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THE PRIVATE PRACTICE OF PSYCHIATRY*

By SOL WIENER GINSBURG, M.D.†

There has been extraordinary ferment and growth in psychiatry in the past twenty-five years and it has been my good fortune to participate in and observe the changes that have occurred. It may prove useful to review some of these changes to see which have been fleeting, which more lasting, and to consider some of the lessons to be learned from the changes as well as from those things which have remained steadfastly unchanged. Much of what I shall say will be an extension of earlier comments.††

My first teacher in psychiatry was Thomas Salmon. He was genuinely devoted to psychiatry but the curriculum at Columbia allowed him no scope. His reputation rested in good part on his war experience, during which he had been Senior Consultant in Psychiatry for the American Expeditionary Forces. He is still remembered largely for his cable from France decrying the vast number of emotional misfits who were being sent overseas and demanding that a stop be put to this practice.

My class at school was peculiarly uninterested in psychiatry, and attendance at Salmon's ten or a dozen lectures in the first year was sparse indeed. This was a shame; he was not only a vital teacher but he gave the students in 1920 what was for most if not all of us our first opportunity to hear the magic name of Freud and to learn something of his work. It may be that Salmon, along with others at that time, understood little of what he had read of Freud, but he knew somehow that he had stumbled on greatness and was eager to pass on the word. He encouraged us to read Freud and it was at his suggestion that I began to study the *Introductory Lectures* and *The Interpretation of Dreams*.

There was little else of psychiatry at Columbia in those days to remember.

* Presented at Winter Veterans Administration Hospital to a staff forum on May 10, 1954 in Topeka, Kansas.

† New York, New York.

†† Ginsburg, S. W.: Some Notes on the Private Practice of Psychiatry. *Bull. Menninger Clin.* 10: 188–195, Nov. 1946.

There was not even an independent psychiatric clinic; the patients with emotional and mental problems were seen in the neurology clinic. We were invited to go to the state hospital for a visit in our last year to "see" the patients. I went a few times on my own and was promptly labelled as a freak by my classmates. The paucity of instruction and the official attitude toward psychiatry may well have had something to do with the fact that so far as I know I am one of only two psychiatrists in my class.

I came to Mt. Sinai Hospital as a resident in 1925 and my psychiatric training may properly be said to have begun then. As early as 1913 Oberndorf had organized a psychiatric clinic within the Neurology Department. It was manned by a group of psychoanalytically oriented psychiatrists, even though it had to hide under the title of "Mental Health Class," for respectability's sake! When I came to the hospital, the clinic was headed by Oberndorf and staffed, among others, by such analysts as Lorand, Monroe Meyer, Broadwin, Shoenfeld and Silverberg. It was a real psychoanalytic treatment and teaching center, the first of its kind I believe in any general hospital in this country.

May I digress at this point to say a word about "Obie,"* as he has been known to students, colleagues and friends? I had been at the hospital only a few weeks when a case of hyperthyroidism was admitted to the wards. At that time, these patients were treated by a method euphemistically called "skillful neglect," which consisted of putting the patient to bed, giving him a high caloric diet and plenty of sedation. I had heard casually at medical school that emotional factors occasionally played a role in the etiology of hyperthyroidism, but this remained an academic abstraction until Obie told me to talk to the patient about herself and to listen to anything she wanted to talk about. In 1925 this was revolutionary treatment and this contrast in the degree of knowledge and sophistication about such matters is one index of the changes that have occurred since. In that instance and in untold others, Obie was a pioneer, enabling me and many others to see the person with the sickness and the life story beyond it, and this before any notoriety had made of psychosomatic medicine an etymological horror and a fashion in medicine.

After completing my analytic training in Europe I began private practice. The alternative to this was a staff job at a state hospital. The opportunities for learning in such hospitals were poor, the salaries inadequate. The demand in the community for psychiatrists was great. Research positions did not exist so far as I knew and I had little, if any, conflict about my choice.

Almost at once I was busy, especially since I was continuing my interest

* Doctor Oberndorf died at the age of 72 on May 30, 1954.

in pathology and holding a part-time Fellowship at Mt. Sinai Hospital. I mention my rapidly increasing practice because it posed a problem for me even as it does for young men today. Once one is submerged in an overwhelming load of patients, all plans for study, teaching and research can quickly evaporate. Then, as now, easy rationalizations were at hand.

My patients fell into two groups, as they have continued to do. There were a considerable number of consultations and a smaller number of patients in therapy. The latter came five or six times a week and I am a little horrified when my notes reveal clear indications of an unpleasant rigidity about such matters as time, and fixity of appointments. Perhaps the first change that struck me as I reviewed early records was the almost total absence of the kind of psychotherapy I now practice a great deal. It is hard for me to remember why it took me some years to apply to private practice the lessons I was learning at the clinic. We saw patients there, as we still do, once or twice a week for about half an hour and the results were often remarkably good. This was and is especially gratifying when one recalls that clinic patients are the least knowledgeable, the most unsophisticated, and, practically without exception, burdened by serious reality problems. I see few patients five times a week, many two or three times and not a few only once a week. I find this one of the most exciting aspects of practice today as contrasted with my beginning years. It enables me to offer help to a great number who could not possibly afford or manage the time required for intensive therapy.

Of course the debate as to the wisdom of such a procedural change goes on endlessly and there are still many analysts who see patients only on a five times a week basis. I must say I was heartened when recently I referred a patient to a colleague in another city. I had been seeing the patient two or three times a week in what is now called psychoanalytic psychotherapy and although she had done quite well, I thought she should undertake more formal analytic work. The patient was ready for this but my colleague said she saw no one more than three times a week except students in training, and would prefer to continue on this basis with my patient.

The next thing that struck me as I reviewed old records was the almost total shift in the types of illness presented by patients. The most striking changes are these: the manic depressive conditions have practically disappeared from my practice; it has been almost two years since I last saw such a patient. Whereas conversion hysteria, anxiety hysteria and neurasthenia were frequent diagnoses in the old days, they have been replaced with the obsessive compulsive states, the so-called borderline conditions, and most strikingly, schizophrenia. This is, of course, a purely impressionistic estimate. My experience is not at all uncommon, but we still need carefully controlled studies both to establish the facts of this change and

to try to explain it. Obviously it must represent something more than a shift in diagnostic acumen or a change in nosological fashion.

As I reconstruct the situation, I made a diagnosis of schizophrenia with the usual criteria on "typical" patients, almost all of whom I immediately hospitalized. If I saw schizophrenics similar to those I now treat in the office as a routine matter, they either escaped my attention or I labelled them quite differently. Certainly a good number of the then depressions in younger people would be called schizophrenia today. I tested some of these early cases against both my own usual clinical criteria and the Hoch-Polatin criteria for the diagnosis of pseudo-neurotic schizophrenia. In four or five instances I could be certain that a diagnosis of schizophrenia would have been warranted, but there is not the slightest suggestion that I ever thought of such a diagnosis at the time.

More important and much more exciting than this nosological shift is the fact that many of us today treat patients in the office that we would never have dared tackle in the recent past, with most gratifying results. For myself, practice has outstripped theory and I use pretty much a homemade sort of supportive, activating, deep therapy which is most difficult to describe, as it is, indeed, to practice, fitting the treatment to each patient in a highly individual way.

One device I find of great help and great interest is that after some schizophrenics, especially the young patients, have reached a reasonable degree of stability I encourage them to discontinue office treatment but to remain in close touch with me by letter and telephone. This has its drawbacks; my wife has come to know the inevitable evening calls and to recognize Tom or Mary. Her comment is that she thinks I am doing first rate case-work with these patients, a compliment perhaps of some theoretic interest.

Many patients I see now are in the general range of character disturbances; people who are having difficulties in interpersonal relations but with few if any "symptoms." They work, often at top level jobs; they function in society, often quite usefully from society's point of view; they are on boards and committees and belong to organizations but withal they are miserable. It is certainly tempting to reflect on their illness as part of our world's tensions. But I am not fully persuaded. It seems reasonable to expect that these tensions contribute to our patients' difficulties, but I wonder if they do more than provide the setting within which the illness develops.

Then there are many patients with psychosomatic problems, who are referred because they suffer from illnesses in which emotional factors are now clearly recognized. There are two interesting extremes in these patients as I see them—they usually are referred too early or, (and this is clearer) much too late. I see a steady stream of patients referred by doctors who work in highly sophisticated hospital settings. These patients have relatively minor symptoms but are told that these are manifestations of emotional illness and that they should seek analytic help.

My favorite illustration of this group had been a young man who was referred to me because of a single patch of psoriasis, but recently I saw an equally impressive example of "premature" referral. A young man, an applicant for a position requiring a preliminary physical examination, fainted when blood was drawn from a vein. He told the examining physician of one similar incident while in the Army. He is in excellent health, happily married, has good relations with his children, has had excellent and satisfying jobs, and is in line for promotion to a top executive post.

Theoretically one might say that in each case there was a symptom which suggested, or in the instance of the man who fainted, indicated an emotional conflict. Both of the referring physicians have real knowledge of psychodynamics and one of them has had a successful therapeutic analysis. But weighing the symptom against time, money, and lack of motivation, I advised the patient not to start an analysis. The physician of the man who fainted disagreed with me and sent the patient to another analyst who undertook therapy with him. The internist, a close friend, reported that my colleague attributed my opinion less to a lack of knowledge of pathology than to my general "conservatism"!

The rightness of my estimate is not important; I wonder if we have not become overly sensitive to the role of emotional factors in illness, and if especially in our teaching of undergraduates, we are not a bit too enthusiastic and somewhat unrealistic. One therapeutic tool is available for such patients and too infrequently used. In the clinic we often get satisfying results from casual, supportive psychotherapy in many psychosomatic problems but confronted with similar problems in private practice, we seem impelled to offer intensive, reconstructive therapy or nothing. This is rather a shame; I know no more grateful patients than those freed from a distressing symptom even though nothing more profound is attempted. I recently saw a man of fifty with a lifelong character problem and anxiety state. He had finally developed frightening and crippling attacks of angina-like pain. It was possible for him to come only once a week and in twenty-odd sessions his pain had gone, although to be sure he was still the same rigid, domineering, egocentric character. I do not think this any miracle but only a satisfactory result of therapy based on the limited and realistic goals which I had set for both the patient and myself.

But as though to negate my conservatism and undo my caution, I must say that most of the patients I see with somatic illness have been far too long coming to a psychotherapist. Two illustrations: A forty-nine year old man, tense, overactive, overambitious, had frank overt symptoms of colitis for eleven years. He had had innumerable proctoscopies and X-ray exam-

inations, and one laparotomy in which only his appendix was removed, but which he was led to believe would result in a shunting of the food past the diseased bowel. On his doctor's advice, he had taken two leaves of absence, each lasting a year or more, and was finally referred to me by a urologist whom he had consulted not about colitis but about his diminishing sexual potency. When asked by the patient if he should undertake analysis, his family doctor said, "I never knew a sane analyst in my thirty years of practice but if you want to go to one, that's your funeral." I must report not only that the patient is persistently ill as the result of a severely scarred and deformed lower bowel, but that eleven years of extraordinary secondary gains from illness make it difficult to effect a real change. Recently, his doctor made a home visit to see the patient's wife for some minor illness and paid the patient (and me) a minimal compliment by saying: "You must be better. At least you waited until morning to call me instead of your usual call at 2 A.M."

A young man was referred to me by an internist who had recognized the nature of the patient's asthma and told him bluntly that he needed psychotherapy. The patient was passive, dependent, tense and self-deprecating. Every escape from home and mother was blocked by illness which forced him back, literally, to his mother's home, though he was obviously never far from it psychologically. He needed and wanted psychological help but was for years dissuaded by his family doctor who told him that he would be wasting his time and money, and that he (the doctor) had never seen a patient helped by psychoanalysis. This doctor, by the way, suffers from lifelong, severe and debilitating migraine!

When I began in practice, psychoanalysis and psychiatry were quite suspect and the doctors with whom I was associated were often critical, suspicious and questioning, and referred patients in a manner that seemed to say, "All right, show me what you can do." I remember bitter conferences, tense ward rounds when psychoanalysis was openly mocked, and certain chiefs who referred only "hopeless" cases for psychiatric consultation.

It was clear that one of my greatest responsibilities as a private practitioner would be a kind of public relations-educational-liaison job with the referring doctors. I still believe it but if we have gained a vastly greater acceptance of our work, it is hardly because we deal more adequately with the general practitioner or specialists who send us our patients. In my opinion, we hide behind the obvious necessity for observing our patient's confidences to disregard the physician, to treat him with scant courtesy and often with deprecating condescension.

Just one example of this: A physician, a close friend, referred a patient to me following her return home after a profound psychotic depression requiring hospitalization. For three years I saw her on a casual basis and not entirely satisfactorily. I finally suggested she undertake an analysis and recommended a consultation. She went to see the consultant of my choice who sent her to a younger analyst without ever discussing this with her doctor or me. When a change to still another analyst was necessary, we were neither of us asked about the wisdom of the move or the choice of person. Now, I am not speaking of people at the periphery of our profession but of trained, experienced people of repute. What does one do when a highly reputable and experienced medical colleague, a great admirer of the psychiatric skills, tells one that with rare exception he has never had a report from any analyst to whom he has referred a patient, rarely even a courtesy note or call to thank him for the referral, and that in general he assumes he no longer has any relationship with patient or analyst, once therapy has begun. I would be more eager to question these yarns or ascribe them to jealousy, if my own experience with analysts to whom I refer patients was not essentially identical. When I send a patient to an analyst, I ask him to please let the referring doctor know that the patient is in therapy, perhaps give him a notion as to the diagnosis and possible prognosis, and once in a while perhaps drop him a line telling him what goes on. I can only say this is rarely done: in fact I have had patients referred to other analysts by the person to whom I sent them so that I am unable to tell the referring doctor who is treating his patient. When a friend tells me that with very few exceptions he finds he no longer takes care of the medical problems of his patients who are in analysis, I cannot believe this reflects only his own attitudes and it surely cannot reflect on his competence and skills, which are outstanding. I believe this is worse today because analytic time is difficult to arrange and the general attitude seems to be that the analyst is doing the referring physician a favor.

Looking through my early records naturally brought me to some reflections on the cost of my services and of psychiatric services in general. In a city like New York our skills and talents are available to a very small degree to the poor who attend clinics and almost entirely to the economically upper classes whom we see in our offices. (The only exceptions to this are a group of professional workers, especially social workers, who seek and get analytic help but often at a cost which impoverishes them and robs them of even some necessities for reasonably decent living. They often seek such help for minimal problems and can rarely be induced to undertake anything but "classic" analysis. There are many unresolved questions about this group of people.)

In general, if one accepts as a minimal fee fifteen dollars a session and three times a week as a minimal requirement, we have an expense of over two thousand dollars a year, a staggering sum, and out of reach of any

except a tiny percentage of the population.* I understand this, more or less, but I contend that it is very difficult to do one's work responsibly under such socially deleterious circumstances. This is a value problem of the first order and unless we can find methods to deal with it, I believe it must endanger our work. From candidate selection, through training and on to practice, we are encouraging a tendency which I believe should be scrutinized critically. Aside from the painful impact it may have on an individual patient in quest of help, it has even more important *social* significance and consequences.

Another aspect of private practice that I regret to find has not improved is the problem of the patient who needs to be hospitalized. Here again, the cost is a serious deterrent to prompt and proper referral; the inadequacies of care in all except one or two hospitals present a discouraging picture; and the still complete disregard for the referring psychiatrist is for me at least a source of annoyance and often embarrassment. The father of a schizophrenic girl I had referred to one of the oldest and reputedly best private mental hospitals in our vicinity called to ask when I wanted to see the girl now that she was home. I referred her to this hospital nineteen months previously. In that time, I had a note telling me she had been admitted and asking for a summary of my experience with her, a copy of a standard status sent on my special request and no further word of any kind at any time whatsoever. I visited her twice because of the family's insistence: I avoid such trips since they usually serve only to satisfy the family's need for information which could and should be given by the staff.

The introduction of shock therapies represents the most noticeable and dramatic change in practice through the years.† I remember with remarkable vividness the night we saw the first patient who had improved with insulin shock therapy. She was an old catatonic schizophrenic, in such a deteriorated condition that it was thought "safe" to treat her. And to be sure, she had "improved" in that she would now get out of bed and managed to make sounds that were more or less intelligible. I recall even more vividly Jelliffe's brilliant discussion of the great day ahead in which schizophrenics would be cured promptly and certainly with this new magic. Only those who knew Jelliffe can understand the excitement of the evening and the illusions we carted home with us.

* Most analysts make exceptions for an occasional patient who pays "token" fees. One of the social consequences of the cost for our services is the considerable number of gifted and highly endowed but impoverished young people whose ultimate contribution to society promises much but the fulfillment of which may really depend on our willingness to adjust our fees so that they can get the necessary help.

† Space prevents discussion of other important changes, such as the use of psychological testing and the development of group therapy.

I have no statistics and they would not be reliable; I can only say that with few exceptions I find the use of the various forms of shock therapy most disappointing in practice. The postpartum depressions of which I see few since they are usually referred directly to psychiatrists (and non-psychiatrists) who do shock therapy; the depressions at the menopause which, for the same reason, I rarely see in practice and the depressions of the later years do well with electric shock therapy, but that would about end my list. In schizophrenia, except where intense excitement occurs, I prefer the tools of psychotherapy. One of my friends, an enthusiast for shock therapy, complains he has the worst luck just with *my* patients.

There is a climate to private practice; How does it differ from that which existed when I began in practice? First, there is much more acceptance of our work at all levels—patients, families, physicians, other professions, social agencies, universities. It is rare these days for a lay person, much less a physician, to ask that I see an unwilling patient and tell him I am a "nerve specialist" but to be sure not to mention that I am a psychiatrist.

Of course, there are those who hold that we have gone to the other extreme in publicizing our work. I doubt that. It is true that among certain groups there is a special distinction in having been analyzed. Occasionally one trembles at news which comes out of certain gatherings such as the recent Parent-Teacher Association meeting where a psychoanalyst told the audience that every parent should be analyzed if he or she wanted to do the "best possible job" with their children.

The climate of private practice is unsettled by such wranglings in the press as the perennial fight about the practice of psychotherapy by non-medical persons. There are few things that the laity knows less about than the so-called "schools" of psychoanalysis, but their concern with the subject seems great. As the psychiatric-psychological self-help books pour from the press, I find myself increasingly taxed to get patients to tell me what they feel and not what they think this or that means. This was not a problem twenty-five years ago and I truly believe the patients were better off for their very lack of "knowledge."

I find my patients not as concerned as I would expect with world issues nor is this so far as I can discern a reflection of particular pathology. It is by no means only the withdrawn schizoid type of patient who is apparently untouched by these tensions. Even the announcement of the H-bomb and the test that apparently got out of hand did not stir up the anxiety I had anticipated. I know that the world of the neurotic reflects special fears but it is still startling to watch the preoccupation with trivia persist even in the face of world shattering events. Certainly these events produce nothing like the panic the stock market crash produced in my patients, itself a sad commentary on our world.

What of results? It is now an ancient truism that we need to know much more about our results but nothing much is done about it. I have just been over the records of all the patients I have had in therapy. I tackle patients now whom I would never have treated in the office earlier, but I do not believe that this reflects any growth in technical knowledge. It rather represents my experience, a more secure place in the profession, and a greater willingness to assume responsibility. By rule of thumb, from experience, from scrutiny of my failures as well as my successes, I have made many shifts in technique, such as I believe every one makes after years of practice. I find little opportunity for *direct* application of our greater theoretical knowledge; it helps me in my own understanding of the dynamics but I do not see direct connections between the advances in theory and the kind of loosely structured methods I follow.

I believe my results are now generally better, an improvement stemming from several things: (1) more modest goals after a period when as a result of newly developing theory, especially around the greater understanding of ego function, I was too ambitious and perfectionistic in my goals; (2) the practice of trial periods of intermission in the work. Oberndorf emphasized this years ago but it is only in the last five years or so that I have fully explored the merits of this technical device; (3) starting with very sick patients, I am free to interpret as improvement, relative changes toward health which might not be as clearly discernible in less sick patients.

I have left for the last what I consider to be the greatest and in some ways the most important change in my practice and that is my relation to the community. When I began, practice was indeed a "private" matter with only the hours spent in the clinic and hospital as interludes. Like most psychiatrists, I now play an every increasing role in community affairs. We are involved in education, services to social and other community organizations, and research. The role of the psychiatrist in interdisciplinary research is a significant and important recent development.

There are not limits now to the vista of opportunities to work with people in a whole array of nonclinical settings both as teacher and as advisor. Although I do a fair share of such educational work, candor requires me to acknowledge that I am still not entirely persuaded of the wisdom of much that is done in this field and I feel most emphatically that we need to know much more about the effects of our efforts than we now do before we can be certain that we are really accomplishing our goals.

A COMPARISON OF EUROPEAN AND AMERICAN PSYCHIATRY

By HENRI ELLENBERGER, M.D.*

After a three months trip in the United States in 1952, I was asked by some Swiss colleagues to tell them about my observations in America and I tried to describe the difference between American and European psychiatry, seen from the point of view of a Swiss. Later, when I returned to the United States, a friend suggested that I translate the talk I gave in Switzerland into English. Thus, let us imagine that we are in Zurich, and that we are Swiss people interested in hearing about a very different kind of psychiatry.

A European psychiatrist traveling in America is soon overwhelmed by such a wealth of new impressions, experiences, and human contacts, that he easily loses the general picture. Then a little incident will suddenly give him a clue. This happened to me a few weeks after my arrival, while attending a staff meeting where a case history was discussed. A young psychiatrist was reporting on the life history and troubles of a patient and had begun to discuss the diagnosis, when the leader of the meeting gently interrupted him with this question: "What are his problems, and what can we do for him?" This meant that the nosologic discussion, interesting as it was for a European psychiatrist, was considered idle talk and a waste of time by an American. The interruption meant: "Let us go to the question," it was the voice of the principle of reality. It occurred to me then that American psychiatry differs from ours fundamentally in the way of approaching its object. This little incident was the starting point of the following considerations.

First of all: What is a psychiatrist supposed to do, and why do patients come to him? Here we meet a fundamental difference. In Europe, people go to the psychiatrist because of a *symptom*, in America because of a *problem*. In Europe, there is a deeply-rooted idea that only the suffering man needs the doctor.

What brings the European to the physician? A trouble, a disturbance, whether this be a physical or an emotional one. The patient calls it a disturbance, the physician a symptom, both consider it a deviation from a normal state. The task of the European physician, and the psychiatrist, is to put what has deviated back onto the right track, or to return to its former state something which has been altered. In America, many people go to the psychiatrist because of a *problem*. This problem can be some kind of physical ailment impairing the working capacity, but also something

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quite different from what we call a symptom. A European psychiatrist, now in practice in New York City, told me of his surprise with his first American patients. A young girl came to him and told him: "I am much interested in a young man and am constantly thinking of him. This is my problem: Is it real love, or infatuation?" My colleague was not a little amazed at this strange question, but he soon discovered that many of his American patients expected him to be *a man who solves problems.*

Furthermore, we can see that the American concept of freedom and democracy is considerably different from our own, and that it leaves, in general, more room for individual activity and spontaneity. Where we say: "Help the blind," the Americans say "Help the blind to help themselves." Another consequence is that many forms of abnormal behavior are tolerated in America in cases where in Europe, especially in Switzerland, a commitment to a mental hospital would promptly follow.

Let us imagine a patient going to a psychiatrist, say, because of a migraine. What will the psychiatrist do? The European psychiatrist will seek for a causal explanation of the symptom, for something hidden behind the symptom; the American is more likely to center his investigation on the personality and life-situation of his patient. Behind the migraine, the psychiatrist will presume the existence of three main factors: heredity, constitution and somatic processes. Regarding heredity, he will ask the patient if others in his family suffer with migraine and kindred conditions. He will perhaps also correlate the migraines with the constitution of the patient, for instance the epileptoid constitution. Then he will think of a somatic process, such as a malfunction of the liver. That the migraine appeared after a period of stress or conflicts will not impress the European, or at best, it will be considered as a precipitating factor. In the same case, an American psychiatrist will more probably begin his investigation with the interpersonal relations of the patient, asking him whether he has conflicts or difficulties with his family, superiors, colleagues or other people. He will try to ascertain if there is a relation between onset of the migraine and certain events of the patient's life-history; in other words, he will conduct a dynamic exploration. Heredity and constitution will be considered as negligible factors.

It appears that the concept of *disease* itself is held differently. For the European psychiatrist, a mental condition has two categories of phenomena, the visible and the invisible. The symptoms are, so to say, the manifest content of the disease, and the latent content is hidden in the genotype, the constitution, or in a somatic process. While the European is inclined to think of a disease as a spontaneous outbreak of invisible intrasomatic energies, the American is much more accustomed to thinking of it in terms of situation and reaction. It is always a surprise to hear our American

colleagues speak of manic reaction, melancholic reaction, schizophrenic reaction, where we speak of a manic or melancholic form of a manic-depressive psychosis, or of schizophrenia. In our classification of psychiatric diseases, we have, of course, a group called "reactive conditions," but it has a comparatively limited importance; in American psychiatry, this group invades almost the whole table of contents of psychiatric textbooks. Furthermore, the particular kind of reaction is explained, not from the viewpoint of heredity, constitution and process, but from the viewpoint of the individual psychological dynamism.

Now, what is the significance of *therapy*? In Europe, for many centuries therapy was considered an application of the principle of causality. Disease being the effect of a cause, the physician must find this cause and eliminate it. When the cause is removed, the disease must disappear. Progress of European therapy depends on two kinds of research: First, investigation of causes of disease, in order to isolate and define them as accurately as possible, and second, experimental study of various possible therapeutic agents, in order to find out which kinds of clinical conditions they fit the best. The third phase of this dialectic process is finding out which disease and which medication are suited to each other. Then to the principle of causality is added the principle of specificity. It seems that Americans do not worry much about the principles of causality or specificity. Psychotherapy, to them, consists essentially in acquiring a picture of the patient's problems, in order to help him to help himself out of them, and this implies two kinds of intervention: an insight into the dynamism of his personality development, in order to correct the maldevelopments, and an insight into the patient's present situation, especially into his interpersonal relations, to enable a correction of the maladjustments.

These considerations may seem abstract and theoretical, but it would not be difficult, I believe, to substantiate them by a look through the various chapters of scientific psychiatry, comparing the European and American ways of approach. What do they have in common, and in what do they differ from each other?

In the clinical description and investigation of mental diseases, the Americans are as good as the Europeans, as proved for instance by their remarkable description of alcoholic addiction or of child schizophrenia. The same is true for the *anatomo-clinic approach*: there are a number of American psychiatrists who continue to believe that brain anatomy and physiology can help us to understand certain mental conditions and, in the long run, lead toward new therapeutic methods.

We come now to the fields of scientific psychiatry which are more developed in America than in Europe. In the first place comes *dynamic*

psychiatry. Of all the countries of the world, America is the first to have adopted a *dynamic psychiatry* as its leading psychiatric trend. The founder of modern dynamic psychiatry was Adolf Meyer, who called his system "Psychobiology." He was the first to investigate the life-history of his patients in an extremely thorough and accurate way and to enter it into a so-called "life-chart." Meyer was also one of the founders of psychosomatic medicine, and one of the first to introduce psychiatric social work. It is not generally known in Europe that the classical concept of dementia praecox was revolutionized, not only by Eugen Bleuler in Switzerland, but also, at the same time, in America by Adolf Meyer. Bleuler, in calling dementia praecox "schizophrenia," applied a concept influenced by Hughlings Jackson who thought that there were direct symptoms resulting from organic brain disease, and a much larger number of indirect or psychogenic symptoms, expressing the activity of the intact parts of the psyche. This concept opened a considerable field to psychotherapy.

Adolf Meyer, former pupil of Hughlings Jackson formulated a much more dynamic concept of schizophrenia: the schizophrenic, he said, has a constitutionally weak capacity of adjusting to new situations. In consequence of his inappropriate reactions, he is soon involved in a vicious circle of maladjustments and more and more faulty reactions; what we call the outbreak of the psychosis is only the conspicuous manifestation of a long maldevelopment. In consequence of his "psychobiologic" and dynamic approach, Meyer rejected the usual psychiatric nosology and classification, and expounded psychiatric conditions almost entirely in terms of reactive conditions and maldevelopments. This approach was considerably expanded by the triumph of psychoanalysis in America. For Europeans, who saw psychoanalysis scornfully rejected by University psychiatry for such a long time—as it still is in many places—it is a great surprise to see a psychoanalytic psychiatry officially adopted and taught in America. A tremendous psychiatric revolution resulted from this adoption of a psychoanalytic psychiatry. Psychiatric investigation of an individual case was no longer limited to the description of the clinical symptoms and of the life-history, but could be studied in terms of the individual dynamism; this formulation made possible a much more successful psychotherapeutic approach.

Aside from this kind of dynamic psychiatry, we find in America a number of psychiatric approaches which deserve attention. Psychosomatic medicine, ethno-psychoanalysis, social psychiatry, and the experimental study of neuroses, are fields where the Americans have developed a great deal of research from which we can learn. Another approach is the interpersonal theory of psychiatry, elaborated by Harry Stack Sullivan. The basic assumptions of this theory show similarities to certain concepts of Alfred Adler, but Sullivan has developed them into a much more complete system,

and combined it with psychoanalysis. Another somewhat similar approach is the microsociology of Moreno: incidentally, this author is known in Europe only as the inventor of psychodrama, whereas he is primarily a sociologist.

Such are the most important psychiatric approaches in America which are missing, totally or partly, in Europe. Which are the trends less developed in America than in Europe?

First there is what we call *Erbpsychiatrie, i.e.* psychiatric genetics. For us, psychiatric genetics is a century old science, which, especially in Germany, Switzerland, and the Scandinavian countries, has produced a tremendous amount of research, culminating in discoveries of paramount importance. New methods, such as the "mathematic-statistic," and the "twins" method have been added to the former method of studying pedigrees. Institutes have been established where thousands of case histories have been analyzed, the results being published in several textbooks and in hundreds of publications. Conclusions have been so convincing that they have influenced the legislation of several countries, including our own Switzerland. Many Americans ignore this vast amount of scientific work in psychiatric genetics, however, a few isolated students such as Kallmann and Rosanoff represent this trend in America.

Another trend which is much less acknowledged in America than in Europe is *Konstitutionpsychiatrie, i.e.* constitution psychiatry, represented in Europe by Pende, Kretschmer and several others. In America an exponent of this kind of research is Sheldon with his three types. His system is strikingly similar to the old system of Bogolometz, a Russian psychiatrist, who also distinguished three types: the muscular, the asthenic and the digestive. Bogolometz and his pupil Krasnuschkin correlated these types with psychiatric conditions and criminology, pretty much in the same way Sheldon does.

It is noteworthy that there is no such thing in America as that which we call *Characterology*. What the Americans call Personology is something quite different. On the other hand, biochemical and endocrinologic psychiatry are represented in America, but do not seem to have the same importance as, for instance, endocrinologic psychiatry in Switzerland.

Another European trend which has not met with great favor in America is phenomenology. (We are speaking, of course, of psychiatric phenomenology, and not of the philosophical system called by the same name.) The word itself seems to have been misunderstood and to mean for several Americans, either a confusing interference of philosophy with psychiatry, or that kind of clinical description which we call semeiology. In fact, phenomenology is nothing else than a method for analysis of states of consciousness with the help of a new frame of reference; this analysis takes

as coordinates time, space, continuity, causality, and other categories, which enable a much more accurate understanding of the subjective experience of the patient. If this has not been better understood, it is the fault of the phenomenologists themselves. Most of them have written in such a diffuse, lengthy and obscure way, that even a German-speaking, well-trained psychiatrist, has great difficulty understanding them; it would be unfair to expect Americans to understand them better than we can even in our own language.

The questions of terminology, nosology and psychiatric classification, play, in America, a minor role. It is obvious that Americans often use other diagnostic terms for certain conditions than we would. The more one travels from one country to the other, the more skeptical one becomes about the value of international psychiatric statistics. The English call almost any kind of emotional trouble "neurosis." The French apply the diagnosis of feeble-mindedness very liberally; in Switzerland we demand much more serious proof before using it. The French say that the Swiss diagnose schizophrenia in "90 per cent of the psychotics and 50 per cent of the normal." If the Swiss conception of schizophrenia seems exaggerated to the French, what would they say of the American one? For instance, child schizophrenia is a rare diagnosis in Europe, but a rather frequent one in America; Americans diagnose schizophrenia in almost all those cases of children whom we would call "pseudo-debiles." Another difference is that the Americans do not seem to make a distinction between syndromes and underlying disease as we do in Europe. They speak of manic reaction, depressive reaction, and this is the diagnosis; but to speak of a manic syndrome symptomatic of an underlying schizophrenia seems to them a contradiction. The reason for this is their general distrust of nosological theories and classifications, and because, in their psychiatric concepts, the principle of specificity is evidently lacking.

In Europe all psychiatry, as well as medicine in general, is pervaded with the principle of specificity. What is specificity? It means that certain individuals can be identified and classified in a system of abstract patterns which is not a construction of the human mind, but is given by Nature. The English physician Sydenham introduced the specificity principle into medicine. Sydenham contended that the infectious diseases were distinct entities, endowed with an individuality as unmistakable as the individuality of the animal and vegetable species. This principle enabled Sydenham to individualize a number of diseases which had formerly been confounded, such as measles and scarlet fever. After Sydenham, the principle of specificity gained more and more importance in medicine; it is no exaggeration to say that medical progress since the 17th century was largely based on this

principle. The famous French clinician Trousseau declared: "*Le principe de spécificité domine toute la médecine*" (The principle of specificity dominates all medicine). In application of this principle, for instance, the French physician Bretonneau isolated diphtheria, and Louis, typhoid fever, as specific diseases, long before the germs of these infections were discovered.

The therapeutic implication of this principle is evident; in any specific being, there is an intimate connection between all its manifestations. In a specific disease, there is also a necessary connection between symptoms, evolution, prognosis and the therapeutic possibilities. Thus, if we establish the diagnosis, we have the key for the prognosis and the treatment. As an example: suppose we have a patient with an angina; if we recognize it as a diphtheric angina, we will think that the prognosis is rather poor, unless we administer the specific medication, that is antidiphtheric serum; if it were a streptococcic angina, we would make another prognosis and prescribe another specific treatment.

The pioneers who inaugurated a scientific psychiatry at the beginning of the 19th century strove to introduce the principle of specificity into psychiatry. They greeted as a first victory the discovery of general paresis by the young psychiatrist Bayle in 1822; general paresis was the first specific mental disease to be identified. Following the example of Bayle, a great number of psychiatrists eagerly searched for the secret of the mental diseases in brain anatomy. But it soon became apparent that the specificity of most of the psychoses must be of another kind. Clinical psychiatry had given many arguments for the identification of schizophrenia and manic-depressive psychosis as specific diseases, but the proof could not be given by brain anatomy. Proponents of psychiatric genetics contend that it has given these proofs, although many points still remain unclear. For the European psychiatrist, manic-depressive psychosis and schizophrenia are undoubtedly specific diseases. This is probably one of the causes of misunderstanding between American and European psychiatrists. I remember the consternation of a German psychiatrist hearing that certain American colleagues consider manic-depressive psychosis as a form of schizophrenia; for him this was about as fantastic as the assumption that a camel is a subspecies of the elephant. On the other hand, Americans can hardly understand the strenuous efforts of the Europeans to isolate and individualize mental diseases; they have the impression that the Europeans are satisfied with merely labeling the disease. Nosologic discussion of whether paranoia is a subform of schizophrenia, or a specific disease, appear as ridiculous to them as the Middle Ages' theological controversies on the sex of the angels.

If the Americans do not accept the principle of specificity in psychiatry, do they have another principle in exchange? Of course, they have one, and we have already mentioned it: the principle of individual dynamism

and adjustment. This principle was introduced in neurology and psychiatry by the great English neurologist Hughlings Jackson. Jackson borrowed this principle from Spencer and the evolutionists. He conceived the psychological structure as a hierarchy of functions, resulting from evolution; the opposite of evolution he called dissolution (we call it today regression), and he expounded a new concept of mental disease as a disturbance of behavior resulting from regression to various levels of function. This theory deeply influenced Janet, Bleuler, Adolf Meyer, and Freud, and was the basis of our modern concept of neuroses, in Switzerland as well as in America. The difference is that the Americans adopted this concept much more radically and instead of reserving it for neuroses, applied it to the psychoses and almost to the whole of psychiatry. Unfortunately, this concept is not easily compatible with the nosological system adopted by most European psychiatrists. This, of course, is not merely a question of theoretical psychiatry: the adoption of the Jacksonian principle of dynamism and adjustment brought with it weighty innovations in the whole realm of psychiatric work. For example, if psychoses are the result of faulty developments beginning in infancy and childhood, then *child psychiatry* acquires crucial importance, and we are not surprised to hear of its great development in America including the organization of *child guidance clinics*. Incidentally, the children whom we call "difficult children," are called in America "problem children." A problem child is one who has more difficult problems than the average child, and who constitutes a problem for his family and society. The aim of the American child psychiatrist is to find a solution to these problems, from the point of view of the child as well as from the point of view of society. But while in Europe, child psychiatry is essentially conducted by the psychiatrist in collaboration with the *Heilerzieher* (therapeutic educator), in America the role of the social worker is much more important.

Comments on adult psychiatry must necessarily be brief. In the private psychiatric hospitals I visited in America, I had the impression that the young doctors work with more initiative and more group spirit than in Europe. Every doctor has his own office where he interviews patients; that is something which is grievously lacking in our country. Psychotherapeutic work is conducted under supervision, which means that the American psychiatrist works with a supervisor, a colleague who helps and guides him in his work. In general, psychiatric work is much more a group project than in our country. In this teamwork, the two most important collaborators of the psychiatrist are the social worker and the clinical psychologist. It is wrong to translate *social worker* with *"Fürsorger,"* as is usually done in Switzerland: in fact, an American social worker has a very different

kind of work and much more responsibility than does our *Fürsorger*. The social worker is mainly concerned with the family of the patient even to the extent of doing psychotherapeutic work with members of the family on behalf of a better understanding of the patient. He has received a much more substantial professional education than our *Fürsorger*, and is able to help the psychiatrist in a much more gratifying way.

American clinical psychologists are psychologists who have also undergone a specialized professional education, and know much of psychiatry, especially dynamic psychiatry. They perform a thorough psychological examination of the patient, mainly with the help of projection tests, and they are sometimes also active as psychotherapists. In America, there is no psychiatry worthy of the name without clinical psychologists, and it is most regrettable that nothing of the kind exists in our country. American psychiatrists do not usually give tests, and rely upon the clinical psychologist for this kind of examination. They accept their reports with the same confidence which we have for the report of a good laboratory or radiology specialist. In staff meetings, it was always a mystery to me how the clinical psychologists had come to their conclusions: instead of writing a report for each test, as we do, they write a greneral survey of their findings without indicating which conclusion is based upon which test. I believe that I express the general feelings of every Swiss psychiatrist visiting America, if I say that we would be well advised to introduce in our country as quickly as possible the professions of social worker and clinical psychologist.

Now, what about the psychiatrist himself? Here, also, the American and European ideas differ widely. For about 150 years Europeans thought that the secret of mental diseases was hidden in lesions of the brain; in order to be a good psychiatrist, one had to be a good anatomist of the brain, and competence in that field was often the only qualification needed to be appointed head of a big mental hospital. This conception is far from having disappeared entirely. The French, for instance, demand from a mental hospital psychiatrist a thorough knowledge of brain anatomy and pathology, and most of them are good neurologists.

In Europe, many psychiatrists are primarily interested in constitution psychiatry and psychiatric genetics. It seems that Americans have a totally different point of view; for them, a psychiatrist must first be a good psychotherapist. On the other hand, psychoanalysis is acknowledged in America as the therapeutic method par excellence. Therefore, more and more, a psychiatrist must be at the same time a psychoanalyst. A major difference exists between European and American psychotherapy: Europe has many different methods; in Germany the *Autogene Training* of Schultze and *Kontakt-Therapie* of Speer, in Switzerland the method of Jung, and the cathartic method of Frank, in France the daydream method (*méthode*

du rêve éveillé) of Desoille, in Austria the *logotherapy* of Frankl, everywhere the most various methods of hypnosis, auto-hyposis, narcoanalysis, modified psychoanalysis and individual therapy. The result is that few doctors learn these methods and few patients in the hospital benefit from them. In America, there is one method of psychoanalytic therapy, called "psychotherapy," widely taught and practiced. A comparison might be made to automobiles: in Europe, there are a great number of models of all kinds, but the automobiles are more expensive and fewer people possess one; in America there are fewer types, but the automobiles are cheaper and everyone has a car. In the same way, the Americans have chosen one or two particular methods, they teach them thoroughly and use them extensively. In this respect, American psychotherapy is far in advance, and we have no doubt a great deal to learn from it.

Let us hope that the years to come will bring us a new psychiatry, combining the best features of American and European psychiatry, for the greatest benefit to humanity.

CUSHING'S SYNDROME ASSOCIATED WITH CONGENITAL HYDROCEPHALUS AND SPASTIC PARAPLEGIA*

By SHELDON B. COHEN, M.D.†

The case reported in this paper is that of an adult male with congenital hydrocephalus, Cushing's syndrome, mental deficiency, and spastic paraplegia, a disease combination not previously recorded in the literature.

There have been numerous reports of Cushing's disease, or syndrome, since the clinical features were first described in 1932.[1] However, Heinbecker[2] in 1944, was the first to report the association of hydrocephalus with the signs and symptoms of Cushing's syndrome. In his four cases, as well as in subsequent cases which he reported, the hydrocephalus developed in adult life and was unassociated with the gross cephalic enlargement characteristic of congenital or early hydrocephalus.

Soon after Cushing's original work[1] was published, two papers appeared, describing instances of the syndrome associated with paraplegia and quadriplegia.[3, 4] However, in both cases the involvement of the extremities was thought (and partially proven) to be due to lesions of the spinal cord, unassociated with the primary lesion of Cushing's syndrome.

A survey of the literature has failed to reveal any further cases of Cushing's syndrome associated with either hydrocephalus or spastic paraplegia.

Case Report

W. S. entered Topeka State Hospital in 1944, at the age of 31 because there was no one to care for him. At that time his mother had just been hospitalized following a cerebro-vascular accident and his father had died previously of an intestinal carcinoma.

No details of the prenatal period or of the birth history were available. Informants were unable to agree about possible enlargement of the head at birth, but stated that decided enlargement was noticed before the patient was a year old. Physical and mental retardation was noted early. The patient became a town curiosity and people who recalled seeing him during his early years described him as, "A small child in a wheelchair, dressed in oversize baby dresses, with an enormous head which he was unable to hold upright." By the time he was twenty years old he had learned to talk and was able to identify individuals. Spastic paraplegia was noted early and he never learned to walk.

Following the death of his two brothers (respectively of rickets and "summer complaint") in early childhood, the patient's mother devoted most of her time to his care. She attended him constantly and is said to have "spoiled him unreasonably." It may be of interest that he was incontinent when she was home, but called for the bedpan when others cared for him.

* Case report from the Topeka State Hospital, Topeka, Kansas.

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He is said to have beaten his mother during her later years, but was "sly enough to behave" when others were around the house. It was stated that he had had epilepti-form seizures until he was about 25 years of age.

Examination on admission to the hospital revealed a crippled, dysplastic man with an enlarged, hydrocephalic head, which stood out in marked contrast to atrophied, paralyzed lower extremities and underdeveloped genitalia. Blood pressure was 160 systolic, 124 diastolic. He was unable to move his trunk or lower extremities, but had good use of his arms. Speech was slurred and virtually unintelligible. Mental status revealed a marked organic deficit. Blood serology was negative. (There was a questionable history of maternal syphilis.) No other laboratory studies were made at the time of admission. The diagnosis was "Idiocy due to hydrocephalus."

Progress notes during the next two years, 1944 to 1946, reveal the patient to have been bedridden, incontinent and gaining in weight steadily. In 1948, he was found to have an elevated blood sugar (0.380 per cent) and glycosuria. (This was the first recorded urinalysis and blood chemistry.) The diabetes was insulin-resistant, as shown by the fact that units 20 of regular plus units 50 of protamine-zinc insulin had not controlled it adequately by 1950. The patient exhibited polydipsia, consuming six to seven liters of fluid daily, and polyphagia, becoming irritable, loud and demanding if not allowed extra food.

On June 8, 1950, physical examination by the author revealed a grossly deformed white male. There was tremendous enlargement of the head (fronto-occipital circumference was 29 and one half inches), notable "buffalo obesity" of the neck and trunk and marked atrophy of the extremities, especially of the legs. The spine showed marked kypho-scoliosis. The hips, knees, and toes were fixed in flexion and could be passively moved to a slight degree. Both legs were abnormally cold. There was no limitation in motion of the arms, although definite weakness was present. Height was 58 inches, weight 185 lbs.

The large, pumpkin-shaped head was in contrast to the face, which was only slightly enlarged and of normal contour. Across the back of the head in the region of the occiput was a transverse depression. The skin was white, thin, and smooth. There were white striae, resembling striae of pregnancy, over the lower abdomen. Hair distribution was essentially normal; that of the head was sparse and fine with frontal baldness. The retinae showed several small areas of hemorrhage. There was moderate bilateral optic atrophy without gross restriction in the visual fields. Tachycardia (rate of 120) and moderate cardiac enlargement were present. Blood pressure was 180 systolic, 120 diastolic. The abdomen was pendulous. The bodily enlargement was confined mainly to the upper portion of the trunk; that below the umbilicus being of almost normal contour. The reflexes of the upper extremity were hyperactive; those of the lower extremity could not be elicited. Abdominal reflexes were faintly present on the right and absent on the left.

Mental examination indicated a severe organic deficit. The patient was approximately oriented in all spheres but he was unable to perform simple arithmetic. He repeatedly and monotonously asked the examiner, "Give me a penny."

Examination of the blood showed a red-cell count of 5,500,000, hematocrit of 44 per cent, hemoglobin of 15.5 gm. per 100 ml., and a white-cell count of 6,250 with 69 per cent neutrophiles, 29 per cent lymphocytes and 2 per cent monocytes. Fasting blood sugars varied from 118 to 180 mg. per 100 ml. Blood urea nitrogen was 7 mg. per 100 ml., blood cholesterol 185 mg. per 100 ml., and total chlorides (as NaCl) 500 mg. per 100 ml. Urinalysis revealed one fourth to one per cent glucose, albumin, one plus, and numerous hyaline casts. Twenty-four hour creatinine excretion was 0.78 gm. and 24 hour 17-ketosteroids excretion was 12.8 mg. The circulating eosinophile count[5] was 50 per cubic millimeter, dropping to 17 per cubic millimeter after the subcutaneous administration of 0.3 milligrams of epinephrine.

The initial urine volume of 6 to 7.5 liters per day with a specific gravity of 1.002–1.005 raised the possibility of diabetes insipidus. However, water restriction raised the specific gravity to 1.018 and the IV NaCl test of Carter and Robbins[6] showed the pattern of psychogenic polydipsia. X-rays of the spine and pelvis revealed no osteoporosis while those of the skull showed marked internal hydrocephalus. The benzodioxane test gave a normal response.

Electroencephalogram, which included naso-pharyngeal leads, was reported as borderline. Electrocardiograms revealed a sinus tachycardia and right axis deviation. Phenolsulphonpthalein test showed kidney function to be within normal limits.

The finding of normal blood counts in Cushing's syndrome is not unusual, although polycythemia is frequent. The decreased creatinine output is a direct reflection of this incapacitated man's decreased muscle mass. The finding of a fasting eosinophile level of 50 per cubic millimeter is generally taken as an indication of increased adrenal cortical activity, although Fisher and Fisher[7] state the normal fasting range to be between 50 and 300 per cubic millimeter.

The pattern of "psychogenic polydipsia" undoubtedly was due to the patient's low frustration tolerance, resulting from mental deficiency and early maternal overindulgence.

During the next nine months the patient's clinical condition showed little change. Blood pressure at times was as high as 240 systolic, 140 diastolic.

A dermatological consultant was called in on several occasions to treat skin disorders, including intertrigo of the groin and psoriasis of the scalp. It was noted that his tender skin bruised easily. Polydipsia, polyphagia, and polyuria continued unchanged. Elevated blood sugars and glycosuria were the rule. On April 20, 1951, the patient was noted to have an elevated temperature and dyspnea. A diagnosis was made of lobar pneumonia. Treatment, including antibiotics and supportive therapy, was ineffectual and the patient died on May 5.

At autopsy the external configuration of the body was unchanged from the previously described physical examination.

The brain contained 1450 cc. of cerebro-spinal fluid with both the lateral and third ventricles being greatly enlarged. The lateral ventricles measured 15 cm. in diameter. The cortex was quite thin, measuring 1 cm. in places. The cerebral convolutions were flattened. In the posterior portion of the fourth ventricle, an old chronic adhesive arachnoiditis was present, producing a partial obstruction.

Other notable gross findings were cardiac hypertrophy (the heart weighed 530 gm.), coarse nodular cirrhosis of the liver (weight 1575 gm.), a small (130 gm.) pancreas which showed many areas of fat necrosis and small atrophied testes (weight 18 gm.). One of the testes had a small (2 by 3 mm.) yellow, caseous lesion surrounded by pearly white scar tissue.

Section of the heart revealed an area of fresh infarction. The liver was cut up into lobules of varying size by dense bands of scar tissue. A caseous focus, 1 cm. in size and surrounded by a dense fibrous wall, was found in the liver. There was intensive focal scarring of the pancreas, with entire lobules having been replaced by scar tissue. The pancreatic islets were well preserved. There was tubular atrophy of the testes, with an absence of spermatogenesis. One of the testes contained a large, encapsulated focus in which there was early calcification. A section of the lung showed a large wedge-shaped area composed of focal and confluent necrotic caseous material. Most of the foci were surrounded by dense scar tissue.

Grossly, the hypophysis appeared normal. The relative number of basophile, eosinophile and chromophobe cells appeared normal. The intracellular structure did not appear remarkable. A slight cellular exudate, composed largely of mononuclear cells, with occasional polymorphonuclear cells and a single multinucleated giant cell, surrounded part of the posterior lobe. This inflammatory process was thought suggestive of a localized tuberculous inflammation.

Sections of the hypothalamus revealed no definite abnormalities in the paraventricular or supraoptic nuclei. The adrenals, which weighed 33 gm., were not remarkable. There was considerable swelling and dilatation of the convoluted tubules of the kidney. The follicles of the thyroid gland were lined with thin, almost flat, epithelial cells.

Discussion

After nearly 30 years of work, Cushing[1] described a pluriglandular syndrome that has since taken his name. The 12 cases presented, taken from his own clinical experiences and from the studies of others, both in this country and abroad, exhibited the following characteristic findings: (1) Rapidly acquired and usually painful adiposity, being confined to the face, neck and trunk. (2) Kyphosis. (3) Sexual dystrophy; amenorrhea in women and impotence in men. (4) Change in hirsuties; an increase in women and pre-adolescent males, with the reverse being true in men. (5) Plethoric skin with purplish linea atrophica. (6) Vascular hypertension. (7) Tendency to polycythemia. (8) Variable backaches, abdominal pains, fatigability and ultimate extreme weakness. Other frequent findings were dryness of the skin with acne and tendency to skin infections, hyperglycemia, decreased glucose tolerance, polyphagia, polydipsia, osteoporosis, bronze pigmentation of the skin, cutis marmorata, and purpuric ecchymoses.

Although recognizing the possible etiological role of the adrenal cortex, Cushing believed the essential pathology and etiology to lie within the altered structure and function of the pituitary basophile cells. This was based on the finding of pituitary adenomas in six of eight cases autopsied. In the three cases in which careful studies were carried out the adenoma were basophilic in nature. Crooke,[8] in 1935, coined the term "basophilism" after he found similar changes in the basophile cells of 12 patients with the clinical syndrome; six of whom had adenomas of the pituitary gland, three of whom had thymic tumors and three of whom had either hyperplasia or tumor of the adrenal cortex.

Rare cases have been found in which other lesions of the pituitary,[9, 10] chromophobe adenomas, acidophilic tumors and tumors of the pars intermedia were associated with Cushing's syndrome. Hyperplasia and tumor of the adrenal cortex are common findings,[10] with surgical extirpation of the lesion frequently yielding dramatic disappearance of symptoms. Ovarian tumors[10] (granulosa cell, lipid cell, arrhenoblastoma and teratoma) and thymic tumors[10] have, on occasion, been reported in association with Cushing's syndrome.

Albright,[11] in 1942, advanced the premise that all cases of Cushing's syndrome are due to hyperadrenal-corticism, citing as evidence the frequency of adrenal hyperplasia, high 17-ketosteroid excretion, and increased urinary secretion of corticosteroids. He believed that an increase in output of the "sugar hormone" ("S" hormone) of the adrenal cortex caused an inhibition of tissue formation, resulting in the common clinical deficiency of tissues; thin skin, weak muscles, osteoporosis and easy bruisability. Recent advances in the study of ACTH and the adrenal cortical hormones support this idea.[12] Indeed, a not infrequent side effect of cortisone therapy is the production of a Cushing's syndrome.

Heinbecker,[2] in 1944, presented four cases of Cushing's syndrome with associated atrophy of the cells of the paraventricular and supraoptic nuclei. Reproducing the syndrome experimentally, Heinbecker and Pfeiffenberger[18] concluded that the disease state could be due to either a lesion of the hypothalamus or of the adrenal cortex. In experimental dogs they severed either the afferent or efferent fibers of the paired paraventricular nuclei and this led to obesity, hypertension and other signs analogous to Cushing's syndrome in human beings. The thesis offered by these authors is that the paraventricular nuclei are trophic to the pituitary basophile cells and that when the functional activity of the basophile cells is reduced, either by atrophy of the paraventricular nuclei or overactivity of the cells of the inner two zones of the adrenal cortex, the esoinophile cells become dominant. They postulate that the eosinophile cells stimulate the adrenal gland, corpus luteum, androgenic cell and renal tubule cell, while inhibiting the thyroid, ovarian follicle, seminiferous tubule cell and islets of Langerhans, thus producing the clinical picture of Cushing's disease.

Finding a slight to moderate increase in spinal fluid pressure present in many cases, Heinbecker[2] hypothesized that chronic increased intraventricular pressure could cause atrophy of the paired paraventricular nuclei. He mentioned the case of a 33 year old woman with typical signs and symptoms of Cushing's syndrome and neurological findings related to the upper cervical cord. There was a complete block of the spinal canal at the second cervical vertebrae and the spinal fluid pressure was 240 mm. of water. Removal of a meningioma caused reversal of the clinical condition with disappearance of obesity, plethora, acne and hirsuitism.

Castor,[14] in 1950, administering ACTH and cortisone to rats, produced a decrease in the cytoplasm of the paraventricular nuclei. The changes were most widespread with cortisone, being found throughout the hypothalamic and thalamic nuclei. On the basis of this, the authors concluded that the hypothalamic lesions in Cushing's syndrome were due to hyperadrenalcortical activity. This contrast with the previously mentioned work of Heinbecker leaves unsettled the ultimate etiology of Cushing's syndrome.

Known to medical science since antiquity, congenital hydrocephalus has been stated to occur in 210 out of every 100,000 births.[15] The associated mental and physical deficits make longevity unusual.[16] A blockage in the flow of the cerebro-spinal fluid, as a result of malformation or infection, has been shown, clinically and pathologically, to result in hydrocephalus.[17-19] Dandy and Blackfan,[18] in a brilliant experiment, obstructed the aqueduct of Sylvius in dogs and thereby produced internal hydrocephalus. De,[20] producing experimental hydrocephalus by injection of mild irritants into the basal cistern, showed histologic changes in the periventricular structures, presumably as a result of ischemia due to the increased intraventricular pressure.

Yakovlev[21] states that slowly progressive spasticity and weakness of the lower extremities with sparing of the facial and manubrachial innervation is so common and characteristic of hydrocephalus that it warrants the term, "paraplegia of hydrocephalics." This paraplegia has been ascribed to pressure of the brain stem against the foramen magnum, venous thrombosis and stretching of the cortico-spinal fibers to the lower extremities.[21]

It would appear that the extraordinary array of clinical findings in this patient are all possibly explainable on the basis of a congenital obstruction, producing the chronic increased intraventricular pressure and atrophy of brain tissue. Both the decreased intelligence, resulting from the atrophy of the cerebral cortex, and the spastic paraplegia, the mechanism of which is still in some dispute, are common concomitants of congenital hydrocephalus. The emotional instability, with its accompanying polyphagia and polydipsia, though conditioned by the inherent mental deficit and unusual environmental factors, may be thought of as being, in part, due to hypothalamic dysfunction. Fulton[22] describes numerous changes in emotion, appetite and thirst, produced by hypothalamic lesions.

Less clear are the mechanisms responsible for the changes of Cushing's syndrome. The finding of a more rapid course of the disease, osteoporosis, red striae and an increase in urinary corticosteroids (not done in this case), would have made the case more typical of an active phase of Cushing's syndrome. Considering the great variance of disease states from individual to individual and noting that a state of equilibrium was almost approached in the hydrocephalus of this patient, we may think of the disease process as developing more slowly in this patient, so that osteoporosis and marked polycythemia, as seen in fullblown Cushing's syndrome, were not yet reached.

Summary

A case, exhibiting the previously unreported constellation of Cushing's syndrome, congenital hydrocephalus and paraplegia, has been described. The etiology of the individual components was briefly discussed and a hypothesis was made, suggesting a possible common etiology, the increased intraventricular pressure, for all the clinical features. This case (despite the equivocal nature of studies of the hypothalamus), seems to support Heinbecker's theory that a lesion of the hypothalamus can produce Cushing's syndrome without the presence of the classical adrenal or pituitary findings.

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PSYCHOSIS AND PEPTIC ULCER*

By EMANUEL M. HONIG, M.D.†

The relationship between psychosis and psychosomatic disorders has invited the attention and interest of many engaged in research within the sphere of psychosomatic medicine.

An empirical finding which is widely accepted is that a reciprocal relationship often exists between the psychosis and the psychosomatic illness. Psychosomatic disorders may serve as a defense and protective mechanism against a psychotic break. The vegetative neurosis represents a mode of ego functioning which, though defective, is a more highly developed defense than the regressive mechanism of the psychotic patient. When ineffectual in adequately binding anxiety, the psychosomatic disorder is replaced by the psychosis.

The purpose of this paper is (1) to present some empirical data offered to support the viewpoint that there is alternation between psychosis and the psychosomatic disorder, citing the evidence (statistical and individual case studies) upon which this is based; and (2) to report a study of the relationship between peptic ulcer and psychosis made by the author at Winter Veterans Administration Hospital which questions the above thesis.

Hardy[1] presents evidence of an inverse relation between health history and behavior adjustment in a group of Illinois school children, in which the well-adjusted children had more frequent, serious, and prolonged physical illnesses than the maladjusted children. Among children described by teachers as having happy, cheerful dispositions, fewer than 10 per cent had been relatively free from illnesses compared with 23 per cent of the children who appeared to be unhappy and morose.

Psychiatric literature is replete with statistical surveys which show that organic illnesses occur far more frequently in the population at large than in hospitalized mentally ill patients. Gregg[2, 3] points out that among 600,000 deaths in the community, and 26,000 deaths in Massachusetts state hospitals, gastric and duodenal ulcer were given as a cause of death three times more often in the community than in state hospitals.

Ross, Hay, and McDowell,[4] in a survey of 1600 patients in a Canadian mental hospital, noted the low frequency of peptic ulcer in that institution as compared with private medical practice; peptic ulcer occurring in only six-tenths of one per cent in the hospital group, as compared to Bockus' figure of 7 to 10 per cent in the general population.[5]

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In another paper, Ross and others[6] stressed a significant association between peptic ulcer and the manic type of manic-depressive psychosis; namely that the relative infrequency of ulcer among psychotic patients as well as the observation that manic patients have more ulcers than other psychotics, were consistent with the hypothesis that peptic ulcer is not associated with as severe a degree of regression and disorganization as that present in schizophrenia and other psychosis but rather with an affective disturbance.

Swartz and Semrad[7] further add to the evidence by indicating that out of 1034 psychotic patients admitted to Boston State Hospital during the period April 1948 to March 1949, 20 or 3.4 per cent had associated psychosomatic syndromes, while the incidence in the nonpsychotic group was 4.5 per cent. It is interesting to note that of the twenty cases cited, there were eight patients whose psychosomatic symptoms improved with the onset of the psychosis, ten whose somatic illness was unaffected by the psychotic process, and two whose psychosomatic complaints became exacerbated during the course of the psychosis. They conclude that the incidence of psychosomatic disorders was quite low in the total hospital population and lower in the psychotic than in the nonpsychotic group.

The above mentioned studies all appear to support the view that there is an alternating relationship between the psychoses and the psychosomatic syndromes, and specifically with regard to the low incidence of peptic ulcer in psychotic patients as contrasted with that of the general population.

However, there are some findings which cast doubt on this outlook, notably the work of West and Hecker[8] who suggest that there is little evidence in the literature to support the contention that incidence of peptic ulcer is lower among hospitalized psychotic patients than in the nonpsychotic group. They report a 3 per cent incidence of gross peptic ulcer in 130 cadavers of psychotic patients scrutinized over a three year period. Examination of cadavers the world over for incidence of peptic ulcer, dating from as early as 1859, are summarized in a paper by Gordon and Manning,[9] who reported an incidence of 2.75 per cent in 22,956 autopsies at Philadelphia General Hospital from 1920 to 1937. In an analysis of autopsy material from 2,000 psychotic patients, Pollak and Kreplick[10] report an incidence of peptic ulcer of 2.1 per cent. Sturtevant and Shapiro[11] at Bellevue Hospital, New York, cite an incidence in postmortem examination of 2.13 per cent, whereas at Cook County Hospital, Chicago, Illinois, Portis and Jaffee[12] report 3.5 per cent. West and Hecker conclude on the basis of the above evidence that the incidence of peptic ulcer found at autopsy is within a comparable statistical range whether from psychotic or nonpsychotic patients.

The author examined the protocols of autopsies performed at Winter VA Hospital from 1949 to 1953 and found two cases of peptic ulcer among

37 postmortems of psychotic patients, an incidence of 5.47 per cent as compared to fourteen peptic ulcers disclosed on examination of 302 medical and surgical patients, an incidence of 4.6 per cent. Admittedly, there is a relative paucity of cases at this hospital, yet it would appear that these figures do not suggest any significant difference between the incidence of peptic ulcer found at autopsy whether of psychotic or nonpsychotic patients.

In an attempt to evaluate the incidence of peptic ulcer in the Winter VA Hospital psychotic population, the author also studied those cases bearing a dual diagnosis of peptic ulcer and psychosis. Twenty-two patients had such a diagnosis in a total neuropsychiatric population of 800, an incidence of 2.8 per cent. This agrees with the available statistics as related to general autopsy findings, but it is low as contrasted with that quoted above for the general population (7 to 10 per cent). The seemingly low incidence, however, may be attributed to other factors, such as the difficulty in diagnosis of peptic ulcer in the psychotic patient. Pollak and Kreplick, as well as West and Hecker, note that only a small number of psychotic patients express clinical symptoms of peptic ulcer. For example, of the twenty-two patients noted, five presented what may be described as "silent ulcers." In four, the complications of peptic ulcer, hemorrhage and perforation, constituted the initial indication of the existence of the illness. In one patient diagnosed as "schizophrenia, catatonic type," an upper gastrointestinal series was requested by the internist purely on the basis of the symptom of anorexia. Much difficulty, however, attends the clinical diagnosis of peptic ulcer in the psychotic patient because of three factors: (1) No subjective complaints are offered and the presence of the ulcer is first evidenced by its complications. (2) The incorporation of symptoms within delusional productions. (3) The difficulty attendant upon adequate investigation of complaints because of the severity of the psychotic manifestation.

Lack of adequate communication between the psychotic patient and the diagnostician is illustrated by the following case:

> S. R., a 30 year old white male, was admitted to Winter VA Hospital with a diagnosis of schizophrenic reaction, catatonic type. He was withdrawn, negativistic and uncommunicative. Several years after admission, he was given eight electro-convulsive treatments with some improvement in his mental status, to the extent that he was in better contact and participated to some degree in occupational therapy activities. Two months later he regressed to his former pattern of seclusiveness; uncommunicativeness, and ritual posturing. One week later, he vomited, and his abdomen became rigid, with diffuse tenderness noted on examination. He lay on his bed with legs drawn up and his face distorted with pain. Despite the objective findings, the patient did not utter any complaint. Operation revealed a perforated duodenal ulcer and closure was effected.

The following case exemplifies the failure of adequate diagnosis of peptic ulcer due to the overwhelming nature of the psychotic manifestations:

> B. D., a 28 year old white male was admitted to an Army hospital because of an abortive suicidal attempt, confusion, autism, delusions of persecution and auditory hallucinations. A diagnosis of schizophrenic reaction, paranoid type, was made at that time. The patient complained of abdominal symptoms, pain and vomiting; however, these complaints were not adequately investigated because of the assumption that they were related to the psychotic process. He was discharged from military service with persistence of his psychotic ideation and gastrointestinal complaints. A pattern of antisocial behavior followed with intermittent jail sentences because of burglary, car theft, and forgery.
>
> It was not until eight years later that a diagnosis of duodenal ulcer was made, with a subtotal gastrectomy performed. The patient was first admitted to this hospital as a transfer from jail because of psychotic behavior. He was initially seclusive, uncommunicative and actively hallucinating. His assaultive behavior required seclusion and hydrotherapy. He received insulin coma but it was terminated because the initial response did not justify almost daily violent combats in order to complete the treatment. Throughout his hospitalization, he complained of abdominal pain and experienced periodic vomiting episodes. Repeated X-ray examination did not reveal any evidence of marginal ulcer at the operative site of the gastrectomy. The ulcer-like symptoms in association with the active psychosis persisted until the patient's elopement.

In view of the above evidence, it appears that the reputed low incidence of peptic ulcer in the psychotic population might be attributed to the increased difficulties in diagnosis rather than to the exactitude of statistics.

In order to evaluate fully the relationship between the psychoses and peptic ulcer, the author reviewed the twenty-two cases at Winter VA Hospital which demonstrated a history of both disease processes. The past history of each patient was examined, and the information gleaned was corroborated through interviews with the ward physician, and the individual patients, where feasible.

Table I presents the distribution of the 22 patients in this series as to diagnoses, and their classification into three categories. (1) Those patients in whom peptic ulcer and psychotic manifestations were coexistent and simultaneously active; (2) Those who manifested alternation of the psychosomatic disorder and the psychosis; (3) Those cases from which no definite temporal relationship between the two disease processes could be ascertained because of the inadequacy of the history either from the patient, or from the recorded data.

A majority of patients in this series (15, or 68 per cent), are found in the first category where the peptic ulcer and psychosis were coexistent and concurrently active. A historical survey of these fifteen patients reveals

TABLE I

No. of Cases	Diagnostic Groups	No. of Cases of Coexistence	No. of Cases of Alternation	No. of Cases in Which No Temporal Relationship Was Found
12	Schiz. Paranoid	8	2	2
2	Schiz. Hebephrenic	2		
2	Schiz. Catatonic	1	1	
1	Schiz. Simple	1		
2	Schiz. Unclassified	1		1
1	Invol. Melancholia			1
1	Depressive Reaction	1		
1	Manic Depressive Psychosis	1		
Totals.... 22		15	3	4
Percentage....		68%	14%	18%

that the psychosis was manifested first in eleven, with the positive findings of peptic ulcer demonstrated subsequently. It is significant that in those patients in whom the psychosis antedated the peptic ulcer, the former became more florid with the onset of the peptic ulcer. Thus, during the active phase of the peptic ulcer the psychotic process was simultaneously active. In three of the patients, the peptic ulcer was diagnosed first historically, but during the subsequent manifestation of the psychosis, the ulcer symptoms were exacerbated. In the following illustrations of the first category, S. W. manifested both illnesses simultaneously, with concurrent subsidence of both processes.

> G. K. R., a 56 year old, World War I veteran, received a diagnosis of schizophrenic reaction at a Veterans Administration hospital, and was discharged against medical advice four years later as unimproved. He was admitted to Winter VA Hospital because of the exacerbation of psychotic symptoms, assaultiveness, confusion, and hyperactivity, in association with symptoms of abdominal pain and gastrointestinal hemorrhage. Diagnoses of duodenal ulcer and schizophrenic reaction, paranoid type, were made. Both processes remained active, and an emergency partial gastrectomy and anterior gastro-jejunostomy were performed. He was discharged; however, the gastrointestinal symptoms and paranoid ideation persisted, necessitating his readmission and committal.

> S. W., a 57 year old white male was admitted to a Veterans Administration facility with acute symptoms of persistent vomiting, hallucinations and bizarre behavior. Diagnoses of "schizophrenic reaction" and "duodenal ulcer" were made, and it was noted that the two processes subsided concurrently. He was apparently asymptomatic until prior to his admission here because of confusion, gross memory defects, and vomiting. Diagnoses

of "duodenal ulcer" and "manic-depressive reaction, mixed," were made. He underwent surgery because of a perforated duodenal ulcer, and a subtotal gastrectomy was performed. With subsidence of the abdominal symptoms, there was a gradual clearing of the psychosis.

In the second category, that is, the alternation of the two disease processes, their incidence was relatively low with three of 20 cases, or 16 per cent. In each case, one illness subsided with the appearance of the other. In two patients the ulcer preceded the psychosis, and with subsidence of the former, the latter manifested itself. In the third case, the psychosis was remitted with the appearance of an active duodenal ulcer. An example of the second category is the following case:

H. F., a 32 year old Negro, with a long history of peptic ulcer, was admitted to the medical service of Winter VA Hospital because of gastrointestinal hemorrhage. He was placed on a medical regimen and showed gradual improvement of his symptoms. A psychiatric consultation was requested because of overt manifestations of anxiety. A diagnosis of "anxiety reaction" was initially made, but the patient refused any psychiatric treatment, since he considered mental illness a stigma. On complete subsidence of the ulcer syndrome, he was prepared for discharge. He showed evidence of panic, and became withdrawn and hostile. The diagnosis was changed to schizophrenic reaction, paranoid type, and he was transferred to a closed ward on the Acute Neuropsychiatric Section.

The third category represents the four patients (18 per cent) whose illnesses could not be adequately evaluated as to temporal relationship.

In view of the statistics presented, of twelve schizophrenic patients with peptic ulcer in contrast to but one with manic-depressive psychosis, one could question Ross' contention that peptic ulcer is associated with an affective disturbance rather than with as severe a degree of regression as that noted in schizophrenia.[6]

It would appear from the above survey that although alternation of psychosis and the psychosomatic disorder can be readily discerned in certain individual and isolated cases, it may not be as prevalent as much of the psychiatric literature seems to convey. On the contrary, it is apparent that psychosis and peptic ulcer are not incompatible but can frequently occur concurrently.

Of the fifteen cases of coexistence of the psychosis and peptic ulcer, two patients had received a bilateral prefrontal lobotomy. These patients, whom I studied intensively in another connection,[13] developed peptic ulcer after their operation.

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BOOK NOTICES

The Integration of Behavior, Vol. II. By THOMAS M. FRENCH. $6.50. Pp. 367. Chicago, University of Chicago, 1954.

The second volume, as does the first, represents an excellent, a stimulating, indeed a creative effort of a mature author. We are indebted to him for reawakening an interest in dream interpretation, and for strengthening the present trend of ego psychological studies. There is much to learn from this volume and much to agree with. This reviewer is not yet convinced that ego psychological problems as they are reflected in dream material cannot be fully and satisfactorily discussed with the conceptual tools of psychoanalysis which, according to French, need to be supplemented by those of Kohler, Lewin, Mead and Tolman. The comparison of French's reanalysis of the Dora dream with Erikson's reanalysis of the Irma dream points up this question. (Rudolf Ekstein, Ph.D.)

The Psychosomatic Concept in Psychoanalysis. FELIX DEUTSCH, ed. $4. Pp. 177. New York, International Universities, 1953.

This symposium includes five lectures by Margolin, Grinker, Kubie, Gerard and Kaufman and nine brief discussions, originally presented at the Boston Psychoanalytic Society and Institute. The main papers, especially the first three, present the most advanced concepts of psychosomatic illness and reflect the tremendous theoretical advances, particularly in the past ten years. By comparison, the earlier formulations of the 1930's seem naive. All the papers are lucid and although posing more questions than answers, they point the way toward more effective research and treatment of these so-called "psychosomatic" disorders and will enlarge all our concepts of personality. (Lewis L. Robbins, M.D.)

Power of Words. By STUART CHASE. $3.95. Pp. 308. New York, Harcourt, Brace, 1954.

Stuart Chase put semantics on the map with his book *The Tyranny of Words* in 1938. Now 16 years later he writes one on the *Power of Words*, which brings the earlier one up to date, so to speak, but lacks its dramatic effect because we have been thinking about it all the time. He organizes my thinking for me a little by considering linguistics, cybernetics, perception research, and nine other things as all existing *approaches* to communication. Of all these, I am just now particularly interested in linguistics, said to be the most nearly exact of the social sciences. (K. A. M.)

The Gentle House. By ANNA PERROTT ROSE. $2.75. Pp. 177. Boston, Houghton Mifflin, 1954.

A sensitive, understanding woman who has grown children is confronted with the most challenging experience of her life when she takes into her home an orphan Latvian boy of eleven, who has had many terrifying experiences during the war. His constant need for love which he is unable to cope with except by aggression, causes family and neighborhood disruptions. A psychologist and psychiatrist offer help with the boy's problems from time to time, but it is the mother's love for the boy that provides the core for his eventual final successful adjustment. (Edward D. Greenwood, M.D.)

The Annual Survey of Psychoanalysis. JOHN FROSCH, ed. $10. Pp. 724. New York, International Universities, 1954.

The steadily increasing abundance of publications and contributions to psychoanalysis and allied fields makes it extremely difficult for most workers, especially practicing analysts, to catch up with the literature. This is why one cannot help but look upon the colossal effort spent in preparing this second volume of the Annual Survey with respect and gratitude. The careful choice, the logical order, and the clear presentation of the material are only a few of its praiseworthy features. (Ishak Ramzy, Ph.D.)

Individualism Reconsidered. By DAVID RIESMAN. $6.00. Pp. 529. Glencoe, Ill., Free Press, 1954.

These thirty essays cover a wide variety of subjects in keeping with the author's versatility of experience and knowledge. Jacques Barzun says that the secret of this author's great success and popularity is his ability to enhance and enlighten the readers' own faith in the life of mankind. Four of these essays relate to so-called minority problems and are, in the opinion of this reviewer, superb. Four more essays deal with Freud and these, too, strike the reviewer as excellent critique, despite the heavy dependence of Riesman on one writer who is not regarded by many of us as an authoritative psychoanalyst. But the real Riesman part of this Freud section is excellent Freudiana. These essays will be widely discussed and quoted. (K. A. M.)

Films in Psychiatry, Psychology & Mental Health. By ADOLPH NICHTENHAUSER, MARIE L. COLEMAN, and DAVID S. RUHE. $6. Pp. 263. New York, Health Education Council, 1953.

This is probably the best existing guide to the selection and use of films on psychiatry, psychology, and mental health. One section consists of chapters on the art of presenting films for educational purposes. The largest section is a series of discriminating reviews of the better psychiatric films available. Fifty additional films are reviewed briefly, and there is a bibliography to indices of films. Information on length, source, cost, and audience appeal is clearly and consistently presented. As tested by the Medical Illustration Laboratory of Winter VA Hospital in the Topeka program of psychiatric education, this volume has proved to be a valuable textbook for psychiatric instructors as well as an indispensable guide to available films. (B. E. Boothe, Ph.D.)

Observations of the Correctional System of Denmark. By NORMAN FENTON. Pp. 130. San Quentin, Calif., Graphic Arts Students, 1954.

In a clear, simple style, the author presents his observations during a visit to nineteen of the twenty-two Danish facilities for older youth and adult offenders, and to forty correctional institutions in other European countries. Sections describing the social status of Danish prison personnel, the philosophy covering the use of inmate laborers, and the attitude toward the prisoner himself, are eye opening and should provide much food for thought to American penologists. The small but excellent photographs help the text convey a picture of a social structure in which the offender is still given recognition as a creature for whom society has a responsibility. (Alfred Paul Bay, M.D.)

Man Above Humanity. By WALTER BROMBERG. $5.75. Pp. 342. Philadelphia, Lippincott, 1954.

The sweep of the panorama of history intrigues the thoughtful author of this book, which is about the origin and development of psychiatry by a psychiatrist from the psychiatric point of view, notwithstanding the emphasis on psychotherapy in the sub-title. It rightly includes "Our Neurologic Heritage" and a chapter on "The Return of Physiology." There are 958 consecutive references and, bunched altogether in the center of the book, some photographs. We need more books like this to give us a proper perspective, proper orientation and let us trust, proper humility. (K. A. M.)

Maternal Dependency and Schizophrenia. By JOSEPH ABRAHAMS and EDITH VARON. $4. Pp. 240. New York, International Universities, 1953.

Pointing the way to comparatively unexplored areas, this important book reports group psychotherapy in a group of mothers and their schizophrenic daughters. The other half of schizophrenia, the need of the mother for the helpless schizophrenic infant, is brought into sharp focus. This approach helps immeasureably in understanding schizophrenia. It may have value as a therapeutic method. Its greatest value may lie in understanding the normal mother-child relationship, for where, but in investigation of grotesque pathology, have we learned most about subtle nuances of the normal? (Murray Bowen, M.D.)

Behavior Disorders in Children. By HARRY BAKWIN, M.D. and RUTH MORRIS BAKWIN, M.D. $10. Pp. 495. Philadelphia, Saunders, 1953.

In the scope of its contents, this book exceeds the limiting confines of the area defined by the title and even includes a brief discussion of childhood schizophrenia. This perhaps reflects the author's psychological orientation and point of view. It contains much general information of a rather superficial nature on child growth and development and is designed to serve as a "practical guide" to the physician in the psychologic care of some aspects of problems of behavior in children who suffer from a variety of chronic diseases, physical disability, mental retardation and emotional stress. (Seymour W. Friedman, M.D.)

Group Work With the Aged. By SUSAN H. KUBIE and GERTRUDE LANDAU. $3.50. Pp. 214. New York, International Universities Press, 1953.

Not only is this book interesting to read, it also records and describes helpful methods of working with the aged. Many of the problems which are inherent in organizing such a program are discussed in a thoughtful and enlightening manner. The case material takes the reader into the realm of conscious use of program media, as it relates to the needs and capacities of the individuals and the group. The book describes how these aged people were able to combat their problems of progressive isolation from the community and rediscover their creative energy. (Minnie Harlow)

Doctors, People, and Government. By JAMES HOWARD MEANS. $3.50. Pp. 206. Boston, Little, Brown, 1953.

The author for twenty-seven years was Chief of Medical Services at the Massachusetts General Hospital and Professor of Clinical Medicine at the Harvard Medical School. Thus he has experience, authority and intelligence; in addition, he has courage and an open mind. He thinks it is still possible to improve our medical services and while he realizes, like many of us, that the British plan could not be transplanted here, he believes that it has much to commend it and he has courageously opposed the tactics and position of the American Medical Association in the matter. He believes that payment for medical care on a fee basis is outmoded, that doctors ought to all be on salaries from someone and that medicine should be practiced by groups of doctors wherever possible rather than by individuals. Above all, he believes in being open-minded with regard to improving methods of equalizing the quality and availability of medical care. And who can disagree with that? (K.A.M.)

Persons and Personality: An Introduction to Psychology. By SISTER ANNETTE WALTERS and SISTER KEVIN O'HARA. $4.75. Pp. 678. New York, Appleton-Century-Crofts, 1953.

The authors describe their book as frankly partisan in its approach to psychology. It is intended as a text for the first course in psychology in a Catholic college. As such, it attempts to relate psychology to relevant theological and philosophical considerations in order to help the college sophomore to integrate his scientific, philosophical and theological knowledge of man. Its style throughout is admirably objective and scholarly in spite of its avowed bias. The scope of its survey of the field of psychology is comprehensive, although necessarily rudimentary. (J. L. Menninger)

A Manual of First Aid for Mental Health: In Childhood and Adolescence. By SIDNEY L. GREEN, M.D. and ALAN B. ROTHENBERG. $4. Pp. 278. New York, Julian Press, 1953.

The authors have attempted a clear-cut exposition of what people "can and should safely do in the way of First Aid for the mental health of children and what they should leave entirely to the professionals in the field." This idea of writing a mental health First Aid, corresponding to the American Red Cross's *First Aid Textbook*, is unique. The reader, however, is never lured into thinking that rules or formulae can be applied to mental health. Rather they are introduced to a way of thinking about children's behavior which affords the discerning among them some recognition of disturbed behavior patterns. The book serves as a manual for workshop discussions and is outlined in such a form as to be readily applicable to the workshop method. (Arthur Mandelbaum)

Sex Ethics and the Kinsey Reports. By SEWARD HILTNER. $3. Pp. 238. New York, Association Press, 1953.

Hiltner is a theologian and a social scientist. Here he attempts "rethinking the Christian view of sex in the light of the Kinsey studies." In a general way he holds for an ideal of brotherly love as the basis of conduct. This precludes sexual activities just for the fun of it. He agrees with Kinsey that some of our sex taboos are superstition but he feels that Kinsey betrays as much ignorance of religion and psychology as he (Kinsey) finds in the general public regarding sexuality. In my opinion, the author is far too gentle with the Kinsey volumes, but constructively offers a program of morality with which few civilized human beings could take issue. (K.A.M.)

Ways to Psychic Health. By ALPHONSE MAEDER. $3.50. Pp. 200. New York, Scribner's, 1953.

This book is written around fifteen cases of brief psychotherapy. The mixture prescribed by Dr. Maeder consists chiefly of explanation to the patient of the dynamics of his illness, with exhortation, and religious guidance. So little is actually known about the techniques of psychotherapy that it behooves us to listen sympathetically when a colleague tells us how he practices himself. But it must be confessed that—short though the book is—it is difficult to remain sympathetic as we proceed through the pages. This difficulty stems partly from the quaintly Victorian style of the case presentations, and partly from the pedestrian and literal translation from the original German. (Donald J. Watterson, M.D.)

Emotional Factors in Learning. By LOIS BARCLAY MURPHY and HENRY LADD. Pp. 404. New York, Columbia University Press, 1953.

This book originally published in 1944 was reprinted last year. It represents the work of the authors as observers of the teaching and learning process at Sarah Lawrence College. Phenomena in personality development, deviation, and specialization, similar to what psychiatrists see in more extreme forms, are here presented as they appear in adolescents to observant teachers and psychologists. Eleven educational case histories, as they might be called, are presented rather fully in a way which points up to psychiatrists large areas of observation which are often lacking in our clinical data. Our notions of "premorbid personality types" ought to be checked against these "nonmorbid" personality types. (K. A. M.)

Jung's Psychology and Its Social Meaning. By IRA PROGOFF, Ph.D. $5. Pp. 299. New York, Julian Press, 1953.

Doctor Progoff succeeds in his effort to elucidate the theories and explore the thinking of Jung. This introduction of Jung's contributions will help to integrate and enrich thinking in psychiatry and to guide anyone wanting to study Jung's original writings further. Progoff's deep understanding of Jung and his feelings about the magnitude of the psychology of the unconscious allows the reader to "experience" Jung. Part one deals with basic concepts of depth psychology, part two presents an approach to history and society through the "Social expression of archetypes, social symbols" and the significance of the living and dead God. The Jungian School explains some historical and social phenomena by means of mass psychoses. (Karl K. Targownik, M.D.)