sabbath the *Yetzer tov* doesn't say that "the Sabbath observance is beautiful, so don't do it . . . "; it says "Fool, this is dangerous. God says he who profanes the

Sabbath shall die." (Ex. 31:14) In all the examples the *Yetzer tov* addresses the *Yetzer ha-ra* as "fool." In other words the emphasis is not "Be good," but "Be clever."

However there are other meanings for these two terms. In some places Yetzer seems to mean *free will;* in other places definitely instinct. The author ends his article by saying that the nickname "Jewish Science" for psychoanalysis contains a grain of serious truth.

* * * *

A remarkable series of cases is presented by two psychiatric colleagues working in the surgical department of Massachusetts General Hospital. In several of these, death was definitely predicted by the patient, and the prediction correspondingly fulfilled. In all five cases the wish for death was more or less conscious. The most extraordinary of the cases, everything considered, was the "unusually attractive and certainly unusually intelligent and unusually mentally healthy" girl of fourteen who died finally of a metastatic cancer. At the end "despite cachexia and pain, she remained cheerful. A large mandibular lesion, along with heavy sedation, made conversation impossible. Had she been able to speak, those who saw her to the end did not doubt that she would have said good-bye with the same equanimity she maintained throughout her tragic, but happy termination." (Weisman, Avery D. and Hackett, Thomas P.: Predilection to Death. *Psychosomatic Medicine* 23:232–256, May–June 1961.)

* * * *

From "The Training Centre for Concentration and Memory, Bangkok, Thailand" I recently received a pamphlet written by three general practitioners, two anatomists and a physicist and illustrated with many photographs. It is entitled: *A Record of the Discovery and Investigation of How Vision is Attained Through the Cheek by the Blind or Blind-Folded Persons.* The scientists who examined these subjects—there were three of them—believed undoubtedly that something like the title occurs. An appendix contains neurological studies of "Proposed Possible Extra-Ocular Pathways" and another article entitled "Preliminary Tests on the Phenomenon of Extra-Ocular Vision."

Dr. Gardner Murphy studied the article and reserves judgment because: "First, it is extraordinarily difficult to ascertain the adequacy of a blindfold, and the descriptions and photographs here leave the reader quite uncertain as to the exclusion of all visual cues. Secondly, when there are other people in the room who know what is to be seen, such as a needle or

a printed text, it is extraordinarily difficult to tell how much may have been unwittingly conveyed to the subject by the little physical signs which are regularly used by sensitive subjects. I see no reason to believe that deliberate fraud was involved but the precautions are extraordinarily difficult to take without involving inconvenience or putting pressure on the subjects, and such precautions are, unfortunately, very rarely used. I am afraid that under these working conditions it is impossible to draw any conclusions."

° ° ° °

There will probably be some national comment on the special supplement of *The Atlantic* for July 1961 entitled "Psychiatry in American Life." I shall be interested in the appraisal of this collection of essays for several reasons. One of these is that they invited me to contribute an article, and after accepting I had to decline because of being too busy.

I personally felt a little disappointed with the series. After Stanley Cobb's lead article, Professor Seeley seems to be preoccupied with diversions, and Alfred Kazin says that Freud is the only first-class writer identified with the psychoanalytic movement; he selects Sullivan, Zilboorg, Bergler to damn, graciously avoiding all mention of this reviewer. Greer Williams continues to deplore the sad state of American psychiatric hospitals without seeming to have taken a look at Kansas. Ostow writes about drugs; our recent guest, Rieff, discusses "American Transference from Calvin to Freud." Perhaps the best thing of all is a half page entitled, "The Neurotic's Notebook" by Mignon McLaughlin. Samples:

If you had an unhappy childhood, you will always want to sleep late in the morning.

The two unhappiest years in a woman's life: when she is thirteen, and when her daughter is.

Neurotics love being in debt; it proves that someone trusts them.

When men complain that they don't understand women, they mean they don't want to be bothered trying.

° ° ° °

There are 168 hours in a week. Of this total, about 67 are occupied with sleeping, washing, dressing and toileting; meals (eating, not preparing them) occupy perhaps 14. This leaves 87 hours to be accounted for. About one-half of these are spent in earning a living. What do we do with the other forty odd?

° ° ° °

The National Parks' principle of land use has spread to over fifty nations. Yosemite was of course our first; it will soon be over one-hundred years old. Yellowstone was founded in 1872 but it is by no means the largest; it ranks fourteenth in size! Canada has one park which is over five times as large (the Wood Buffalo National Park). Kenya has Tsavo and South Africa has Kruger; both are over five million acres in area. America needs some more and some larger parks—not only in Alaska (where we now have three) but close at hand where everybody can get to them and use them. (*American Forests*, June 1961.)

° ° ° °

Good conservation news turns up now and then to keep the bad news from being so monotonous. A chap named Archie Carr, Professor at the University of Florida, knew about the disappearance of the Giant Green Turtle of the Caribbean. It was the usual thing—the blessings of civilization; the eggs were dug up by predators, the female turtles were killed, packs of wild dogs ate the eggs and babies, buzzards and sharks finished the rest. So the Carrs went at it scientifically and set up protection of the laying beaches. Result: more turtles again. (*Saturday Evening Post*, June 10, 1961.)

° ° ° °

For several years I have been consulted on the telephone and occasionally in person by an Indian friend of mine named Frank Takes Gun of Albuquerque. He is a leader in a religious organization known as the Native American Church of North America which makes use of peyote in its ceremonial rites. The laws of certain states erroneously declare peyote a narcotic and hence suits have been brought against various members of this church, which have been dragging through the courts for some time.

On April 25, 1961 the Supreme Court of Arizona dismissed the case pending there, and the decision of the referring court was sympathetic. So the Indians finally won.

"One sad note"—reads the letter of the attorney of Mr. Takes Gun—"the young, brilliant psychiatrist, Dr. Bernard Gorton, who testified in such lucid fashion, passed away on the same day from an asthmatic attack."

K.A.M.

BOOK REVIEW

Achievement in the College Years. LOIS B. MURPHY AND ESTHER RAUSHENBUSH, eds. $4.95. Pp. 240. New York, Harpers, 1960.

Sarah Lawrence College, that gold mine of educational and psychological information, is the locus for this creative investigation of the *ought* of American higher education. It studies 86 freshmen, with a core group of 46 (the total enrollment was 350 at the time, is now 400), throughout their four-year residence. It involves "separate approaches to the same data from different points of view," covering individual backgrounds, psychological and academic backgrounds, and a mass of faculty and student evaluations.

The college is dedicated to the principle that "the acquisition of knowledge is not an end in itself, but that it is the means by which individuals enlarge their capacities, deepen their responses, and broaden their understanding of themselves and their world." To this end the institution has pioneered in undergraduate seminars, guidance and tutoring of individuals, extensive student self-government, on-the-job training, and participation by students in planning highly individual curricula.

With this rich environment, the authors of the present study find it possible to discover what Esther Raushenbush calls "ways in which particular constellations of qualities . . . are related to the way students work and the way they use and respond to the educational experience."

Emphasizing "the students' experience of growth," Doctor Murphy finds, in addition to feelings of intellectual accomplishment and liberation, an increase in interest and ability in working with others as well as increased satisfaction in doing so. She poses a question: "Should the college build on the general aspects of the intelligence of the individual and emphasize a broad exposure to all the main areas of the culture, or should the individual be helped to make his own selection and pattern in line with his preferences?" This and other questions make this book a provocative contribution to education.

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PUBLICATIONS BY MEMBERS OF THE STAFF

BRYANT, KEITH N. and HIRSCHBERG, J. COTTER: Helping the Parents of a Retarded Child: The Role of the Physician. *Am. J. Dis. Child.* 102:52–66, July 1961.

It is often difficult to help the parents of a retarded child accept this diagnosis and follow through with constructive planning. Many parents feel dissatisfied with the assistance they have received from their physician. Study of these cases reveals that in many instances there is a lack of clarity on the part of the physician as to what his role should be, and an unsureness about how to proceed. In this report the over-all diagnostic task, the range of recommendations that must be considered, and the practical ways of sharing the findings and recommendations with the parents are discussed. In addition, some of the underlying attitudes the parents may have about mental retardation which may hamper the helping process are considered.

TOUSSIENG, POVL W.: The Role of Education in a Residential Treatment Center for Children. *Ment. Hyg.* 45:543–551, Oct. 1961.

Academic education gives emotionally disturbed children better tools to cope with the surrounding world and can, therefore, be of great therapeutic importance in a total residential treatment program. The teacher in a residential academic school maintains his role and identity as an educator, but draws freely on the observations of other staff members, *e.g.*, as to the emotional or physical and neurological learning blocks present in most disturbed children. He is flexible enough to adapt himself to the children's fluctuating levels of functioning, without jeopardizing the dignity of the classroom structure. Permissiveness or play in the classroom is confusing and destructive.

MORIARTY, ALICE: Coping Patterns of Preschool Children in Response to Intelligence Test Demands. *Genet. Psychol. Monog.* 64:3–127, Aug. 1961.

This data was one segment of the Coping Project, directed by Lois Murphy under a United States Public Health Service grant. The revised Stanford-Binet and The Merrill-Palmer Performance Tests were administered to thirty-two normal children of preschool age. Responses to newness, verbal tests, performance tests and difficulty were rated on eleven noncognitive variables. Persistent and distinct coping styles were related statistically to capacity to relate socially, positive self-feeling, self-expressiveness and motor facility. Mental age, chronological age and sex contributed to coping skills in lesser degrees. Contrasting coping patterns and implications for mental health were discussed.

ESCALONA, SIBYLLE K. and MORIARTY, ALICE: Prediction of School-age Intelligence from Infant Tests. *Child Development* 32:597–605, Sept. 1961.

A rationale is presented for the hypothesis that in the absence of major variation from an "average expectable environment" infant tests will predict the *general level* of later intelligence functioning within the average and superior ranges. The Kruskal-Wallis one-way analysis of variance by ranks permitted calculation of differences in school-age intelligence range as related to initial assessment of potential intelligence range for 58 subjects tested first in the 3 to 33 weeks age range, and again in the 6 to 9 years age range. For subjects tested at ages 20 weeks and above, both Cattell and Gesell scores showed positive relationships to later intelligence *range* (p values between .10 and .20), whereas clinical appraisal predicted later intelligence range ($p = .02$).

MURPHY, GARDNER: Testing the Limits of Man. *J. Soc. Issues* 17:5–14, 1961.

It has always been considered sound practice to "take man as he is." The assumption is that however he has been pounded, twisted, and warped by the environment, he is still his same old self. These assumptions are being fundamentally changed by various kinds of isolation studies, stress studies, man-in-space studies, which provide a radically different kind of environment from that in which man has ever been known to function. We cannot control this much, but we can watch to see what the *limits* of known human nature may be and what kind of being comes into existence under various new pressures. The pressures are not necessarily baleful either; they may here and there stretch the person into an interesting and even creative new human type. The studies of man-in-space may find out something about new limits of man's potentiality for change.

GARDNER, RILEY W.: Cognitive Controls of Attention Deployment as Determinants of Visual Illusions. *J. Abnorm. Soc. Psychol.* 62:120–127, 1961.

Earlier investigations at The Menninger Foundation have suggested that two independent cognitive control principles determine (a) selectivity of attention to relevant vs. compelling irrelevant material (stimuli, memories, etc.) and (b) extensiveness of attention deployment under ordinary conditions. Successful differential predictions were made from criterion measures of these cognitive control principles to the experiencing of two types of illusions. The two studies described also demonstrate that one of Piaget's general hypotheses concerning attention and perception is uniquely useful in accounting for perceptual consequences of extensiveness of deployment. The place of such cognitive controls in a psychoanalytic conception of ego organization is discussed.

GARDNER, RILEY W.: Individual Differences in Figural After-Effects and Response to Reversible Figures. *Brit. J. Psychol.* 52:269–272, Aug. 1961.

The perceptual phenomena called figural after-effects have been explained by leading gestalt psychologists as consequences of cortical "satiation" brought about by prior stimulation. Several theorists have suggested that these after-effects reflect general principles of brain functioning, metabolic efficiency, etc. If so, individual differences in these phenomena could reflect variations in an important aspect of cognitive organization. This study shows, however, that one cannot predict the amount of kinesthetic after-effect from the amount of visual after-effect. In other words, no general principle can account for the after-effects experienced by one individual and the phenomena are of limited importance to the problem of cognitive organization.

BRIEF BOOK REVIEWS

Contemporary Psychotherapies. MORRIS I. STEIN, ed. $7.50. Pp. 386. New York, Free Press, 1961.

Here is something for therapists of almost every theoretical persuasion: Adlerian, Client-Centered, Existential, Interactional, Interpersonal, Psychoanalytic, Reparative-Adaptational, Transactional, Group and Family Therapy. This book contains a series of lectures on psychotherapy at the University of Chicago where ten outstanding therapists gave theoretical expositions and clinical presentations. While uneven, the papers are of high quality and serve to illuminate, to challenge, to stimulate, to probe further avenues of study, to summarize the past; they illustrate well the great diversity, scope, and growth of psychotherapies. More of editor Stein's able "Introduction," and bibliographies, would enhance the value of this volume. (JEROME B. KATZ, M.D.)

Psychiatric Social Work: A Transactional Case Book. By ROY R. GRINKER, SR. and others. $6.50. Pp. 338. New York, Basic Books, 1961.

The product of ten years of research at Michael Reese Outpatient Clinic focuses on two basic questions: 1. What does the psychiatric social worker do with his time in the clinic and hospital? 2. How does he use his knowledge and technical skill in serving his patients' needs? The answers involve knowledge of psychodynamics, communication, role behavior, and field theory—a synthesis which the authors call "the transactional approach." Detailed case histories and comments make the book provocative and useful to practitioners, teachers, and supervisors. The transactional concept is by no means new, however. Whether the authors' approach, especially in terminology, clarifies or confuses the social worker's function, is a question. (ROSE FARKAS, M.S.S.)

The Psychogenesis of Mental Disease. Collected Works, Vol. 3. Bollingen Series XX. By C. G. JUNG. $4.50. Pp. 312. New York, Pantheon, 1960.

The death of Carl Jung is a timely moment for the appearance of this beautiful volume containing ten of his important writings. The most famous is "The Psychology of Dementia Praecox," 54 years after its original publication still basic reading for every psychiatric resident and every candidate in psychoanalytic institutes. It was Jung who stood up against the nihilistic psychiatry of his day—the brain psychiatry of Griesinger and others—and showed that some patients with "dementia praecox" were curable by psychological methods. In 1916 cases of recovery from "schizophrenia" began to be reported in American psychiatric literature. Almost as far back, under Jung's inspiration, I started a folder labeled "Reversible Schizophrenia," in which I put case histories of patients whom I saw recover from what we had called schizophrenia. (K.A.M.)

Report of the Second Institute on Clinical Teaching. HELEN HOFER GEE and CHARLES G. CHILD, III, eds. Pp. 199. Evanston, Ill., Assn. of American Medical Colleges, 1961.

How can we improve the medical school curriculum to insure a dependable finished product? What positive steps can we take to reconcile the attitudes which divide the basic and the clinical scientist, the traditionalist and the innovator? The discussions comprising this report deal with these and related problems. They reflect, too, the conflicts and uncertainties with which medical education has been confronted for two decades. Incidentally, John D. Benjamin contributes a thoughtful presentation of psychiatry as a scientific discipline. (Nathaniel Uhr, M.D.)

Motivation and Emotion: A Survey of the Determinants of Human and Animal Activity. By PAUL THOMAS YOUNG. $10.75. Pp. 648. New York, Wiley, 1961.

Rich in data and references, broad in scope, sophisticated in its eclecticism, and tolerant of diverging viewpoints, this new volume brings Young's previous two books on motivation and emotion up to date and integrates them appropriately. One can bicker about the proportionate weight given to certain data and observations, one can argue Young's definitions, but students of motivation and emotion cannot leave this work alone. Eminently readable too, it maintains a pleasant hedonic tone and motivates one to read on, despite its imposing length. (Paul W. Pruyser, Ph.D.)

Recognizing the Depressed Patient. By FRANK J. AYD, JR. $3.75. Pp. 135. New York, Grune & Stratton, 1961.

A useful monograph based on the study or treatment of 500 depressed patients, written to assist the nonpsychiatrist physician to recognize and treat depressive illnesses. Depressions are among the most common illnesses encountered by the general practitioner, yet only a minority require psychiatric referral or hospitalization. The underlying pathology of depression is said to be related to physiological changes in the central nervous system. The detailed description of symptoms and differential diagnosis is helpful. Treatment

recommended includes a thorough examination, supportive psychotherapy, and the appropriate use of tranquilizers and antidepressant drugs. Referral to a psychiatrist is advised when suicidal intent, severe agitation, or disturbing delusions are present. (Herbert Klemmer, M.D.)

Clinical Child Psychiatry. By KENNETH SODDY. $8.50. Pp. 480. London, Bailliere, 1960.

In an unpretentious, warm, often humorous way, Doctor Soddy discusses what can go wrong after the child is conceived, is born, and grows, and explains these disturbances in the simplest possible language. The interaction with parental attitudes and problems, as well as with the larger cultural and socioeconomic environment, is never forgotten. Numerous exceptionally well-written case histories followed by brief and penetrating comments are worth more than whole chapters on the same subject. The chief virtue of this book is its basic approach and philosophy, its way of helping the reader find a vantage point from which the children's difficulties can be understood, so that rational treatment can be instituted. (Povl W. Toussieng, M.D.)

A Prelude to Medical History. By FELIX MARTI-IBÁÑEZ. $5.75. Pp. 253. New York, MD Publications, 1961.

This is a charming book of essays written with a light touch, tracing origins and ancient development of the practice of medicine from antiquity. The chapters are based on lectures given at the New York Medical College. A helpful table of medical and historical chronology is included in the appendix. This is a book to be read, rather than to be studied. (K.A.M.)

The Annual Survey of Psychoanalysis, Vol. 6. JOHN FROSCH and NATHANIEL ROSS, eds. $12. Pp. 612. New York, International Universities, 1961.

This survey of the literature of psychoanalysis has become a standard fixture in the psychoanalytic library. No one would want to miss a volume even though he had previously read most of the articles reviewed. This volume covers the year 1955. There are very few changes in the arrangement of the contents, which cover psychoanalytic history, critique, theory, clinical studies, education and applications. The uniformity and similarity of the contents are suggested by the fact that volume 5 (which I have just carefully re-examined) contains 608 pages, and this new one, 612 pages; volume 5 has a bibliographic list of 263 items while volume 6 lists 301 items. (K.A.M.)

Report Writing in Psychology and Psychiatry. By JACK T. HUBER. $3.50. Pp. 114. New York, Harper, 1961.

This little book is fresh, direct, even brisk in style. It provides a useful survey of some of the problems the clinical student—both psychiatrist and psychologist—faces as he becomes responsible for the preparation of clinical reports. Much of the book is really a summary of the few published books and articles on the problem of report organization and report writing. Topeka's contributions are quoted extensively but some important papers on the subject, such as those by Forer, are not even mentioned in the bibliography. (Martin Mayman, Ph.D.)

Psychology: An Introduction to the Study of Human Behavior. By HENRY CLAY LINDGREN and DONN BYRNE. $6.50. Pp. 429. New York, Wiley, 1961.

An excellent textbook which covers the standard material of a first course in psychology in briefer but better than average fashion. Major emphasis falls on social and emotional factors in behavior; one-fourth is given to various applications of psychology in industry, counseling, and world affairs. Especially noteworthy is its clear presentation of current issues including studies by Harlow, Witkin, Hebb, and other psychologists whose work is "news." Abundantly illustrated (pictures, cartoons, and diagrams), it should draw student approval. Probably useful to any psychologist for quick reference to recent developments in unfamiliar areas. (Kathleen K. Sinnett, Ph.D.)

The Meaning and Measurement of Neuroticism and Anxiety. By RAYMOND B. CATTELL and IVAN H. SCHEIER. $12. Pp. 535. New York, Ronald, 1961.

This ambitious volume reports extensive data and draws implications for clinical theory and practice from five years of research by the senior author and his co-workers in the Laboratory of Personality Assessment and Group Behavior at Ohio State University. Their intent is to provide the diagnostician with more precise assessment techniques and the personality researcher with new ways of testing hypotheses concerning motivation and behavior. (Charlton Price, M.A.)

The Hypnoanalysis of an Anxiety Hysteria. By FREDERICKA F. FREYTAG. $6.50. Pp. 412. New York, Julian Press, 1959.

An interesting detailed description of the hypnoanalysis of one case, presented as an illustration in which such a case can be treated more rapidly with hypnosis than with ordinary or traditional techniques. From this point of view, it has much to offer of interest to the experienced psychotherapist interested in the use of hypnosis. The reviewer sees as a striking flaw in this otherwise interesting and valuable book the inadequate discussion of the transference and counter-transference phenomena. (John A. Turner, M.D.)

Adolescents: Psychoanalytic Approach to Problems and Therapy. SANDOR LORAND and HENRY I. SCHNEER, eds. $8.50. Pp. 378. New York, Hoeber, 1961.

Nineteen authors consider the special conflicts which they feel make the period of adolescence a separate stage of development and which produce major tensions for the adolescent and his parents and teachers. Earlier unresolved sexual and aggressive conflicts re-emerge; oedipal wishes are intensified; competition and separation anxiety between adolescent and parents make communication between them difficult; healthy independence and maturation are opposed by rebellion or clinging. All this occurs in the subculture of adolescence with its specific social and sexual mores. From the case records and the theoretical formulations in this book, one can gain understanding of the adolescent–parent and the adolescent–therapist relationships, and the unique problems and potential inherent in both. (J. Cotter Hirschberg, M.D.)

Prevention of Mental Disorders in Children. GERALD CAPLAN, ed. $8.50. Pp. 425. New York, Basic Books, 1961.

A comprehensive handbook of programs for the promotion of mental health in children with emphasis on primary prevention beyond the usual approach of early detection and early treatment. The eighteen chapters cover many facets of interrelation and interaction of children with parents, teachers, and all those who come in contact with children, and their importance in the prevention of mental disorder in children. Dr. Lois B. Murphy has a chapter of note on the mental health significance of stressful experiences and crises during the normal development of a preschool child. The book is thought-provoking but not dogmatic. (Leslie Y. Ch'eng, M.D.)

A Handbook of Emotional Illness and Treatment. By RICHARD C. ROBERTIELLO. $3.95. Pp. 159. Larchmont, N.Y., Argonaut, 1961.

A thoroughly intelligible though necessarily oversimplified manual useful to laymen and to physicians unversed in psychiatry. The lengthy dictionary of common psychiatric terms, while somewhat categorical, will prove illuminating to the nontechnical reader. The author's objective view of methods of treatment is a distinct asset. (Nelson Antrim Crawford, M.A.)

Religion, Culture, and Mental Health (Proceedings of the Third Symposium, 1959). ACADEMY OF RELIGION AND MENTAL HEALTH. $3.50. Pp. 157. New York, New York University, 1961.

In this little volume, experts in the fields of anthropology, sociology, religion, and psychiatry, dispensing with the usual clichés about religious and psychological togetherness, voice their respective viewpoints on the mental health of man. This book reads well—the tone is generally informal and there is less redundancy than in the previous volumes of this series. The views presented are, for the most part, clearly stated and thought-provoking. Of special note to scholars in the area is the appendix by Professor Douglas Heath. This is an exhaustive, carefully prepared outline of research possibilities based on the proceedings of the first three yearly conferences of the Academy. (Philip Woollcott, Jr., M.D.)

Curiosity. By HERMAN NUNBERG. $3. Pp. 88. New York, International Universities, 1961.

A penetrating essay embodying a psychoanalytic interpretation of curiosity, illustrated by the analysis of a businessman patient successful in finding answers to reality questions in his work, but obsessed by such unanswerable questions as when the Renaissance began and when it ended. The human need for causality, as well as the synthetic function of the ego, the author concludes, stems from infantile sexual curiosity. He points out the value of curiosity in stimulating intellectual performance, but warns of its destructiveness when too much aggression is released. (Nelson Antrim Crawford, M.A.)

The Open and Closed Mind. By MILTON ROKEACH. $7.50. Pp. 447. New York, Basic Books, 1960.

The studies of belief systems Rokeach describes extended over nearly nine years and involved both American and British populations. His results stand in refreshing opposition to some common stereotypes concerning authoritarianism and dogmatism. These traits, he demonstrates, may be as prominent in ideological middle-of-the-roaders as in those extremely right or left of center. Rokeach also presents intriguing evidence that discriminatory preferences may be psychologically based primarily on belief congruence, rather than on ethnic or racial congruence per se. Of particular value is his consideration of ideological findings within a conceptual framework that includes affect, cognitive structure, and situational determinants of social behavior. (Riley W. Gardner, Ph.D.)

Design for a Brain: The Origin of Adaptive Behaviour. By W. ROSS ASHBY. $6.50. Pp. 286. New York, Wiley, 1960.

A thoroughly revised edition of the well-known 1952 text, developing general principles for the understanding of adaptive behavior. The brain model advanced is deliberately mechanistic, excluding all references to consciousness and other subjective phenomena; the model problem used throughout the book is: a kitten will first approach a fire in a happy-go-lucky way, exposing itself to hazards, but when grown up will react to fires adaptively, jumping away from falling coals, approaching when the fire goes down, seating itself at the place of optimal warmth. The concepts of stability, homeostasis, step function, system, etc., are discussed mechanically, logically and mathematically. (Paul W. Pruyser, Ph.D.)

Mental Health in the United States: A Fifty-Year History. By NINA RIDENOUR. $3.50. Pp. 146. Cambridge, Mass., Harvard University, 1961.

A comprehensive and well-organized record of dedication and achievement, from the founding of the first mental hygiene society by Clifford Beers in 1908. The author, long connected with the movement, emphasizes the importance of disseminating scientific information on mental health among more and more people. Dr. William C. Menninger contributes a stimulating introduction to the book. (Nelson Antrim Crawford, M.A.)

The Psychoanalytic Study of Society, Vol. I. WARNER MUENSTERBERGER and SIDNEY AXELRAD, eds. $7.50. Pp. 384. New York, International Universities, 1961.

This series continues the previous *Psychoanalysis and the Social Sciences* founded by Roheim. It contains original papers, most of which have been read in recent years at society meetings, by eleven authors, dealing with the following topics: totalitarianism, soldiers' efficiency, values and the superego, cross-cultural studies on child training and illness, Eskimo hysteria, a case study of an active racist, a case study on creativity, a comparison of Freud and James Fenimore Cooper on origins of culture, and the development of Hebrew monotheism. Unreviewable in short space. Though bound and in book format, one may regard it as a journal with diverse papers, lacking unity and running text. Interesting, but of variable quality. (Paul W. Pruyser, Ph.D.)

The Real Bohemia. By FRANCIS J. RIGNEY and L. DOUGLAS SMITH. $5. Pp. 250. New York, Basic Books, 1961.

Psychiatrist Rigney and Psychologist Smith have produced a pioneer scientific study of the Beats as represented in one of their major habitats, North Beach in San Francisco. Based on observation, interviews, and psychological tests, the conclusion is that, like earlier Bohemians, the Beats possess creative abilities, but are plagued with inhibiting internal conflicts and external persecution. Their behavior, the authors explain, "represents an exaggerated and prolonged version of the dynamics common to everyone." An understanding and fascinating book. (Nelson Antrim Crawford, M.A.)

Residential Treatment for the Disturbed Child. By HERSCHEL ALT. $7.50. Pp. 437. New York, International Universities, 1961.

From many years of experience in the Jewish Board of Guardians, Mr. Alt portrays objectively the developmental changes which occurred in the use of the various professional and nonprofessional groups working with children in residence. For those interested in training programs and research for improved staff patterns, this book provides a new stimulus. The role of cottage parents, as well as of social workers, psychotherapists, and educators, is explored, with well-selected illustrative material. The book should be read by all working in residential treatment facilities or in state hospitals with children's wards. (Edward D. Greenwood, M.D.)

Ninth Life. By MILTON MACHLIN and WILLIAM READ WOODFIELD. $4.95. Pp. 321. New York, Putnam's, 1961.

The authors of this review of the Caryl Chessman case "discovered him less than a month before his ninth scheduled execution date." They had both considered him undoubtedly guilty and felt that public sympathy was being "wasted on an unregenerate criminal psychopath." After examining exhibits and a transcript of the trial they became convinced that his arrogant behavior in the courtroom and his insistence on being his own defense lawyer, which antagonized the court and the public, led to his dubious conviction and savage sentence. These authors appear to feel that Governor Brown sacrificed his political career not by contemplating clemency but by being so undecided and vacillating that he embittered both sides.

It is disturbing to learn that when for the ninth time a stay of execution had been granted, the message did not reach the warden until the cyanide pellets had been dropped. Even then Chessman might still have been rescued, they say. (K.A.M.)

Preconscious Stimulation in Dreams, Associations, and Images: Classical Studies. By OTTO PÖTZL, RUDOLF ALLERS and JAKOB TELER. *Psychological Issues*, Vol. II, No. 3, Monograph 7. $4. Pp. 156. New York, International Universities, 1960.

This monograph is an English translation of two classical experimental studies on subliminal perception and memory trace of a kind which once intrigued Freud. These were long forgotten, but are now being rediscovered as lying at the core of psychoanalytic ego psychology. A masterful summary by Fisher brings out the actuality of these early papers and integrates them with contemporary research. (Paul W. Pruyser, Ph.D.)