# THE BULLETIN OF THE MENNINGER CLINIC

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# BULLETIN of the MENNINGER CLINIC


Topeka, Kansas



The Treatment of Chronic Criminals · Georg K. Stürup, M.D. ........ 229

Like Father, Like Son · John A. Tribbey, M.D. ........ 244

The Use of the Prison Code as a Defense · Charles R. Keith, M.D. and Richard A. Stamm, M.D. ........ 251

The Abused Child · Patricia T. Schloesser, M.D. ........ 260

The Reporting of Child Abuse · William M. Ferguson ........ 269

Activities of the Menninger Foundation ........ 271

Reading Notes ........ 273

Publications by Members of the Staff ........ 281

Brief Book Reviews ........ 282



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# THE TREATMENT OF CHRONIC CRIMINALS*

GEORG K. STÜRUP, M.D.†

It is a matter of good fortune, considering the state of our knowledge, that the majority of persons who come into conflict with the law for the first time are more or less harmonious people in society, and prove themselves sufficiently capable of managing their future patterns of behavior as to avoid subsequent conviction for lawbreaking. We should not think that they conform to this degree without many personal difficulties, or without psychic scars. However, it is true that the bulk of lawbreakers pass back into the community without too great difficulty. If they become recidivists, they have joined the group of sensitized, regressed, true criminals on the production line of crime.

A small proportion of first offenders have greater difficulties in the reorganization of their pattern of behavior, but nevertheless somehow manage to get by, with the ordinary and sometimes rather specialized aid from the facilities at the disposal of well-run penal institutions and probation services. They may even, in retrospect, see this period as a difficult but valuable time in their lives. This is often mentioned by advocates of the old prison and probation system, and certainly this group does exist, even though it is small.

We should not forget another minority which certainly will not develop through ordinary facilities, even though there may be therapeutically-trained specialists on the staff. This minority greatly needs help, but to a greater or less degree will resist any attempt to help them. The punishment

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itself, which is forced upon them, and the subsequent bitterness which they generate will influence their future personality development and behavior patterns in very complicated ways—seldom for the better.

This minority is forced, in effect, by the classical system of punishment, to continue their criminal careers until eventually age stops them; they actively resist traditional systems of correctional therapy. The active hard core are likely to expect terrible sufferings from their surroundings, and it is my impression that many of them are very immature in their reactions to any sort of authority but especially to correctional authority. Their evasion and lack of hope is a characteristic type of psychopathic protection, behind which they hide their insecurity, their anxiety, and anything which can possibly remind them of normal guilt-feelings. For this group of deviates I have for many years preferred a less committing term than psychopath, "insufficiency of character," and by this have tried to identify a group of persons who because of psychological deviation, which is not intellectual, cannot manage life in society.

Any of these minorities of lawbreakers which we are describing are prejudiced against people with an ordinary, socialized life pattern, and their prejudices are very often supported by special techniques of integrating their experiences. For example, some sexual criminals have an odd way indeed of perceiving sexual relationships, and may genuinely believe, when they see a small girl behaving in a gay and joyous way in the street, that she is in fact desiring sexual intercourse; and there are many less dramatic examples of this similar misperception of reality.

This nucleus group of criminals and serious lawbreakers with insufficient character, as I use the term, are generally thought to be incurable other than by the passage of years; but it is wrong to regard them as hopeless. It must be admitted, of course, that with some we will fail, and that it is difficult to make a safe prognosis in any case, but even in very complicated cases it has proved possible to promote their social development and their reasonable readaptation to society, when adequate tools for their treatment are given and intelligently used.

We must place these persons under unusual and forceful pressure to stimulate their motivation for change and not merely punish them in relation to their antecedent lawbreaking. Traditional punishment has been proved to be without value in these cases. Likewise, a sentence stated to be for treatment gives such an inmate an easy opportunity to demonstrate that the sentencing and treating authorities, who believed that he thereby could be changed, are just as foolish as all other authorities he met before. By subsequently committing a new crime he proves, in his own view, that they, the authorities, are wrong.

### The Incentive of Social Protection

If, by contrast, the lawbreaker is sentenced expressly for the protection of society, then the only way in which he can prove the authorities to be in error is by subsequently establishing his fitness for release and further proving his capacity to live in society. Provided the accent is strongly on social protection, and treatment is a possible, but not a necessary subsidiary of the community's social protective reaction, then he is in a reality situation which he can use to establish his capacity to disprove their classification of him. Treatment itself will, of course, in practice be an essential element of the functioning of such an institution, but it is important to realize that it is not its fundamental justification for existence.

Some people would agree with this, and would further hold that the therapist must have full charge of the social protection–treatment period; meaning that he should not only have responsibility for what goes on in the institution, but also should freely determine the duration of the segregation. With that I do not agree. The fact that the sentence is given primarily for community protection seems to me to make the justification for its imposition and continuation from month-to-month a matter to be handled by an observant and diligent court. Only within the reality of such a law-community relationship can effective therapy be done.

It is further of value, in practice, that the same court which has the responsibility for making the determination of society-protection in the first place should also bear the responsibility of determining the duration of actual segregation, and should undertake the task of determining when the criminal should be released on being satisfied that there is a sufficient reason to think that he may not perform another serious crime.

Within these legal powers and judicial controls it is then the task of the institution, with the therapist in a responsible position, to use indeterminate segregation further to stimulate and manipulate the criminal's motivation to change his life pattern, bearing in mind that such a change will never be something which is easy to achieve, nor comfortable for the person undergoing it.

### The Danish System

This describes the principles of the Danish law under which my insti-

tution operates. We get in our special detention center in Herstedvester the group of mostly chronic criminals, whom no one wants in the prisons, nor in the mental hospitals, nor in the institutions for mental defectives in Denmark. Despite power under law to hold them for a protracted period, in practice we keep them for a surprisingly short time.

The institution at Herstedvester started in 1935. In the early years thereafter, those inmates who came to us for the first time spent a norm of a little more than four years in the institution; by 1953 the norm had been reduced to about two and one-half years, and it has stayed at this figure since then.

In these 18 years we have received 900 new cases, all severe criminals. All of them have since been discharged; some of them we have seen as inmates several times after their first discharge. The second visit of those who come back has often been shorter than their first visit, partly because the crimes have been less severe than those which brought them to us in the first place, and partly because failure has stimulated them to a larger effort next time. Over-all, the result has been clearly satisfactory.

In April, 1963, ten years after these first 900 were for the first time received in Herstedvester (the 1935 to 1953 receptions), less than ten percent were in criminal detention. Generally speaking, every time a group is sent out, 50 percent survive in the general society. This succession of successes rapidly cuts down the group remaining in crime. The results, judging by a period of five years after each inmate leaves the institution, have been a little better in later years.

### Principles of Treatment

In classical medicine it is frequently stressed that diagnosis must precede treatment; this means that, to start with, we should analyze the dynamics of the criminal under consideration, should then establish a treatment plan, and, finally, on the basis of our scientific investigation of him, try to help him. I must admit that I have failed completely to follow this scheme. I usually require a prolonged knowledge of the inmate before I have sufficient facts for any understanding of the mechanisms relevant to the development of his specific criminal career. Further, it often takes him a long time before he is motivated to the sort of reaction to the institution and its staff members which is essential to our work. Only after his adaptation to our work is it possible for him to participate in the development of a treatment plan for himself, which can be followed effectively for any length of time. Hence, my first basic principle is: The inmate must participate actively in the development of our treatment plan for him and even then the plan which we have worked out together must be capable of modification from time to time, always with the inmate's active involvement in its modification.

When one first meets these chronic serious criminals in the institution, nearly all of them feel that our attempts to help them are an intrusion into their privacy. This reaction is very understandable, for it is surely a hurtful insight to have to realize that something in one's own personality is responsible for one's pattern of criminal behavior or has certainly been an important factor in the unsatisfactory way of life which one has been leading. It is even more hurtful to one's self-respect to have to admit to the need to let someone collaborate with you in trying to "cure" such a personality peculiarity. But despite the difficulties and understandable resistances, it is essential that the inmate comes to share with us the effort of his treatment and to appreciate that the alternative is protection of the community through long-protracted security without effective treatment for him.

### The Therapy

Over the years, we have developed a specialized form of treatment which I call "Integrating, Individualized Growth Therapy." I am not at all happy with this collection of words, but it is the best summary I can think of for the three important elements which make up the treatment system which we have evolved. Treatment has to be *individualized.* Each man must join with us in defining for himself, with our assistance, a treatment plan that has reasonable likelihood of assisting him to leave the institution, and to lead a life without crime in the future. Plan making itself is an essential technique for rebuilding his self-respect. The analytic and reconstructive elements in the plan have to be *integrated* in the daily learning process in the institution; and the results of the application of this plan have to be experienced by the inmate as his *own personal growth*, in such a way that later he does not have to be thankful to anyone for his cure. "Cure" here means, of course, not subsequently committing a crime. His self-respect will be greatly developed by his own realization that, in spite of his many handicaps, he has managed with assistance to develop himself sufficiently to live out a respectable pattern of behavior in the community.

This recidivating minority group of serious criminals—the prototype criminals—do not trust us and do not want our help; their whole past experience has been antipathetic to such an expectation. In Herstedvester we make no promises of cure to them. They have been sent to us by order of a

court for the protection of society, and our main duty is to fulfill the court's order. The whole burden of the future, legally and in fact, rests on their shoulders; the decision genuinely is theirs; we are here to help them to avoid the force of the court's segregating order if they want us to, and only if they want us to.

It is of first importance, therefore, to stress directly and openly to the new inmate that it is his own responsibility either to change his pattern of behavior or to remain in the institution. Some will readily accept this choice. The situation in which he finds himself may be enough pressure for a person to convince himself that he wants help from the therapist and other staff members, and this will sufficiently motivate him to participate with energy in the rest of the reception procedure, especially the analysis of his personal history and of the situations in the past which have proved crucial to his criminal career. With this type of case it is quite easy early to take up serious discussion of his own future possibilities. Usually, he will have some vague and unrealistic ideas which have to be criticized and tested as to their reality, but he may reasonably quickly succeed in developing a broader and more sober picture of his own possibilities in society as it is, accepting all the difficulties which he must face, and accepting them as something which he may regret but cannot change. This itself is, of course, a clear mark of personality development; it will then be a joint task for the inmate and the institutional authorities to try to convince the court that the inmate may be sufficiently safely paroled, so that in continued close collaboration with the institution, while on parole, he can test out in practice his ideas of his own future. For such a person, the motivation which he has developed and the understanding support which he will continue to receive will be enough professional help for him to avoid crime. One rejoices in such simple cases, but it is unhappily true that far from all our inmates act in this helpful way.

There are others, the majority of our inmates, who believe that they know how to organize their own life, and who see their task as that of manipulating those in authority in the institution to take consequential actions before the court which will lead to their release. They will try to show that they know from long experience how to handle situations in institutions, and that Herstedvester is fundamentally just another institution. They will overtly participate in therapeutic work, but they will be reluctant and suspicious.

For these less tractable cases the first principle must be to let them see, in practice, that it is not easy for them to control what happens. Those in authority at Herstedvester may have to behave quite differently from the expectations that these inmates have formed. This calls for a joint and difficult effort by the whole staff. There must be a development of a degree of insecurity on the part of these inmates in their evaluation of the authorities.

Something of this can be achieved in open discussion, preferably with a group of newcomers. In a series of group activities, with someone in a senior position in the institution as leader, and with some assistance from other staff members, the new inmate will be given an opportunity to ask questions concerning his stay in the institution, to speculate on what life is going to be for him in Herstedvester and also about his possibilities of getting out again. In this situation the person in authority can behave freely with the group, handling them as if they were a distinguished group of experts—which in fact they are on the problems which most concern them—and making clear to them that he is not at all scared of discussing in a realistic down-to-earth fashion the "hot" questions, and is not the sort of person who can be easily manipulated, like others in authority in the institutions in which they have found themselves in the past. The senior therapist must demonstrate, beyond any possibility of doubt, that he is emotionally disengaged as to their future; that he is willing, with the staff of the institution, to be of use only if they genuinely and completely want him to; but that he is totally unprepared to be manipulated by them. He may openly admit that sometimes they may succeed in cheating him, but he takes the position that he will enjoy and be stimulated by the effort to avoid such cheating.

### Examination and History

Throughout, the inmate will be shown that he is respected as an individual human being. I like to demonstrate to him what one might call firm but fair play. Nothing will be taken for granted; as far as possible, everything will be checked, words concerning the incidents of his past life not being sufficiently reliable for this purpose. The inmate must personally experience that the institution endeavors to be skeptical in all matters of information, critically testing his own explanations as well as information it has received from other prisons, from other government agencies and from private authorities. For this reason, we must in all cases take the trouble to arrange for a new physical examination and to work through his case record history in great detail from a therapeutic point of view; we

must talk with relatives and interview everyone we can reasonably contact who can give us information about his past history.

It is important to give the new inmate ample opportunities to correct his own previous statements about his history or personality development. What he said in court and what was said about him in court may be only partially truthful, if truthful at all. In this initial phase, when he first feels the burden of an indeterminate time before him, he is often insecure and may give up enough of his skepticism of our sincerity to feel it of value to try to help us to build up a chronological and truthful case record. It is my experience that it is easier, both for the inmate and for the therapist, if a dynamic understanding of each man's case is built up around a chronological sequence. This also makes it easier to see some of the important situations in their historical and psychological perspectives. It is also a great help to a more realistic approach, to allow the inmate adequate opportunities to comment on statements concerning various periods of his life which have been made by other important witnesses. Many times he has not known about these statements until we bring them to his attention; sometimes he has known about them, but has not made the effort to evaluate them.

### Interpersonal Relationships

We are equally interested in his day-to-day behavior in the institution. He must see every contact within the institution with therapist, with staff, with fellow inmates, as a challenging task of developing maturity in his own interpersonal relations. He must come to see that he is facing the considerable task of changing his whole attitude.

Through his own description of his life pattern, as well as through what we observe in his correspondence, in his behavior toward his visitors, and—if possible—in the visits of a therapist or a social worker to his own home, we attempt to evaluate to what degree the interpersonal relationships between the inmate and his family, his friends, and his peer groups are broken, or more or less permanently altered.

Some of this material is easily obtained if, as early as possible, we give the social worker, who is later going to handle the case during the parole period, an opportunity to help settle the social problems which are usually troubling the new inmate very deeply. Later, periodic leaves to the home will give an ideal opportunity for direct observation and for later influencing his interpersonal relationships.

Some cases will be motivated for further attempts at self-responsibility through this type of therapeutic effort; but often such motivation has a short life, and we will have to await the development of other possibilities which will generally emerge through the emotionally loaded situations which the inmate encounters.

### Emotional Outbursts

In the setting of a mental hospital it is common to try to pacify the angry patient—sometimes with the aid of drugs—and this may indeed be necessary in order to keep a reasonable peace in the ward; but on the other hand it may be of more value to use such disciplinary situations for therapeutic purposes. When a non-psychotic inmate is disturbed, angry, sad—we rarely see him very happy—he is often more able to remember important messages brought to his attention than he is if such messages are given him in a time of peace and stability.

In such disturbed times an inmate in Herstedvester may be able to confide in another inmate or to a member of the staff who happens to appear at the right moment. If there is not a serious threat to minimum discipline in the institution, the staff member may wait and listen for some time to the angry outburst and then perhaps persuade the annoyed inmate to sit down and explain to him why he is more angry than on another occasion when he seemed to have just as good a reason. In very severe disciplinary situations a member of the therapeutic staff will usually be called upon immediately. If he knows the case sufficiently well he may be able to find some similarities to former criminal behavior of the inmate or to other times when the inmate has handled situations in this type of unreasonable fashion. These outbursts we regard as great therapeutic opportunities.

We do not manipulate the inmate deliberately to create such outbursts, but we have created an institution in which there is enough freedom, and a sufficiently complex structure of interpersonal relationships facing him, to permit them to occur. In such moments it is often possible to obtain from the prisoner what psychologists call an "Aha-experience"—a feeling of "At last I understand."

Using such situations as a springboard, it is sometimes possible, in an hour or two with the inmate, to review the crucial periods in his life history, and to have a realistic discussion of the possibility of his avoiding such behavior. And it may even be possible for him to understand that it is necessary to isolate from his fellows, for a short time at least, a person who disturbs the peace and order of the ward or the workshop. He may also accept the idea that he needs time to think through his situation, and that

had he been a victim of such an outburst he would have expected the authorities to enforce discipline. This again illustrates the point, underlying the whole philosophy of the institution, that this type of therapeutic handling of a disciplinary situation is not a substitute for more traditionally disciplinary reactions, but is rather a supplementing, motivating and complementing element in them. If this type of acceptance can be achieved, it will give the man a realistic understanding of his own pattern of behavior, and will be experienced by the staff and other inmates as some support of the general climate of the institution.

Sometimes it happens that an inmate will not open up at all to a member of the staff or to a therapist, but that we can gain contact with him through another inmate. This relationship can be used for therapeutic purposes if the total ambiance of the institution is such that the therapeutic purpose is constantly before staff and inmates alike, and provided the inmate who is the recipient of the confidence of another inmate, and has some understanding of his psychological development, has a feeling of confidence in discussing this inmate's needs with a therapist. The inmate placed in this awkward therapeutic position must be made to realize that this is only a temporary phase, and that it is important that the inmate he is proposing to help should rapidly come into direct contact with a staff member. We are, of course, always perceptive of the risk that in this way we may be stimulating or building up a homosexual relationship, and we take great care to avoid this.

### Anamnestic Analysis

Either out of emotionally loaded situations or directly out of the reception process there may develop, in cases who are neither too dull nor borderline psychotic patients, the need for an anamnestic analysis: a careful, radical excavation of the inmate's prehistory seen from all possible perspectives, and at the same time experienced as a learning process. Such an analysis can be started in many different ways. It may continue steadily over a long period or it may be interrupted, starting and stopping one time after another. In some cases the inmate may volunteer his own case history as a written autobiography, usually on a very superficial level. When this has been carefully discussed, he may be led to write another such autobiography, usually at not quite such a superficial level; and later, for some parts of it, another and another, and so the maturing process continues.

During this type of analysis of a life history with the inmate, he may live through one emotionally loaded moment after the other several times over, but as these episodes recur, they are usually reduced and rationalized, without the risk of disciplinary complications. The therapist and the inmate will then frequently be able to perceive a repeating pattern.

### Training in Appropriate Behavior

There is a temptation for the therapist to see the work he does in his office as standing alone in the therapeutic development of the inmate; but it is not so. The training of the inmates in ordinary patterns of behavior in the institution is continuing at the same time, and we endeavor to create a totally therapeutic setting for his life. Everything which happens on the soil of the institute, and on his visits outside the institution, is part of that training. The attitude of the staff to the inmate, from the first day of his arrival in the institution, is an important practical demonstration of our respect for him as a fellow human being and has its complement in the staff's realistic behavior concerning his daily work and the daily routine of the institution.

Having a group of inmates who are different from those in other penal institutions compels us to react differently. To a degree we cannot, and should not, avoid an authoritarian role. We do, however, in all the many small things of life for the inmate in the institution attempt to underline that we are interested in his rehabilitation and that for us rehabilitation means more than merely avoiding his return to the institution. It involves a genuine desire to help him to stay out permanently because we want to prove that our institution works better than the normal prison. Of course, we make quite clear to him that we are willing, because that is our duty to the community, to take him back into Herstedvester if he is not able to succeed in his life in the community.

The staff must demonstrate in their daily behavior that life in the world can go on without too many difficulties, without disturbing other people too greatly, and that this is the more comfortable way to live. We do not want to create a rigid military-like system of suppression of initiative. This means that we cannot have a large ward with many inmates in it; our experience is that not more than 15 is tolerable; but with 15 it is possible to stimulate continuous attempts to evaluate what is relevant and significant in any given situation.

For example, two inmates fight. We do not ask who began the fight; rather we isolate both of them immediately for disturbing the order of the ward. Then, during isolation, we try to discover what really happened and to discuss it with all who were involved, and then we usually send them

both back to the ward when they have calmed down. This involves a training process for staff as well as for inmates, which makes it easier for all of them to keep a peaceful climate in the ward, especially if we do not moralize.

The "climate" in the institution depends on the attitude of the staff to the inmates and the attitudes of the inmates to the staff. This does not mean that I advocate a complete liberation from rules. We cannot tolerate any violence, and react against such acts as just described. During the early formative years at Herstedvester there were many cases of violent assaults. In the years since 1945 these have been extremely rare. Likewise we cannot tolerate gross abuse. Nowadays we are seldom troubled by a member of the staff losing his temper, but frequently an inmate will lose his temper and abuse a member of the staff, reflecting on his antecedents, his job or his personality in grossly unkind terms. This cannot be permitted by the superior staff, and the psychiatrist must never lend himself to even a hint of its tolerance. We must maintain effective control of what is basically a security institution; we must continuously stress that we dislike this type of extremely inappropriate behavior, even if we do not dislike the person who reacted inappropriately. Such a firm but accepting human attitude must be taught more or less indirectly, in practice, through example by the people in charge of the institution.

The attitude of the staff is related to the way in which they experience their job, and judge its significance. If we had two groups—the specialists and the general staff—living and working in a sense isolated from each other, both groups would tend to experience their jobs as more or less antagonistic to each other. It is essential that all collaborate if an integrated treatment climate is to emerge. To achieve this, it is desirable that all members of the superior staff represent only themselves, and not their group of psychiatrists or psychologists or social workers, whenever they talk or act in the institution. The specialist should be willing to inform the ordinary staff members of general points of view of the work of the institution and of his own personal observations, thus helping them to feed back relevant information concerning their own observations of what happens during their working hours in the wards or in the workshops. In order to stimulate such mutual exchange of necessary information, we hold daily conferences where all the different specialists meet with representatives of the ordinary staff in the institution. All important decisions are made here.

In an institution like Herstedvester we need many different specialists—psychiatrists, psychiatric nurses, psychologists, teachers, social workers, administrative staff and the general staff. The group to meet daily would soon grow to an unwieldy size if the institution were too large. It is the problem of staff communication and staff relationships which fixes the optimum size for a treatment institution for chronic criminals.

Such an institution should not be so small that it does not require at least two of every type of specialist staff member; but at the same time we must not have too many of them. It seems difficult for a group consisting of more than four specialists to avoid relating to each other as a group, independent of other groups. We have found a group of three psychiatrists, three psychologists, three teachers to be very convenient, even if this means that in order to get the social work done, inside and outside the institution, we must have at least seven social workers. Probably, with more than 300 on parole, we should have more than seven social workers. This group of specialists, together with representatives from the administration, from the general staff and from the workshops, is already rather big, and it seems to me that it would be very difficult to get a unit larger than this really involved in a collaborative treatment effort in an institution like ours.

This means that the nucleus of the institution is a group of about 20 highly-trained, experienced staff members. Already this group is a little too big for the development of an abiding "we-feeling." This leads me to some further comments on the structure of the institution, particularly in its group activities.

Criminal actions are examples of interpersonal relations, and the training of criminals in new ways of handling their interpersonal relations must be obtained in some form of group activity not directed by the criminals. We use three different types of group activity:

1. That group activity which goes on in every ward, every workshop, in the dining hall, and throughout their ordinary day, with the "operating group" in which they live their daily life in the institution.

2. Special group counseling. The operating group sits down for group discussions of problems in their own behavior. It is not "counseling" in the traditional sense of one person advising another; it is the type of "group counseling" which Norman Fenton in California has been prominent in developing; though in Denmark we rather resist the use of this term but esteem this type of work.

3. Group therapy. By group therapy here I mean the same group of

usually about ten to 15 criminals discussing similar problems, but this time under the guidance of a trained psychotherapist.

General experience with different types of groups seems to me to have established that more than 15 in such a group, if they are supposed to be at all active, is difficult to manage. This seems also to us to be the practical size for therapeutic control in the ward. In Herstedvester we try to continue this active group life in the workshop, the schoolroom, in hobby activities, in recreation and in their dining room altogether. This also enables the same staff members, when they are together with the same group of inmates day-after-day for a reasonably long time, to know them well.

Administrators sometimes say that a guard is a guard, that one is as good as the other; but in Herstedvester we try to use a qualified correctional officer and to make him an active member of the retraining group. His training is of a practical nature, concentrated on trying to understand the fundamentals of what upsets people and how they can be expected to behave. With developing experience, and the training he gets in Herstedvester, he may go further and engage in more spontaneous group discussions with the inmates, concerning difficulties in their work habits, their family relationships, or their financial arrangements.

Let me stress the importance of social work, both inside and outside the institution. It has become a cliché that social work should begin when the man is received into the institution, but it is still difficult to transform this thought into reality. But if it can be achieved, the social worker has a fine opportunity to get an early emotional contact with the inmate, and with his family, at a time when they are not longing to get him home again and have not begun to erect their defenses of pretense. It is a good foundation for development of trust in the future and it helps to secure that continuity in the therapeutic work which is of first importance.

We run our own after-care services. We do not rely on assistance from any other state agency. It is often said that in large countries it is impossible to run such outpatient services from the base institution. I do not believe that this is necessarily true. For each population group of two or two and one-half million we have found it desirable to establish a specialized institution like Herstedvester. When a man is paroled from such an institution it should be at a time when he realizes that he still needs our continuing help. Very often the lonely recidivist—and this describes most of them—wants to live near us, and we experience considerable difficulty in persuading him to move sufficiently far away from the institution. If too many settle down just around the corner from the institution, it may easily lead to serious objections from the neighborhood.

How social work is to be carried out, and how continuity of treatment is to be achieved, is a long story. But briefly, passivity will in many cases be more valuable than activity. It helps the parolee to understand that we are helpers who realistically accept that we are not able to control his daily life, but may be useful in helping him to avoid getting into new serious troubles, especially troubles of a criminal nature, if he gives us the opportunity to do so as soon as he is faced with difficulties. But certainly passivity is not in itself sufficient. Broad special experience is required for timing and graduating intervention in the most useful way, and it seems to me that we know less of work in this field than of our work in the institutional phase. Basic teamwork seems more difficult to establish and maintain under outpatient conditions.

I have tried to avoid complicating this survey of the principles we apply in Herstedvester by the use of too many fine technical terms because it seems to me of first importance that if these principles have validity, as I believe they do, they must be capable of presentation to and discussion by various types of people, with diverse training and experience, who are essential to a genuine effort at rehabilitation of a substantial proportion of our chronic criminals. I want to be able to discuss these principles with experienced members of my custodial staff, with lawyers, psychiatrists and psychologists. I want none of these people to judge that I estimate the one higher or more important than the other, though I know that particularly the general staff have the heaviest burden and get the least reward. The only way I can help this group to overcome their reluctance to participate in such discussions is to demonstrate in practice that I am genuinely interested in their comments as well as in their daily collaboration.

# LIKE FATHER, LIKE SON: A PROJECTION-DISPLACEMENT PATTERN*

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The familiar phrase "A chip off the old block!" usually denotes society's pride that a son is following in his father's footsteps, and implies that the son has incorporated desirable paternal character traits. There is another side of the coin, however, wherein errant footsteps are followed and shame replaces pride. This phenomenon, which might be facetiously termed "A chip off the old blockhead," is one with which most workers in the field of child psychiatry soon became familiar; that is, the frequency with which a son begins to take up the behavior pattern of an antisocial father. This paper is an attempt to list and discuss some of the pertinent characteristics seen in studies of these boys and their families.

The author was impressed by a number of similar cases encountered among boys admitted for an initial study to the diagnostic unit of the Kansas Children's Receiving Home, Atchison, Kansas. The Kansas Children's Receiving Home is an institution operating under the Division of Institutional Management of the Department of Social Welfare of the state of Kansas. There is a residential unit as well as a diagnostic unit. Boys and girls six to 16 years of age from all Kansas communities are referred for a psychiatric inpatient evaluation for a period of four to six weeks. Referrals are made by juvenile courts, social welfare departments, schools and physicians for a variety of clinical problems. Following the period of observation and diagnostic procedures, a staff conference is held in which representatives of the referring agencies participate. In these conferences, the reports of the investigation are shared with the community representatives, and an attempt is made to arrive at realistic recommendations for further care.

For this study, a period of time from July 1, 1961, to July 1, 1962, was arbitrarily selected and it was found that of 55 boys referred for diagnostic study, ten, or 18.2 percent had histories which were so similar as to constitute a behavioral pattern. In general, the picture presented is that of a boy whose parents are divorced, and whose father had a long-standing history of antisocial behavior. Before long, as the mother had always "known," the son begins to get into trouble.

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## A Composite Picture

A composite case history would be as follows: The boy's parents married impulsively when the mother was in her mid-teens. The father was five to ten years older than the mother and was probably already in trouble with the police. The mother usually came from a poor, but honorable and strict family. After a few years of a wretched marital relationship, characterized by the father's stealing, drinking, and physical abuse of the mother, the mother divorced her mate and remarried. The second husband was much more stable and responsible than the first, had no criminal background and tended to be a poor but steady man who more often than not was a traveling man and had little time to spend with his wife, children and stepchildren. Although happier in her second marriage, the mother likely continued to be an anxious, tense, irritable person who worried a great deal and felt rather dissatisfied with life.

The boy is about 14 years old, not doing well in school, and has a 50 percent chance of being named "Junior" after his deviant father. He is the oldest boy in the family and his siblings are described as being "no trouble." The boy is quite cognizant of his natural father's shortcomings; in fact, he has been told many times by his mother that he resembles his father, that he will "wind up just like your father—a no-good bum." He has been told by his mother that she lives in constant fear that he will grow up to be like his father, "who used to drink and beat me up." These dire predictions, emphatically repeated at frequent intervals, soon assume the proportions of a "self-fulfilling prophecy." The boy's developmental years are characterized by a variety of problems, the most common of which are feeding problems and enuresis. The boy is generally not welcomed by his peers who feel that he talks too much and is hypercritical. Although he likes sports and participates in them, his coordination tends to be below average.

The boy's problems have been aggression as exhibited in school, stealing, and disobedience toward his mother. There usually is a superficial relationship between the boy and his stepfather. The boy behaves better when the stepfather is home, but the stepfather is often away. The stepfather has not adopted the boy.

To sum up, the outstanding features noted in these ten cases are:

1. The mother was young (six of the ten were 18 years of age or younger when wed), and the marriage was impulsive in nine of the ten cases (four mothers were pregnant before marriage). Eight of the ten mothers often uttered prophecies that the son in question would be like his father.

2. Seven of the ten fathers used alcohol excessively; theft was their most common antisocial act (four of the ten). Six of them had been charged with desertion or nonsupport of their families at various times.

3. Of the seven stepfathers in the series, six had superficial or poor relationships with their stepsons; none of the seven adopted these boys.

4. Eight of the ten boys were the oldest male children; five were named "Junior" after the deviant father. In eight of the ten families, no other siblings presented any kind of psychiatric or behavior problem. Of the total of 22 full siblings (14 female; eight male), only two others presented problems and these were the only two older brothers in the group.

5. The boys' symptoms were enuresis and school aggression in six of the ten cases; theft and defiance of authority in five cases. Aggression, theft and defiance are obvious antisocial symptoms. Michaels[1] has reported that persistent enuresis is frequently associated with behavior problems.

Psychiatric and psychological evaluations reveal a boy of low average intelligence with much repressed hostility, weakened ego functions, frustrated dependency needs and poor impulse control. The most common diagnosis is that of adjustment reaction of adolescence with marked anxiety and depressive features. Follow-up treatment seems to be most successful when the child is separated from the family and placed in a residential treatment center. The mother is usually quite resistant to casework and has a poor prognosis for coming to some understanding of her role in the boy's behavior problem.*

## Discussion

There are three questions which present themselves for discussion: The first is that of whether or not the son identifies with an antisocial father as a sort of corrupt ego ideal. The next is the degree to which the mother might influence the son's development of antisocial behavior and the third is the question of why such poor results are achieved on an outpatient basis.

It would seem that the father's criminality or deviant behavior alone would not be sufficient to explain the son's unacceptable behavior. There

* In the only case (No. 9) in which there were good results on an outpatient basis, an older brother returned home from placement elsewhere. It would seem that this older brother who had previously presented a behavior problem, simply took on the scapegoat role again, accounting for the more apparent than real resolution of our patient's difficulties.



are two reasons for this: First, the son does not seem to have known the father very well since in seven of the ten cases such sons were separated from their fathers before they were three years of age and there would not seem to have been the opportunity for a strong identification process. Second can be cited the report of McCord and McCord[2] whose 20-year study of parental role model attitudes and disciplinary methods of normal and predelinquent boys resulted in the findings that the effect of a criminal father on criminality in the son largely depends on other intrafamilial factors. The McCords found that if paternal rejection, absence of maternal warmth or maternal deviance is coupled with a criminal role model, the son is extremely likely to become a criminal. The sons imitate their fathers' criminality when other environmental conditions (rejection, maternal deviance, erratic discipline) tend to produce an unstable, aggressive personality. They conclude: "It seems fallacious to assume that sons imitate their criminal fathers because they have established an affectionate bond with the fathers and 'identify' with them. Rather, it would appear that rejection by the father creates aggressive tendencies in the child who, having witnessed a criminal model in childhood, tends to channel aggression into criminal activities."

However, although no warm bond is established, and no identification takes place in the usual sense, the father still may have a powerful psychological influence on his son's development by serving as a nucleus for the formation of a "Negative Identity" as defined by Erikson.[3] He explains this as "... an identity perversely based on all those identifications and roles which, at critical stages of development, had been presented to the individual as most undesirable or dangerous, and yet also as most real. For example ... a mother who is filled with unconscious ambivalence toward a brother who disintegrated into alcoholism may again and again respond selectively only to those traits in her son which seem to point to a repetition of her brother's fate, in which case this 'negative' identity may take on more reality for the son than all his natural attempts at being good."

In addition, other relatives and members of the community may also reinforce the "bad" identity by associating the boy with his no-good father's history and reputation. Such reinforcement at a critical time, when an adolescent is searching for an identity, may have a far-reaching effect: "Since they think I'm bad (I might as well be), or (I guess I am) bad." That this role of a certain identity has in a sense a life of its own seems borne out by the fact that if another member of the family can be the recip-

ient of the role, the "victim" may then shed the mantle of the errant father as in Case No. 9.

### Mother–Father–Son Dynamics

The second question, that of the mother's role, is one which has many facets. First must be considered the mother's relationship to the natural father. Usually the mother has married the abusive father in a rather impulsive move away from her own family life which has tended to be dull, poverty-stricken and strict. She is aware of her husband's antisocial tendencies and might well receive unconscious vicarious gratification from his acting them out. As she reaches young adulthood, however, she seems to mature to the extent of making a judgment that she is in an undesirable situation and she then obtains a divorce. She considers herself well rid of her husband, but she still has feelings toward him and these are likely directed toward his oldest son who bears his name. She continues to harbor strong unconscious antisocial impulses and sees them acted out by her son as his father did before him (a la "superego lacunae" of Adelaide Johnson[4]).

Ruth Eissler[5] describes a case in which a mother goes into an acute depression whenever her son's delinquency improves under therapy. She concludes: "The aggressive and asocial behavior of the love object thus served three functions: 1) The object satisfied her own inacceptable impulses by carrying them out in reality; 2) She secured a masochistic gratification which served as a punishment and relief of her guilt feelings; 3) She could use son or husband as a scapegoat, pointing at them as the criminals, and thus reassuring herself of her own innocence. As soon as the love object no longer served this triad, the conflict which had been carried into the external world, by proxy so to speak, again became internalized and shattered an equilibrium which had been based on the continuous reassurance furnished by the misbehavior of an ambivalently loved male object. In the patient, on the other hand, the loss of his mother's love stirred up unbearable anxiety which consequently made him again gratify her unconscious needs in order to regain the security of her love."

The mother's hostility is directed toward the former husband whose personification is the son who plays the scapegoat role for all the children in the family because he is the oldest boy and "looks like" his father and is named after him. At a deeper level, her hostility is directed toward her own "bad self" which she has projected onto the father and the son.

This unconscious hostility toward the son and the need to use the son as a tool of obtaining vicarious gratification underlies the mother's presentation to the son of the bad identity mentioned above. In addition, it may be that the boy is looked upon by the mother as the evil product of her impetuous sin of breaking away from her family and that he must be sacrificed in order to expiate her guilt. At any rate, the essential mechanisms seem to be an initial *projection* by the mother onto the husband of her own antisocial impulses, and a later *displacement* to the son, of the feelings originally directed toward the husband. Thus, the mother's distorted view of the son becomes the source of the negative identity, later reinforced by relatives and the community.

To add to the effect of the mother's attitude is the lack of an adequate real-life masculine identification figure. Perhaps a stepfather, present in the home, and sincerely interested in the boy, could exert a beneficial effect, but in these cases, such a stepfather is a rarity.

A further complication in the mother–son relationship occurs when the son approaches puberty and unconscious oedipal impulses re-enter the picture. It may be that the son's antisocial behavior, *e.g.*, theft, leading to incarceration and separation from the mother, may be escapist behavior as a defense against the forbidden relationship with the mother, and also serves as punishment to assuage unconscious guilt. This kind of incestuous threat is likely to be more pronounced in the relationship because the mother may have come to see the son as so much a reincarnation of the bad father and unconsciously looks upon the son as the father rather than as the son. Wylie and Delgado,[6] in a study similar to this, show that aggressive boys whose fathers are absent develop a highly sexualized relationship with their mothers and assume some of the father's role. They add also, incidentally, that poor results are obtained with treatment in that appointments are not kept; the mothers express dissatisfaction with treatment, etc. Another report[7] stresses the immaturity, insecure masculine identification, and poor peer adjustment of boys whose fathers are absent from the home as compared with girls whose fathers are absent and other boys whose fathers are present.

### Outpatient Treatment

The final question deals with the poor outpatient treatment results. One factor has already been touched on: that it may be necessary for the son to flee the relationship in an attempt to handle incestuous impulses. This would make outpatient treatment with the son continuing to remain at home very threatening for the son. Another explanation is that the mother

has such an overwhelming need to completely sever herself from her antisocial impulses that she rejects her son as well and in a sense throws the baby out with the bath water. This is borne out in that both mother and son seem greatly relieved when the son is placed in a residential center.

### Therapeutic Implications

In view of the fact that this syndrome is one which is very difficult to treat in its developed stages after the boy has reached puberty, when his antisocial behavior pattern is crystalized, and he has chosen the negative identity (and mother has in a sense remade her life in a way which does not include the boy whom she considers the noxious product of a hateful marital relationship), it would seem that the greatest concentration of effort should be made toward either prevention or early treatment.

What is meant by this is that in those situations in which case workers, physicians, probation officers become acquainted with this kind of pattern involving an impulsive marriage, an antisocial father, and a son, they should be aware of the likelihood that a pathological relationship will develop which will end in the son's also becoming a problem to society. Therefore, since the syndrome can be easily spotted, it would seem sensible that efforts be made to identify these cases and perform counseling and therapy early so that the pathological pattern will not develop. It would be analogous to the heightened degree of alertness that a public health agency manifests toward possible cases of infectious disease.

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# THE USE OF THE PRISON CODE AS A DEFENSE


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Common sense tells that the prison, a society of antisocial people, should be chaotic, disorganized and troubled with continual fighting and bloodshed. The so-called sociopathic personalities are described as being cruel, unruly, and blunted in sympathy for the rights and feelings of others. In prison, they are forced to live, work, and play together in cramped quarters requiring an interpersonal give and take usually expected only of more mature groups. Furthermore, the prison inmates are subjected to restraints which were difficult for them in society at large, *e.g.*, monotony of routine, regimentation and the need to comply with authority.

However, prisoners get along together with surprisingly little difficulty. Riots and other major troubles (even escapes) are less frequent than the public realizes. Many theories have been advanced to explain the surprisingly stable organization of the prison community. One of these theories is that the prison, by virtue of its authoritarian structure, forces the prisoner to conform. Sykes and other sociologists,[1-3] who have studied prison societies extensively, attribute the formation of a cohesive, stable inmate social organization to the fact that the prisoner is subjected to excessively harsh, dehumanizing, environmental stress. As a result of this threatening life situation, the prisoner bands together with his fellows and sets up a rigid self-imposed code of behavior, thereby protecting his self-esteem and personal integrity against the onslaughts of his captors. This set of behavioral rules, commonly known as "the prison code," has been documented by prison observers for many years.

This code interests psychiatrists working in a prison hospital because it indicates what the prisoner thinks about himself and his environment. From it we might seek leads to help us understand better the personality structure of the prisoner and the collision that occurs between himself and his environment.

### Defining the Prison Code

A young mental patient at the Medical Center for Federal Prisoners who


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has been incarcerated previously in many state and federal penitentiaries has written this about the code:

"Lesser tenets of the code may vary slightly from country to country and from prison to prison, but in the main the code seems to be universal. As I see it, the code serves two important functions: It gives the convict a set of principles to live by, for although he may be surrounded by the most degrading conditions, he may comfort himself with the knowledge that he has enough character to live by the precepts he has adopted even though it would be easier to succumb to the pressures of his surroundings and become just another spineless nonentity.

"Adherence to the code affords protection of one sort or another. For example, throughout history the lot of the convict has been a miserable one. Sometimes he was tortured and brutalized, and sometimes he was merely subjected to bad living conditions. Today these things do exist, though to a much lesser degree. However, the convict's natural protection against this sort of thing is by banding together and helping each other when the going gets rough. Here I will try to list the main standards of the code in their respective importance:

"1. *Don't be a stool pigeon*: It's commonly accepted by thieves that when one steals he is taken aside. He has declared himself to be against the law. Therefore, the law and its minions are his natural antipathies. Therefore, when one aids the law for personal favors he is not only considered a traitor to his kind but also a completely characterless individual who might be capable of anything. When men are locked up in prison they are in bad enough shape without some stool pigeon coming along and making it worse. In essence, the 'stooley' is trading on his contemporary's misery. Surely people on the outside don't like a person who is always carrying tales on his fellow-workers to the boss. Convicts are no different and that comprises the case against stool pigeons.

"2. *Don't steal from other cons*: In prison everyone is in the same boat. No one has much and it would be very low indeed to steal what little another convict has. However, some cons interpret this rule as not pertaining to stool pigeons. They are so hated and so held in contempt that some consider them game for most anything at all.

"3. *Have courage*: Among thieves and convicts a very high value is placed on courage as it is a necessary and desirable commodity to have when one is stealing or in prison. So with the emphasis placed upon courage, there are no higher compliments in prison that one can pay another. The first is to say, 'he is a good man.' Meaning that he is a firm follower of the code and the other is to say 'he has lots of nuts' or 'he has nuts like a water buffalo' meaning very brave or that 'he has nuts like a field mouse,' meaning the opposite.

"4. *Mind your own business*: This rule also goes under the title of 'do your own time.' This means do not intrude into another's affairs. In prison there is very little privacy, therefore, it is all the more valued. Many things which are done in seclusion on the outside must be done more or less openly in prison. So it is customary for convicts to create mental walls where they are necessary.

"5. *Don't look for trouble*: Those who subscribe to the code do not throw their weight around. It would be impossible for one to live by the code and be a bully at the same time. However, when someone forces trouble on you, make him wish he hadn't. Fight him to win for surely you are right if you have followed the rules.

"6. *Keep your mouth shut*: This is one of the widest rules and one which offers the most protection to its followers. For example, about half the men in prison would not be there if they had kept their mouth shut in the police station when they were first arrested."

A few other statements by the prisoner-patient are as follows: "If you live by these rules no one would ever talk behind your back." Also, "If you believe in the code you look down on passive homosexuals. They aren't solid people. They are weak characters. The code also frowns on competition with a 'solid guy' and his wife (meaning his passive homosexual partner)."

The above has been quoted from the patient at some length because of his acquaintance with the prison code and his ability to record it. His willingness to share the code, in itself a voluntary "breaking" of the code, came about when the patient wanted to please one of the authors with whom he developed a positive relationship. This code is expressed by prisoners at regular institutions as well as by those in the prison hospital. Its accuracy is affirmed by correctional officers and sociologists who have worked in regular correctional institutions and correctional hospitals.

### Deciphering the Code

In many respects, the prison code is similar to that of society at large with the all-pervasive exception that it proscribes any emotional ties with authority. Authority is seen as being alien, distant and threatening. One needs to defend oneself against authority lest it reduce him to a "spineless nonentity." The "man" or "guard" is always on one side of the fence, the inmate on the other. The prisoner treats authority, rules and regulations, social norms—the very instruments society has constructed for his protection—as being weapons of his worst enemy.

The prison code and its resulting behavior epitomizes much of the sociopathic person's psychopathology. The code is clearly a continuation of the sociopath's lifelong problem of lacking ability to trust and identify with parents and parental surrogates. Case histories show that many of

these patients transfer their mistrust and troubled identifications from the home to authority within the social-legal framework and then to authority existing in the prison system. They vent their vengeful, destructive feelings against authority for various reasons: as a reaction to deprivation and rejection, as an outcome of their failure to control primitive aggression, and, as stated by our prisoner correspondent, as a defense against the fear of being overwhelmed and emasculated by their environment. The code also typifies this type of prisoner's need for external controls, though consciously denying them. He sets up a depersonalized, externalized code of behavior whereas in the more normal or neurotic personality most of the mores controlling sexual, aggressive and interpersonal behavior are internalized, largely unconscious and based on parental identifications. The need for the sociopathic person to set up this conflictual type of relationship with the environment, as set forth in the prison code, may account for recidivism as much as the unconscious sense of guilt and unfulfilled dependency needs, which are the more usual explanations.

The so-called prison code represents some of the ego defense mechanisms of the sociopath. The first one has already been mentioned, that is the use of the social organization to act out disturbed object relations, particularly those object relations of a parental surrogate nature. His gravitation to a prison environment where authority is harshly and often arbitrarily enforced allows the prisoner to justify his need for, and hatred of, the prison administration. Many need to project feelings of hate and guilt onto others and so unconsciously seek an environment which provides ready-made objects for this purpose. In prison, he appears to be acting normally *because* of his hatred of authority since many people, including prison guards and perhaps society in general, view prison as being an ineffective, onerous method of rehabilitation. The prisoner may then ask with partial justification: "Can you really blame me for hating and insulating myself against this oppressive system?"

The code reinforces the prisoner's image of the "badness" of authority while reducing to comfortable stereotypes his view of his fellow prisoners. According to the code, the world is populated with villains who "snitch" and good fellows who are "square" toward each other. Those who submit to authority are weak and those who keep silent are objects of emulation. Through this mechanism, the prisoner can disavow himself of his own wish for passivity. By magically populating the world with predictable characters described in the prison code, the prisoner can allay some of his suspiciousness toward his fellows. He can also assume, as our prisoner correspondent does, that the hostility of others cannot hurt him because of prison code prohibitions. For instance, other thieves cannot steal from him or talk behind his back. The prison code thus becomes insurance for the prisoner against his own and his peers' dangerous impulses.

In following the code, the prisoner finds approval for his need to repress and isolate feelings toward himself and others. He can thus avoid dealing with troublesome interpersonal problems. Soon after a suicide occurred on a ward at the Medical Center for Federal Prisoners, one of the authors made rounds to explore and deal with reactions patients might have had to this horrifying event. He anticipated some repression and denial of feeling by the patients but he did not know what form this would take. He got some of his answers when many of the patients repeated that part of the code which says "you should do your own time." The patients showed little or no apparent anxiety about this suicide. A common answer to how they felt about it was that each prisoner has a right to end his own time as he sees fit. Similar responses come from patients who witness or hear about upsetting events such as fights among prisoners and self-mutilations even when the victims or participants have been friends.

The code also encourages nonverbal communication in contrast to verbal. For example, it may condone a fight between two enemies in preference to submitting their difficulties to an agent of prison authority. Doing the latter would make the prisoner suspect of being a "stooley." Such an orientation circumvents introspection and its attendant anxiety.

In summary then the prison code serves the prisoner's following psychological needs:

(a) It provides him with a kind of external guidance which he can accept. The grave superego defects observed in the sociopath probably result from his inability to internalize parental authority figure identifications and their moral demands. The resulting gap is filled by the prison code which justifies and rationalizes this personality malformation.

(b) It provides ego ideals within the group which may serve as rules and models for behavior.

(c) It absolves him from guilt feelings, since he is loyal to the group as prescribed by the code.

(d) The code provides some stability for his stormy peer relationships by encouraging libidinal relationships with peers and displacing troublesome aggression onto authority figures.

(e) The code helps the sociopath deny any conscious recognition of his desires to be passive and dependent by promoting the fantasy that he has been singled out by the law officials for continued incarceration against his wishes.

(f) It provides him with a safe distance from troublesome interpersonal relationships when he needs it.

(g) The code perpetuates the antisocial life style which got the prisoner incarcerated, *i.e.*, rebellion against a standard code of behavior. Outside the walls he "rebels" against convention; inside he rebels against the penal authority. It helps preserve the distorted self-concept and self-esteem of the chronic offender.

The types of prisoners at the Medical Center for Federal Prisoners cover a wide spectrum of psychopathology, including the more normal first offenders, the sociopathic personality disorders, and the chronic, regressed schizophrenic patients. Treatment consists mainly of dynamic milieu therapy applied, as much as possible, within the prison setting. This delicately balanced marriage between dynamic psychiatry and the prison has resulted in some amelioration of the rigidity, harshness and the "dehumanizing" aspects of prison life so well described by sociologists and others. However, many prisoners cling to prison code behavior even after they have spent considerable time in this comparatively relaxed milieu. This should be expected because their need for the defense mechanisms embodied in the code is dictated by factors that are basic to their personalities.

Many groups of people, who find themselves in alien, rejecting cultures, construct codes of conduct similar to the prison code. Groups such as ethnic and racial minorities, dyssocial persons whose family heritage contains attitudes contrary to the prevailing mores, and prisoners-of-war—these groups tend naturally to isolate themselves from the unfriendly authority around them. In fact, American soldiers in Korea were taught to adopt a set of behavioral rules toward their captors quite similar to the prison code, should they become prisoners-of-war. Yet these people can rather quickly adapt to more favorable surroundings since they have often been raised in families which have fostered identification with other family members and parental authority. In contrast, the individual with an antisocial character disorder does not show this flexible adaptation; his code springs from his attempts to handle a more primordial damage, occurring in early formative years.

Other groups of prisoner-patients, *e.g.*, those with a diagnosis of a neurosis, neither use nor need the prison code. Conflicts of the neurotic prisoners are largely internalized and accompanied by guilt. Their criminality and acting out may appear superficially similar to the sociopath's behavior but examination of the underlying motives will usually reveal the difference. These prisoners show more evidence of a superego based on parental identifications and greater ability to obtain gratification from past memories and internalized love objects in contrast to the sociopathic personality who constantly must seek new love objects and emotional support from his environment. These neurotic prisoners have an inner code which may not control behavior well but which does not depend so much on group reinforcement and external stimulation as does the sociopath's code of behavior.

Prisoners who have received a diagnosis of schizophrenia often either ignore the code or use it as a defense against further object loss. During regression, the schizophrenic patient decathects objects and identifications which are still available to the neurotic, and may lose contact with the group and its code, thus becoming an island unto himself.

> A schizophrenic prisoner on the "regressed" ward discovered that a mentally deficient youth had stolen two packages of his cigarettes. The schizophrenic prisoner grabbed a mop handle and went after the youth; all the while, he shouted to the officers that they should help him find the thief. Thus, he broke every taboo of the prison code.

Closer examination of some sociopaths often reveals that they are basically schizoid individuals who use a mistrustful "prison code" façade as a defense against becoming emotionally involved with either inmates or officials.

> A prisoner from Alcatraz, thought to be sociopathic, was cold, suspicious, and distant from officers and doctors. When the ward doctor began to talk with the patient regularly and to make some attempt to form a relationship, the patient's façade disappeared and he began to hear voices which accused him of being a "snitch" and "rat." He then asked to go into a segregation unit where he could become completely isolated.

Often, as the schizophrenic type of patient recovers from a regressed state, he enters a phase in which he attempts to use the prison code as a bridge to his fellow prisoners. The ward doctor is sometimes in the paradoxical position of encouraging a schizophrenic prisoner to follow the prison code as an intermediary step in recovery from his illness.

## Handling the Code in Treatment

Most treatment-oriented observers of the prison have stated that the prison code is the major impediment to a therapeutic program. The emphasis in the literature has been to view the prison code as a product of the punitive, harsh prison environment. Certainly we would agree that the first and most obvious task is to reform the philosophy and structure of the prisons to minimize the destructive environmental effects on the prisoners.

However, it is our thesis that even if the prisons were transformed entirely into therapeutic communities, the prison code would still exist in some form. The prison code is a group of ego-defenses primarily used by the sociopathic person and secondarily by the schizophrenic type of prisoner. Workers in the field of juvenile delinquency have noted that a therapeutic nonpunitive environment is experienced by the delinquent as an attack on his defenses, resulting at times in increased anxiety and an actual temporary deterioration of behavior. Therapeutic tackling of the "prison code defense" often requires modification of the usual psychiatric treatment techniques. Redl and Wineman,[4] Eissler[5] and Jones,[6] among others, have described variations of the standard psychotherapy and milieu treatment techniques which they believe are necessary to form a workable interpersonal relationship with the sociopathic character disorder. These variations include establishing the therapist's omnipotence, the giving of gifts, surreptitiously using the "prison code" behavior to strengthen the available ego functions, focusing on resocialization rather than unconscious conflicts, and the use of group government. Some of these specialized techniques are utilized to protect a fragile therapist-patient relationship and to prevent the patient from using one of his other important defenses—running away. Within the secure prison-hospital setting, the patient cannot run away from the therapeutic milieu, thus making it possible for the psychiatrist to use more often the usual techniques of interpretation, confrontation, and clarification of the prisoner's behavior and defenses.

If the doctor knows the details of the prisoner's activities and friendships on the ward, he can then put the prison code secrets into words in an understanding and nonpunitive manner, often to the prisoner's surprise and relief.

> A patient complained to the doctor about his anxiety concerning a letter from home. The doctor replied, "I believe you're really worried about someone on the ward putting pressure on you." The patient blurted out, "You're right, somebody is. I can't tell you his name but he spells it S-M-I-T-H."

## Conclusion

The prison code consists of a set of behavioral rules which are quite similar to the mores of society at large except for the all-pervasive interdiction against identification with parental-authority figures. The code has at least two major sources of origin. One source is the need of the prisoner to protect himself from the harsh, restrictive prison environment. The other source is his need for a defense which protects him from identifying with feared, hated authority figures which might cause anxiety, guilt and dissatisfaction with his antisocial behavior. The prison code can be largely dissolved by social reformation of prison structure and philosophy, and by utilizing psychotherapeutic techniques designed to deal with the "prison code" as an ego-defense mechanism.

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# THE ABUSED CHILD

PATRICIA T. SCHLOESSER, M.D.*

Salisbury, "His passion is so ripe, it needs must break."
Pembroke, "And when it breaks I fear will issue thence the
foul corruption of a sweet child's death."
Shakespeare, *King John*, Act IV, Scene II

Violent attacks upon children are not new to society. What is new is the increase of these attacks upon infants and the very young child by parents. Within the past five years, articles about abused children have appeared in the medical literature with increasing frequency. The age-old problem of cruelty to children ranges from simple neglect to physical abuse and even homicide. Mistreatment of children has been sufficiently frequent for our society to weave into the fabric of juvenile laws provisions to protect children from severe neglect and mistreatment. Also, states such as Massachusetts long ago established societies for the prevention of cruelty to children.

The medical profession, however, has only recently become aware of this cruelty as a medical problem. In 1946, Caffey[1] described multiple skeletal lesions consisting of fractures of the long bones accompanying subdural hematoma. In the early 1950's, additional cases were reported which were ascribed to accidental trauma. As the "battered child syndrome" emerged as a medical concept, it was initially considered to be the result of accidental injuries by a sibling. Woolley,[2] in 1955, seems to have been the first to point to intentionally inflicted injury as the etiological factor in many of these cases. A sufficient number of cases has now been collected to indicate that these injuries were most often inflicted by a parent.

Physical abuse of young children is now suspected by physicians when roentgenographic surveys reveal fractures dating from different times without clinical disease to account for them. There may be a fresh fracture of one bone, a healing fracture of another, and an old healed fracture of still a third. Any one of such fractures may be the result of an accident, but the presence of several at various healing stages reduces the possibility of natural explanation. The medical profession has shed new light on the total problem as the cases being seen by physicians are occurring mostly in children under three years of age. The majority of abuse cases, which come to the attention of the courts, have been beatings of older children

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or simple neglect of young children. In 1963, of 310 dependency and neglect cases heard in a Kansas Juvenile Court, 15 percent involved the beating of children five to ten years of age.

Apparently attitudes described by Dickens in the last century, that children are troublesome little beings who should be treated sternly, continue to prevail today. Occasionally cases of death of children have been investigated by public agencies and criminal procedures have resulted. Many cases of sudden death in infants are not being recognized as abuse cases and investigations are never made. Infant death certificates, reviewed by the State Health Department, reveal situations suggestive of infanticide, such as that of a two-month-old, illegitimate baby who "fell down the basement stairs" and died of a skull fracture and subdural hematoma.

In the winter of 1962, the Children's Bureau called a conference of pediatricians, judges, lawyers, social workers and other child experts, to discuss this problem. They concluded:

1. The problem of physical abuse appears to be a growing one.
2. The problem is complex and requires the efforts of medical, legal and social workers to treat.
3. Parents who abuse their children are most difficult to treat in ways to assure that the abuse is stopped. Therefore the abused child is usually in an emergency situation where he must be removed from the home if he is to be saved.
4. Management must include adequate diagnosis, a comprehensive system of reporting to appropriate agencies, expert investigation, social diagnosis and, if necessary, court action to protect the child.

An indication of the magnitude of the problem is revealed by a nationwide questionnaire survey conducted by Kempe and his associates.[3] Response from 71 hospitals and 77 district attorneys revealed 749 children were abused during a period of one year. Of this number, 78 died and 114 suffered permanent brain damage. In a study[4] of 180 abused children in 115 families referred in 1960 to the Massachusetts Society for the Prevention of Cruelty to Children, only nine percent of the cases were referred by hospitals or physicians, though they had been involved in over 30 percent of them.

The failure on the part of physicians to report has several reasons. Probably the first reason has been misdiagnosis. First injuries are often missed and the pattern of abusing families has been to shift doctors or hospitals

with second injuries. The idea that parents could abuse their children is so abhorrent to many physicians that they deny the fact even when there is strong evidence that this is occurring. Probably many physicians fail to report incidents of child abuse to public agencies when they have only suspicion and no proof and insufficient time to investigate further. In the past, physicians have also failed to report because of fear of liability suits. In recent years, physicians have become convinced that child abuse constitutes a medical and social emergency. Unless prompt preventive action is taken, the risk of permanent central nervous system damage and even death is great.

During the past year, a number of cases of abused children were reported to the Division of Maternal and Child Health, Kansas State Department of Health. Also, during the same time, an apparent increase in the number of these cases was reported in Kansas newspapers. A questionnaire survey of physicians was initiated by the division in cooperation with the Child Welfare Committee of the Kansas Medical Society. Questionnaires were sent to a thousand Kansas physicians; 337 were returned with 37 physicians reporting a total of 50 cases of child abuse during 1962 and 1963. Description of these cases, though incomplete for some, included: age of child and parents, the "abuser," the injuries, occupation of parent, number of siblings and final disposition of case. The division has also obtained selected information on an additional 35 cases, occurring during the same two-year period, from the records of two urban and two rural county health departments, one urban juvenile court and the Kansas Bureau of Investigation.

## Results

Information on the 85 cases reported by the physician survey and agencies' records are summarized in Table 1. There were 14 deaths in the series. The cases occurred throughout the state with 28 in small Kansas towns. In one town of 1,000 population, two infants died from beating within a year. In another community of 10,000 population, there were four cases with two deaths.

A. *Age of abused child.* The ages were stated in 71 cases. Of these, 70 percent were under three years of age and 32 percent were under six months of age.

B. *Type of injury.* The injuries sustained included: fractured skulls, subdural hematoma and other brain injury, fractures of ribs and extremities, contusions, lacerations and soft tissue injuries, starvation and strangulation. All of the deaths occurred in children under four years of age. The more extensive injuries, particularly to the skull and brain, occurred in the very young infant. The abuse of the older child usually took the form of beatings with few fractures.

C. *The abuser.* In 31 cases the abusing parent was not stated or not determined. The mother was the abusing person in 55 percent of the known cases. It is interesting to note that the father was more frequently the abuser of the older child and abused by whipping, whereas the mother was more frequently the abuser of the very young infant. In those cases in which the father abused the young infant, he was frequently burdened with an unusual amount of child care and the precipitating cause was claimed to be excessive crying.

D. *Age of parents.* The age of the parents was stated in 51 cases: 80 percent were under 25 years of age and 32 percent were under 20 years of age. Parents in their early twenties often had married before they were 20 and had children too soon and too often.

Table 1
REPORTED INSTANCES OF ABUSED CHILDREN
IN KANSAS 1962–1963

Total Cases 85 Deaths 14

| Category | Number |
|---|---|
| **A. *Age of Children*** | |
| 0-6 months | 23 |
| 6 months to 1 year | 6 |
| 1 year to 2 years | 10 |
| 2 years to 3 years | 12 |
| 3 years to 5 years | 4 |
| 6 years to 14 years | 16 |
| Not stated | 14 |
| **C. *Abuser*** | |
| Mother | 30 |
| Father | 11 |
| Stepfather | 5 |
| Other relatives | 4 |
| Non-related | 4 |
| Not stated or undetermined | 31 |
| **E. *Race*** | |
| White | 68 |
| Negro | 4 |
| Oriental | 3 |
| Not stated | 10 |

| Category | Number |
|---|---|
| **B. *Type of Injury*** | |
| Fractured skull and other fractured extremities and contusions | 7 |
| Fractured skull (Subdural hematoma or brain injury—cerebral hemorrhage) | 8 |
| Fractures of ribs and extremities | 16 |
| Contusions, lacerations, soft tissue injuries | 21 |
| Starvation and severe neglect | 12 |
| Strangulation | 5 |
| Not stated | 16 |
| **D. *Age of Parents*** | |
| Under 20 years | 16 |
| 20–25 years | 24 |
| 25–30 years | 6 |
| 30's | 4 |
| 40's | 1 |
| Not stated | 34 |
| **F. *Disposition*** (Multiple actions were taken in some cases) | |
| Legal sentence of abuser (usually second- or fourth-degree manslaughter) | 9 |
| Psychiatric care | 8 |
| Juvenile court referral | 30 |
| Children removed | 21 |
| Physician warning | 2 |
| Public health nursing visits | 28 |
| Not stated | 22 |

E. *Race.* The majority of the families were white. The non-white cases occurred in approximately the same ratio as in the general population of Kansas.

F. *Final disposition of case.* In 22 cases from the physician's survey, the final disposition was either not stated or no action was taken. Those cases referred to the juvenile court received the most comprehensive management, often including referral for public health nursing visits, removal of the children and psychiatric care.

**Case Histories**

Illustrative case histories selected from this survey are as follows:

*Family No. 1.* Parents were under 20 years of age at the time of their marriage. The father is an oil field worker. The first child, a three-month-old infant, was found to have multiple fractures of the skull, extremities and ribs, at different times. The mother was placed in a state mental hospital. After discharge she had a second child who at four months of age was also found to have fractures of the skull, extremities and ribs. The parents are now separated and the children have been placed in foster homes.

*Family No. 2.* An 18-year-old mother referred herself to the health department as she stated she hated her two-week-old infant and feared she might hurt her. The infant girl and her two-year-old sister were being cared for by their mother in the home of their grandparents. The mother admitted that she hit the infant on the side of her face and tried to smother her because she hated the child. She also admitted beating the two-year-old and leaving marks on her. The mother signed papers for the adoption of the infant and asked that she be allowed to continue caring for the two-year-old girl. She is in psychiatric treatment.

*Family No. 3.* A two-month-old infant was brought to the physician's office dead. X-rays revealed old fractures of the ribs and tibia and recent fractures of the radius and ulna. Hemothorax and hemorrhages in the thymus were found at autopsy. The 21-year-old father, a farm laborer, admitted the abuse. The mother was 16 years old and the father frequently "sat" with the baby. The father stated that he "shaked" the baby because the baby would not stop crying and held the nightie tight around the neck until the infant stopped breathing. The father was charged with second-degree manslaughter.

*Family No. 4.* An 18-month-old baby was brought to the physician with the complaint that the baby fell down the stairs. The infant died in the hospital from cerebral hemorrhage and fractured skull. She had a fractured skull and numerous contusions and scars from old injuries. The mother was 23 years of age, was eight-months pregnant at the time of the injury and had another child of three years. The mother admitted beating the child. Previous history revealed that the mother had had a nervous breakdown shortly after the birth of the three-year-old child and was hospitalized in an army hospital. She had also been married twice previously. The father was employed at a service station and was wanted for passing bad checks in another state and for failure to pay alimony to his previous wife. Interviews of neighbors revealed that there had been repeated beatings also of the three-year-old child. The mother was sentenced to two years in prison with a charge of fourth-degree manslaughter.

*Family No. 5.* An 18-month-old child, cared for in a day-care center at a military establishment, was noted by the attendant to have bruises on the face and head, to have fever and to be irritable. Upon hospitalization, it was found the child had a fractured humerus. The mother is aged 20 and the father 24. The mother admitted abusing the child. She had married at 15 and was pregnant at that time. Her husband was 18. There are two other children and the mother is again pregnant. With each pregnancy, the mother felt more angry with her children. Two years earlier she sought help from a psychiatrist complaining that she had tried to suffocate her 13-day-old child. Her husband is in the service and frequently out of the state. The family has always lived under crowded living conditions. The children were temporarily removed from the parents. At present the mother is under psychiatric care and the family is visited frequently by a public health nurse.

*Family No. 6.* A four-year-old boy died at home. The mother first claimed that the child had fallen out of the car. Later investigation revealed that the mother had repeatedly beaten this child on the head and she finally admitted it. She is 26 years old. There are five children, all from a previous marriage. This child was found, upon autopsy, to have hemorrhage under the scalp, extensive edema of the brain, and an old fracture of the humerus. The mother had previously been warned by the school because the older children frequently came to school with black eyes. Neighbors were also aware of frequent beatings. The mother had been charged with burglary in another state. She was charged with first-degree manslaughter and sentenced to five to 21 years.

*Family No. 7.* An anonymous letter was sent to a newspaper editor describing mistreatment of a two-year-old boy. The public health nurse

was requested to investigate. The family had moved to this state a week prior to the complaint. The mother was 28 and the father 30. The father worked for the refuse department. There were three older children. The nurse found this child to be seriously malnourished, to have bruises and cuts over his head, forehead, body and extremities. The sheriff was notified and removed the child from the home and placed him in the hospital. In addition to the injuries described by the nurse, he had a fracture of the femur and rib and skull injuries. He weighed only 20 pounds. There was no evidence of mistreatment of the three siblings. The child was made a ward of the court and is presently being cared for in a hospital out of the state.

**Discussion**

In 38 families the occupation was known. The occupation of the wage earner in this survey revealed, in contrast to previous reports, that the majority of them were in low income occupations, the largest proportion being common laborers. Also listed were some employed as truck drivers, several in military service, in retail stores, as a janitor, a waitress, a service station employee. There were also students, unemployed persons and some held several jobs. One general characteristic seemed to be the high mobility of these families with very few having nearby relatives or other roots in the community. A number of families had been actually rebuffed by the community.

In several families, a pregnancy had preceded the parents' marriage. Records of the Massachusetts Society for the Prevention of Cruelty to Children also revealed that premarital conception had occurred in almost 50 percent of the families.[5] Of note is the fact that so many of the Kansas parents were under 20 years of age. The majority of the families were new to the community and often isolated by the community. Many families had gross socioeconomic problems in addition to marital difficulties. By the time the incidents of child abuse occurred, these problems had multiplied and intensified. A number of the parents had a record of previous, minor criminal offenses, dishonorable discharge from the service and previous unsuccessful marriages. A major social change, which may be influencing the apparent increase of cases, is the disappearance of the extended family (parents, children, grandparents, aunts, uncles and cousins), which provided in the past a built-in protection in the immediate environment. The nuclear family of today are often adrift from their original community.

The high incidence of mothers being the abusers, in the case of very young infants, confirms our knowledge of emotional disturbances being triggered in the postpartum period. The English law takes into account the fact that infanticide is closely linked with postpartum disturbance in the mother so that the legal management of this type of homicide requires psychiatric care. Many of these mothers fail to master the crisis experience of childbirth sufficiently to assume their parental tasks. Several histories revealed women whose first violent attacks upon their children occurred during the postpartum period.

A high incidence of childhood beatings is found in the history of parents who have abused their children. Doctor Kempe[3] explains the underlying causes with a twist of the Biblical saying, "Do unto others as you have been done by."

Since a majority of these children are first seen by a physician or hospital, a high index of suspicion by the physician is essential to save them. The following characteristics are helpful to the physician in making the diagnosis: Indications of neglect, such as failure to thrive; a characteristic age of under three years; evidence of fractures, subdural hematoma and soft tissue injuries sustained at different times with insufficient trauma to explain the degree of injury. The physician must feel free to report cases upon suspicion as it is not always possible for him to confirm the diagnosis.

Agencies responsible for investigating and making recommendations may be the juvenile court, the health department, the public and private social welfare agencies, the police and the county attorney. Numerous cases have shown that subsequent injuries occurred to the children, many of them fatal, when the child was returned to his own home prior to an investigation. In the Kansas survey, the child was better protected when the case was reported to one of the public agencies. In a number of cases of suspected abuse cited by physicians, the families received no services. Those cases brought to the attention of the community agencies more often received psychiatric treatment, the children were removed and placed in foster care, and supportive public health nursing visits or social case work services were provided. The public health nurses have been surprised that they were welcomed into homes even after an abused child was removed. It suggests the parents were relieved to have an outside authority set limits to their destructive impulses.

In order that physicians and hospitals will feel free to report these cases, the Children's Bureau drafted, in 1963, a model law[6] for reporting suspected cases of child abuse and offered it for consideration by states. This legis-

lation includes two major points: (1) Required reporting by physicians and institutions of suspected cases of child abuse; (2) Provision for immunity from liability for such reporting. Already laws have been enacted in California, Colorado, Florida, Minnesota, Ohio, Pennsylvania, Tennessee, Wyoming and Wisconsin. The office of the General Counsel of the American Medical Association, in a recent editorial,[7] urges: "It would seem more desirable to devise a program of legislation which would confer immunity from litigation and damages on physicians, lawyers, nurses, social workers and other professional people who, in good faith and on reasonable evidence, seek to protect abused children by reporting in confidence suspected problems to the proper, designated authority."

**Summary**

Eighty-five cases of abused children occurring in Kansas during 1962 and 1963 are summarized. Fourteen of these children died and a number of others suffered permanent central nervous system damage and obvious psychological traumata. A high proportion of these cases ocurred in very young parents overburdened by their child care responsibilities. Kansas physicians, community agencies, and the lay public are becoming increasingly aware of this condition. In order to initiate protective services, cases of inflicted injury to children must be promptly reported to proper agencies of government for investigation, as may be indicated. Legislation should be carefully devised which will provide the most effective protection for these children.

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## THE REPORTING OF CHILD ABUSE

William M. Ferguson, Attorney General of the State of Kansas, issued an opinion concerning the reporting of instances of child abuse by physicians on September 24, 1963. At this time he wrote an article that appeared in *The Journal of the Kansas Medical Society** from which the following is quoted.

> "Several months ago I became concerned about the alarmingly high incidence in Kansas of the 'battered child syndrome.' The Shawnee County Juvenile Judge had requested an Attorney General's opinion defining the privilege, if any, attaching to a doctor's examination of a child who appears to have been beaten, sexually molested or obviously neglected.
>
> "During the time this problem was under consideration the Attorney General's office was apprised of the deaths of two infants in this state as a result of beatings administered by parents. As a result, I was determined to write an opinion which would encourage doctors to report cases of the 'battered child syndrome.'
>
> "The basic objective was to bring these cases to light in order to protect the lives and well-being of children who are helpless to protect themselves. Other than parents, it is the medical doctor who is most likely to have knowledge of the beating or molestation of a child. The opinion, therefore, was directed primarily to doctors.
>
> "Doctors have a strong sense of their ethical obligations and, like anyone else, are reluctant to expose themselves to avoidable litigation. Many doctors had the concept that any information acquired by a doctor in connection with his examination and treatment of *any* patient is legally privileged and may not be revealed to anyone. The purpose of the opinion was to dispel this illusion."

The questions answered in the Attorney General's opinion were:

*Question I:* Is the testimony of a physician who treats the injuries of an abused child admissible over the objection of the child's parent or other custodian accused of the mistreatment?

*Answer:* Yes. The parent or custodian may not claim the physician-patient privilege in behalf of the child.

*Question II:* In what manner, and to whom, should the physician

* FERGUSON, WILLIAM M.: Battered Child Syndrome. *J. Kansas Med. Soc.* 65: 67–69, 1964.

report evidence that a child who was examined by him appears to have been mistreated?

*Answer:* To protect the child, report should be made directly to the Juvenile Court.

*Question III:* Is the physician subject to personal liability if a report of physical mistreatment is made to the Juvenile Court?

*Answer:* No, if the physician reports only his medical opinion as to the condition of the child he has examined.

The opinion then cites the legal codes and precedents upon which it was based. The question of liability is discussed further, as follows:

"This opinion has said that the physician has a duty to report suspected cases of child abuse. If he carries out this duty, is he in danger of a suit for defamation should he be in error?

"It is our opinion that he is not. In conveying information of child abuse to the juvenile judge, he reports that in his medical opinion a particular child is being mistreated. He accuses no one of a crime. Under such circumstances, he will not be in danger of a suit for defamation. It is also well settled that even slanderous statements are privileged if made in good faith in prosecuting a suspected crime."

Mr. Ferguson's article comments:

"The release of this opinion was almost immediately fruitful. Within a few days after its publication a news story appeared in the *Topeka State Journal*, headlined 'Child Abuse Incident Reported.' The story related:

" 'The Kansas attorney general's opinion physicians should report cases of suspected child beatings has resulted in one such report regarding three children who have suffered numerous injuries, Malcolm Copeland, judge of Shawnee County Juvenile Court, said Monday.' "

Several months later, on May 6, 1964, the Kansas Medical Society passed a resolution recommending that the Kansas Legislature consider new legislation in 1965, that would require physicians, nurses and hospitals to report instances of suspected child abuse and would provide them with immunity from liability for such reporting. The reasons given in the resolution for recommending specific legislation were those mentioned by Doctor Schloesser in the preceding article.

## ACTIVITIES OF THE MENNINGER FOUNDATION

A grant of $500,000 from the Richard King Mellon Charitable Trust of Pittsburgh, Pa., has been received by the Foundation for construction of the proposed Student-Faculty-Conference Center. The Center, which is now being planned, will be located on the West Campus and will provide space for seminars, conferences, continuing education for graduates of the Foundation's training programs, and meeting space for faculty and students. Dining facilities will be provided and, possibly, living quarters for seminar participants.

It is estimated that the building and furnishings will cost from one and one-half to two million dollars. Some funds had already been raised through contributions of alumni and others.

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Homer Jameson, chief of maintenance and engineering, and Dr. Irwin Rosen were 1964 recipients of Alfred P. Sloan Travel Awards. Mr. Jameson traveled to various parts of Europe studying architecture and landscaping. He also visited a number of botanical gardens and attended the International Garden Show in Vienna, Austria.

Doctor Rosen toured Holland, France, and England. He visited colleagues and psychiatric facilities in each of the countries and attended the Sixth International Congress on Psychotherapy in London where he presented a paper on "Choices in Psychotherapy Research."

The Sloan Travel Awards are financed by a grant from the Alfred P. Sloan Foundation in New York to The Menninger Foundation for psychiatric education. The grant also has made it possible for the Foundation to bring distinguished persons from all over the world to Topeka as Alfred P. Sloan Visiting Professors in the Menninger School of Psychiatry.

The grant from the Sloan Foundation, which dates back to 1953, has been extended for three more years, beginning in May of 1965, and has been increased to $100,000 a year.

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Graduation ceremonies for 57 Fellows and students in the Foundation's professional training programs were held June 13 in the theater of the Topeka Veterans Administration Hospital. The graduates included 30 physicians who completed training and 27 persons in eight other programs—adult psychiatry, child psychiatry, criminology and delinquency, psychiatric training for medical practitioners, clinical psychology, psychi-

atric social work, theology and psychiatric theory, and pastoral care and counseling.

Thirty-one physicians began training in the Menninger School of Psychiatry on July 1. Eighteen are assigned to Topeka State Hospital and 13 to Topeka VA Hospital.

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Beginning September 1, Dr. Robert Wallerstein will spend a year as a Fellow at the Center for Advanced Study in the Behavioral Sciences at Stanford University. Each year 50 persons from the behavioral sciences are invited to the Center to pursue their special areas of interest, free from all clinical, teaching, and administrative responsibilities. Doctor Wallerstein is associate director of research at The Menninger Foundation.

* * * *

New officers of the Alumni Association of the Menninger School of Psychiatry are Dr. Carroll Elmore, president, The Menninger Foundation; Dr. Lawrence Kennedy, vice president, Topeka State Hospital; Dr. Dean Cook, secretary, Topeka VA Hospital; and Dr. Dennis Farrell, treasurer, The Menninger Foundation. They were elected at the annual meeting of the Association held during the American Psychiatric Association meeting in May.

* * * *

A recreation area for patients is being developed at the Foundation's West Campus. Completed this summer were a swimming pool, bathhouse, and a six-acre lake. Plans for the area include softball diamonds, an all-weather play area and skating rink, field sports area, archery range, and facilities for other outdoor activities.

* * * *

A supplemental grant of $13,000 has been awarded to the Foundation's cognition research project by the United States Public Health Service. The grant will be used to extend the project's study of twins and their parents. During the past year, 62 twin-family groups were given an extensive battery of tests and interviews. The supplemental funds will make it possible to administer additional psychological and physiological tests to 100 of the twins.

The study of twins and their parents is designed to provide information concerning hereditary, parental, and familial characteristics as determinants of the development of personality organization.

## READING NOTES

Editor's Note:

The *Bulletin* finds it is impossible in its publication schedule to print the entire record of a book-a-day reading which Dr. Karl Menninger entered upon January 1, 1964. We have therefore made a selection from the notes to date and are presenting some of his current comment.

*February 15*: *The Door to the Future* by Jess Stearn (Doubleday, 1963) is a book of unbelievable and inexplicable prophesies, healings, clairvoyance and telepathy, written by the Associate Editor of *Newsweek* who won the Page One Award in Journalism. He has written several other books. He writes as a reporter but he admits he was convinced now and then. As Dr. Gardner Murphy says, while readable, such books cannot be taken seriously by a scientist because it is impossible to authenticate the material reported without taking an enormous amount of time and space.

*February 17*: *Capital Punishment* is another kind of book on this subject published by the United Nations in 1962 (Sales number 62.IV.2).

It begins by saying that for a long time the problem was regarded as purely academic, but now is "particularly acute." It surveys the problem as it exists in a large number of contemporary countries and summarizes principles, practices, substitutions, and special problems that have practical applications. Arguments pro and con are summarized and various proposals listed. How the authors, who remain anonymous, got so much information into 76 pages is a mystery.

*February 18*: Dr. T. J. Machler recently bequeathed a library treasure to us entitled *The White Spots of Epilepsy and Other Phases of the Disease* by Edward Aloysius Tracy (R. T. Howard, 1926). Few readers will know what white spots of epilepsy are, or were. They are local anemic spots caused by vasoconstriction, observable on the arms, face, and the back of the hands, about the size of pin heads or larger, "present in cases of incipient epilepsy." This "epilepsy" is a condition which is quite curable, the author believes after several years of research, and he read a paper on this at the Boston meeting of the A.M.A. in 1921.

This little, out-of-print book appeals to me because it was dedicated to Dr. Elmer E. Southard and because the preface contains a letter from Doctor Southard to Doctor Tracy suggesting that "the proof of the existence of Tracy Spots ought to be made photographic and I am wondering whether you would not show us some of the spots in cases at the Psycho-

pathic Hospital and allow me to get Mr. Herbert W. Taylor, a very competent photographer whom we have used in photographing lesions very difficult to show in pellagra, to photograph the spots."

*February 19: The Right of Life* by Norman St. John-Stevas (Holt, Rinehart & Winston, 1964) defends the Catholic position that human life is always (or should be) inviolate. The author has much to say about animal life and plant life which are evidently expendable. War he seems to think is inevitable. I recognize my own inconsistency because I think capital punishment is inexcusable under any circumstances but not euthanasia. Part of the problem is the question of who is going to decide what life should be taken.

*February 20*: *The Origin of Medical Terms* by Henry Alan Skinner (Williams & Wilkins, 1961). The title of this book is exciting and I was startled to notice that it was a second edition; I had never heard of it. The first edition appeared in 1949 and this one was copyrighted in 1961. The first edition received many compliments, judging from the jacket of this edition, and surely the idea is a fine one. Many medical terms are traced etymologically and defined historically and as presently used. One is bound to be disappointed on details—specific omissions and sometimes specific inclusions. To illustrate the latter, I see no need to include such words as insect, forensic, light, caliper . . . ; these do not seem to me to be medical terms. I found the inclusion of some of the proper names hard to justify. But, in general, the book makes most interesting reading, opened on most any page.

*February 21*: *Moral Treatment in American Psychiatry* by J. S. Bockoven (Springer, 1963). It may be true that great men leave behind them footprints on the sands of time, but a good many travelers never see some of these guiding footprints. One might safely venture that of the thousands of psychiatrists in the United States now using "moral treatment" (along with perhaps some chemical treatment, which we can't very well call "*im*moral"), scarcely a dozen realize that the very same techniques, the very same practices with very similar, successful results were carried out by some of the pioneers of American psychiatry 125 years ago. What Doctors Ray and Butler and Earle and Kirkbride and Brigham and Todd put into effect with great success (meaning that better than 75 percent of all patients were recovered or improved within a year) was all destroyed within a period of a few years by a series of unrelated events: the Irish potato famine, the Civil War and the captious criticisms of over-conscientious Pliny Earle. The discharge rate fell to 4 percent, approximately where it stood when this reviewer was in medical school. The will *not* to believe quickly triumphed over the will to believe, and the mentally ill suffered the consequences for a century. For this dark hundred years mental illness was incurable because psychiatrists and others had lost their faith and hope. And then, in 1948, came the new revolution; moral treatment was reinstated and the mentally ill were once more regarded as curable, and so proved to be.

This is what this book is about. Not only have I quoted from it extensively in a book of my own (*The Vital Balance*) but I have ordered twenty copies for private distribution. I recommend similar action on the part of interested colleagues.

*March 31*: Some of the outstanding lectures given at the Aspen Institute for Humanistic Studies (1963) have been bound up in a brochure. Ordinarily this is not something I would review but two of these articles are so outstanding that I think I should call attention to them.

The renowned Greek scholar at Glasgow University, H. D. F. Kitto, presents a beautiful summing up of Thucydides' Conception of History. It will make you want to read him again.

Then there is an essay by Diana Trilling, literary critic and respected writer, who analyzes the play *Who's Afraid of Virginia Woolf?* in a most penetrating fashion. It is popular, she says, in the same way, and for the same reason, that various psychoanalytic plays were popular several decades ago. Unconscious or partially unconscious problems, impulses, and conflicts of the listeners are vividly, sometimes crassly, crudely and shockingly expressed. Thus, in spite of the sometimes tawdry dialogue, and in spite of the fact that the people in the play talk and act in a way unfamiliar in ordinary life, most of us, the members of the audience, leave feeling relief if not uplift. I am not doing this essay justice, but if you have been one to shrug your shoulders at this play, as I have, perhaps we had both better take another look.

*April 10*: I wish that when I was writing an address on the comradeship of believers and skeptics, I had known about Professor Holmes Hartshorne's book, *The Faith to Doubt* (Prentice-Hall, 1963). The paperback copy I just read was kindly presented to me by Dr. Robert Foster,

formerly of our staff and now a marriage counselor in Oklahoma.

Hartshorne examines psychological, sociological, epistemological and moral criticisms of religious belief and does so without defensiveness. "Truth and doubt belong together. As St. Augustine observed, serious doubt is always for the sake of truth . . . Doubt is the cutting edge of reason. . . ."

There are many beautiful citations. The author brings out the fact that only in the face of skepticism and criticism does faith develop. He quotes the beautiful Twenty-second Psalm beginning, "My God, my God, why hast thou forsaken me . . . I cry by day, but thou dost not answer; and by night, but find no rest," followed by the famous comforting Twenty-third Psalm. Perhaps they should always be read together.

*April 13*: *The Gutenberg Galaxy: The Making of Typographic Man* by Marshall McLuhan (University of Toronto Press, 1962) was recommended to me by Margaret Mead. The author is said to be known for his stimulating explorations in communication, especially technicological devices.

The general point is that type, text, reading, and so on, determine our mode of thought, that being accustomed to a line of reading as we are has no effect upon our concept of organization in industry, marketing, welfare, and so on. He says many startling things such as:

"Print had the effect of purifying Latin out of existence."

"Print created national uniformity and government centralism, but also individuals and opposition to government as such."

I have an uneasy feeling that I ought to sit down and study this book.

*April 29*: In *Love Against Hate* (1942), Mrs. Menninger and I tried to develop the idea that work had an important role in the maintenance of mental health. This is not a new idea, of course, but apparently it needs to be restated frequently. Look how much more concerned the labor unions are in shorter hours than in replacements. The naïve notion that work can and should be replaced, as soon and as much as possible, by play or idleness, is still popular despite innumerable historical records of national and personal disaster where this has been done.

Our Doctor Levinson wrote an article on the meaning of work for *Think* Magazine (January–February, 1964), and this was reprinted in the *National Observer* and *Supervisory Management*. Among many comments, he received the gift of a book on *Work*, published in 1903, by Hugh Black, a distinguished clergyman, discussing such topics as the Duty of Work and the Moral Need of Work. One of our young men read it and proposed putting it in the historical archives! No doubt it seemed to him a quaint, old-fashioned, outdated, naïve essay coming from the period of long ago when people approved of working!

*May 25*: The beautiful photograph of a wistful, questioning child on the front cover of Anne Simon's book, *Stepchild in the Family: A View of Children in Remarriage* (Odyssey, 1964), should sell the book even if the content were not important and significant, which it is. Mrs. Simon is both a psychiatric social worker and a professional writer. Besides that, she is, as she says, a stepmother and a stepchild. She reviews the unpleasant aura historically associated with those words and shows how this aura is sometimes justified but more often not. The book is divided into Becoming a Stepchild and Being a Stepchild with discussions of the legal, psychological and sociological complications of various combinations and circumstances.

*June 1*: Bert Kaplan of Rice has collected with great discrimination excellent selections from the literature of subjective accounts of mental illness (*The Inner World of Mental Illness*, Harper & Row, 1964). Although I had read many of them before, I now read them all over again and I cannot think of a better way for a doctor to begin his study of psychiatry. From Saint Augustine and Tolstoi and Dostoevsky to Clifford Beers and Anton Boisen, up to Van Wyck Brooks, Jane Hillyer and many a lesser-known writer, the book scans the subterranean depths of a great ocean in which there are many beautiful as well as horrible things, mostly unperceived from the surface.

*June 4*: *The Ethics of Sex* by Helmut Thielicke (Harper & Row, 1964) is one of the most dignified, intelligent discussions of various aspects of sex behavior that I have read. Abortion, divorce, birth control, homosexuality, artificial insemination and other topics are covered. I commend it to both psychiatrists and clergymen.

*June 5*: In connection with the above book, one might think of a newly translated Swedish novel, *Dr. Glas*, by Hjalmar Soderberg (Boston, Little, Brown, 1963). The author is said to be the most distinguished Scandinavian novelist, but I think he cannot have made his reputation on this dreary tale of a doctor who has neither self-understanding nor self-control when it comes to treating the unfaithful wife of a local minister.

*June 8*: I am proud to have a presentation copy of C. O. Wright's history entitled *A Hundred Years in Kansas Education*. It was published by the Kansas State Teachers Association (1963), the fortunes of which constitute the bulk of the material. One chapter is a pictorial glimpse of a hundred years in Kansas education, and I am glad that Wright was not too modest to include a picture of himself, because surely he left the stamp of his love and dedication and life ambition upon the course of the organization.

I know my mother would like to have seen this book. She was very proud of having been the chairman of one division of the State Teachers Association about 1887. In my opinion she was one of its most distinguished members. Although she died nearly twenty years ago, the course of Bible Study she inaugurated continues to be taught along the lines that she structured using the text and questions that she wrote and enrolling many more participants today than during her lifetime. This teaching was an outgrowth of the methods and experience acquired by her in the public schools of Kansas, the initiation to which she has described so vividly in *Days of My Life* (Richard Smith, 1939). Obliged to drop out of the Abilene High School because of a new tuition cost of $2.50 a month, she began supporting the family of eight by teaching in the Dickinson District School at $4 a week in 1879. The school was six miles from her mother's homestead and she rode her pony to and from school daily. She was then fifteen years old!

My mother would have applauded Mr. Wright's lifelong efforts to improve the standards of teachers and teaching in Kansas, of which this book constitutes a painstaking record, and so do I.

*June 9*: My brother Edwin is preparing a book on peculiar trees or things about trees that seem peculiar to us. Recently a long-time friend of the Foundation, Miss Frances Adams, gave me a beautifully illustrated booklet by a friend of hers, Anne Ophelia Dowden. It is entitled *The Secret Life of the Flowers* (Odyssey, 1964) and contains a description and diagrammatic illustrations of the sexlife of some of the flowers, especially where the mechanism of fertilization is different from what you may think. For example, for some of the milkweeds, not insects but a hummingbird is required!

*June 15*: Elegance in the use of the English language added to sound scientific observation and theorizing characterizes a collection of essays, edited by Ismond Rosen, regarding pathological sexual behavior (*The Pathology and Treatment of Sexual Deviation*, Oxford University Press, 1964). The faculty of the Menninger School of Psychiatry has recently concluded that we have been giving insufficient attention to these areas in our teaching. This has been partly from a lack of up-to-date texts. These essays on many aspects of the matter—clinical and legal—will be particularly helpful in this connection. Of them I am prejudiced in favor of the lengthy and competent study of female homosexuality by our friend, Masud Khan.

*June 16*: Solomon, not Franklin, invented lightning rods. Nero invented the slot machine. The Hindus, long before Jenner, used cowpox virus. The Chinese had compasses and digitalis and seismographs, 1000 B.C.

Who invented the radio? In October, 1866, an experiment was performed in the presence of Senator Pomeroy of Kansas and Representative Bingham of Ohio, in which messages were sent from one ridge of mountains to another ridge in Virginia—a distance of 14 miles. The inventor was a dentist, Mahlon Loomis. ("The Real Beginning of Radio," by Otis B. Young. *Sat. Rev.*, March 7, 1964.)

Over thirty years ago an American lawyer-scientist-inventor-editor-psychologist, Joseph Rossman, published a book, examining the psychology of invention and supplying inventors with a great deal of information about themselves. As an examiner for the United States Patent Office for many years he had acquired much knowledge and had added to this by submitting a questionnaire to over 1500 inventors, research directors and patent attorneys.

Now, after the passage of the years, the author presents a third edition entitled *Industrial Creativity: The Psychology of the Inventor* (University Books, 1964). Gardner Murphy leads off with an excellent introduction, saying that he was impressed with the author's experience and literary style 30 years ago and rejoices that the publishers had the vision to bring out this new edition. I agree with him. The gist of his conviction is that invention isn't just luck—it is imagination, perseverance, analytic ability, curiosity and a lot of other things, including hard work. But it is also idiosyncrasy. Immanuel Kant had to see a particular tower from his window; when trees grew up and hid it the City Council had the trees topped. The poet Shelley munched bread. Schiller nibbled on rotten

apples. Doctor Johnson required the sound of a purring cat, Gautier the smell of printer's ink.

*July 15*: *In the Midst of Plenty: The Poor in America* by Ben H. Bagdikian (Beacon Press, 1964). The author of this well-written, convincing book might be called a documentary recorder. He has been a newspaperman and a feature writer for *The Saturday Evening Post*, and has received numerous honors for his distinguished reporting. Here he reports on the poor in America whom we don't see, and some of us even doubt the existence of, and whom at least one of us has declared to be where they are only because they are shiftless and lazy. This is a disturbing book; it disturbs me even though I thought I knew that these things existed and had a tendency to look on some of my friends as rather exceptionally ignorant. But I discovered that I, too, am exceptionally ignorant—at least I didn't know quite how bad things are for so many people. Now that Mr. Johnson has discovered it, and has declared his intentions to Congress and to the nation, we shall want to know more and more definitely about the people we are trying to help. Well, here they are described with unforgettable vividness.

*July 17*: One of the most intelligent, perceptive, readable, and to us most satisfactory reviews of *The Vital Balance*, appeared in *Scientific American* (April, 1964). It was written by emeritus professor Edwin G. Boring of Harvard, who has been one of the great influences in teaching psychology to three generations of students. His autobiography, *Psychologists At Large* (Basic Books, 1961), containing certain selected letters and papers representative of his life's work, is written with such simplicity, wont, candor, and undefensiveness that reading it is a most agreeable experience and partially makes up to this reviewer for the unfortunate fact that, so far as I know, our paths have not crossed physically and we have never met. Many psychiatrists and psychoanalysts will remember his frank discussion, reprinted here, of his former analyst with his retrospective appraisal of his own psychoanalysis.

The librarians will have a hard time classifying this book for it is at the same time history, biography, autobiography, and a psychological research report.

K.A.M.

## PUBLICATIONS BY MEMBERS OF THE STAFF

SATTEN, JOSEPH: Barriers to Progress in Corrections: The High Cost of Taking Science Seriously. In *Proceedings of the 93rd Congress of the American Correctional Association 1963*. New York, American Correctional Association, 1963.

The basic principles of the behavioral sciences are widely known but have not been put into practice in institutions. Only superficial changes have been adopted since the American Prison Congress in 1870. Though the mass media, the criminal law and the inadequacy of funds reflect public confusion and indifference, the main barrier to progress has been the inability of correction officials to accept unequivocally the goal of preparing inmates for release rather than just of preventing escapes. A warden who wants to make changes can do so. Wardens should give up their traditional roles, take responsibility for creating institutions where various professions can work together as a team and speak out publicly on the controversial issues that they usually mention only in private.

LEVINSON, HARRY: Anger, Guilt, and Executive Action. *Think* 30:10–14, March–April 1964.

Many people have sought to make management a highly rationalized process devoid of the influence of feelings. Most decisions about people, however, are not made in terms which are as rational as managers think. Specifically, much of the irrational in management practices arises because of people's efforts to cope with their own anger and to avoid the anger of others. The fact that managers have angry feelings, when they so often think they should not have such feelings, or that it is wrong to feel angry, leaves them feeling guilty for their anger. With these two feelings to contend with, executives frequently make decisions in such a way that they can deny their anger to themselves and appease their consciences. In short, we can speak of management by guilt. Such management is destructive to the subordinate, to colleagues and to the organization as a whole.

REINERT, R. E., WILLNER, ALLEN and SINNETT, E. R.: Patient Government. *Psychiatric Studies and Projects*, Vol. 2, No. 6, April 1964.

This monograph describes the growth and development of a patient government organization which was founded in 1947. The first section traces changes in the structure and general atmosphere of the hospital, and parallel changes in the growth of the patient organization. The second section describes general variables influencing patient government: the role of the administrator, advisor and patient leader; relationship of patient government to group therapy and factors promoting stability and continuity of the organization. The third section discusses the initial impact of patient government, and changes in the communication network and power structure of the institution when patient government is used.

WILDER, RUSSELL M.: Emotional Reactions to Initial Attacks of Coronary Thrombosis. *GP* 29:115–120, May 1964.

Of thirteen patients with acute myocardial infarction, two reacted initially with mild anxiety and considerable denial. Six, chiefly older patients, found the attack a socially acceptable means of achieving regression and retirement. Five, all under 50 years old, showed a marked depressive reaction to their illness which was of clinical importance for three to six months. Chest and arm pain after healing of the infarct was common in this last group. The premorbid personality, age and evidences of previous adaptability are important indicators of possible reactions.

## BRIEF BOOK REVIEWS

*Passage Through Crisis: Polio Victims and Their Families.* By FRED DAVIS. $2.95. Pp. 195. Indianapolis, Bobbs-Merrill, 1963.

In many ways this small paper-bound account of 14 youngsters and their families' experience with polio comes to the reader "too late with too little," since epidemic poliomyelitis already seems to be a thing of the past, and since the anecdotal portrayal of the fearsome experiences for the child and his family when polio strikes are the conventional psychological and sociological problems common to all, and well-known to those who have experienced more than one such epidemic. It is of particular interest for its exposure of the problems of hospitalized polio patients, and has historical value because of its careful and detailed portrayal of personal experiences. It contributes most, of course, in the detection and separation of some important psychological and sociological aspects of the hospitalization of a seriously ill child, germane not only to polio but to many serious illnesses which strike a family, and especially those requiring long-time hospitalization. (John Segerson, M.D.)

*The Nurse in Mental Health Practice.* By AUDREY L. JOHN, MARIA O. LEITE-RIBEIRO and DONALD BUCKLE. $2.25. Pp. 212. Geneva, World Health Organization, 1963.

This is another valiant but unsuccessful attempt to clearly define the role of the psychiatric nurse. Based on a World Health Organization meeting to discuss the nurse's role in psychiatry in European countries, the report concludes that there is an inadequate supply of qualified nurses, confusion as to their function (custodial versus "therapeutic") and inadequacies in their training. These difficulties seem to be characteristic of the ten or so countries participating in the conference as well as in the United States. The authors suggest that a standardization of nursing terminology, and studying what the nurse actually does, or should do, might begin to clear the confusion. The interested psychiatric nurse will familiarize herself with this report. (Robert Menninger, M.D.)

*Modern Drugs for the Treatment of Mental Illness.* By DONALD BLAIR. $10.50. Pp. 312. Springfield, Ill., Charles C Thomas, 1963.

The pharmacology, clinical uses, side effects, preparations and doses of energizers, tranquilizers and other drugs used in the treatment of mental illness are described in a concise, clear, and systematic way. A brief but useful introductory chapter discusses the central nervous system structures which at present appear relevant to the neurological and biochemical understanding of emotional reactions. In the last chapter appear the following words of wisdom: "A doctor must never assume that he can dispense with the patient's suffering from a mental illness merely by prescribing drugs." The book is highly recommended to physicians, especially to psychiatric residents. (Alberto Montes, M.D.)

*This Island Now.* By G. M. CARSTAIRS. $3.95. Pp. 103. New York, Basic Books, 1963.

This version of the 1962 Reith Lectures, sponsored by the British Broadcasting Corporation, gives a psychiatrist's diagnosis of contemporary social problems in Britain. Doctor Carstairs views "problems of faulty psychological and social adjustment" as "some of the greatest health problems of our contemporary society," but I found this statement unconvincing. It seemed to me to indicate only that because Doctor Carstairs is a psychiatrist, he finds the health-illness frame of reference congenial. (Charlton R. Price)



*So Fair a House: The Story of Synanon.* By DANIEL CASRIEL. $4.95. Pp. 224. Englewood Cliffs, N.J., Prentice-Hall, 1963.

Admitting futility with former modes of treatment of drug addiction, Doctor Casriel, a psychiatrist familiar with the problem, reports his first-hand study of Synanon in Santa Monica, California. His book, written in nontechnical style for both the lay and professional reader, describes the organization's history and its paternalistic family structure. Case histories are included, along with statistics, causes, dynamics, and the author's classification of drug addiction. Anyone interested in a bold new approach to the voluntary rehabilitation of drug addicts will profit from reading the book. (Jack L. Ross, M.D.)

*Training for Child Care Staff.* $1.60. Pp. 83. New York, Child Welfare League of America, 1963.

Recognizing a need for formal training courses for child care staff in children's institutions, the Child Welfare League of America sponsored two national conferences for those planning and giving training courses for child care workers. This is a compilation of the papers presented at the second conference. The papers and discussions address themselves to the importance of child care, self-awareness of the child care staff, differentials in training child care workers, child care as a method of social work, and developing creative activities for children. The presentations and discussions are all oriented toward social work which is a way of saying that I am sorry there were no psychiatrists on the program of the second national conference for "those giving courses for those workers and for those planning such courses." (Robert E. Switzer, M.D.)

*The Urban Condition: People and Policy in the Metropolis.* LEONARD J. DUHL, ed. $10. Pp. 410. New York, Basic Books, 1963.

This large book consists of 29 articles contributed by a total of 32 authors, representing a variety of professional backgrounds, and many different aspects of the urban environment. Most of the papers were presented originally at the 39th Annual Meeting of the American Orthopsychiatric Association in Los Angeles in March, 1962. All attempt to see mental health and illness in its relationship to social and cultural conditions in modern American cities. Though the character, quality and length of the papers are uneven, the average quality is satisfactory. This is a valiant attempt to forsake the conventional outlook of psychiatric practice and to view mental health problems in the context in which they occur. As such it is a useful and provocative attempt. (William H. Key, Ph.D.)

*Childhood and Society*, Ed. 2. By ERIC H. ERIKSON. $6.50. Pp. 445. New York, Norton, 1963.

In 1950, the author demonstrated the contemporary problem of identity anxiety and traced its development from his "epigenetic" point of view. He thereby influenced favorably the integration of psychoanalytic psychology with the social sciences, as attested by the wide and multidisciplinary use of his concepts, that has necessitated this second edition. Intentionally retaining the original manuscript, Erikson has made parts of it more readable and expanded

others. Most valuable are the new footnotes relating the themes in this book to his subsequent papers. (Ian Graham, M.D.)

*The Self in Transformation.* By HERBERT FINGARETTE. $8.50. Pp. 356. New York, Basic Books, 1963.

In seven sophisticated essays the writer critically reviews some major concepts, practical attitudes and questions of technique in psychoanalysis, attempting to follow a sequence of progressive personality integration. Doctor Fingarette is Professor of Philosophy at the University of California at Santa Barbara and has contributed articles to psychoanalytic journals. He finds that the prevailing view of the unconscious is that of a "hidden reality" but that it is more germane to psychoanalysis to describe it as "meaning reorganization." In reviewing the various classical theories of anxiety the suggestion is made that anxiety is "the other face of the ego," or ego disintegration. In another essay the act of blaming is seen as a moralistic response to an infectious, conflict-arousing situation, with superego aggression directed outward after the action of the wrongdoer vicariously arouses the blamer's own id-impulses.

In "Guilt and Responsibility" the author cuts through many false stereotypes and suggests that the psychoanalytic process ultimately looks for guilt behind guilt feelings and forces the patient to assume responsibility for thoughts and acts over which he did not previously have conscious control. In "Karma and the Inner World" Eastern reincarnation doctrines and psychoanalysis are compared in regard to the underlying self-concepts. It is argued that psychoanalysis postulates the existence of many phenomenal selves held together by a noumenal self which is to be discovered, but on a smaller time scale than is assumed in metempsychosis. Chapters on "Art" and "Mystic Selflessness" complete this volume, which is a knowledgeable philosophical analysis of psychoanalytic theory and therapeutic process. (Paul W. Pruyser, Ph.D.)

*EEG and Behavior.* GILBERT H. GLASER, ed. $12.50. Pp. 406. New York, Basic Books, 1963.

This excellent, multiauthored report of the research conference on Electroencephalographic Correlates of Behavior held at Yale University in 1961, is, of course, not the first attempt at correlating brain wave activity and behavior. Disappointment again lies in wait for the prospective reader anticipating ready correlates between the write-out of the electrical cerebral activity and the broad field of behavior. However, no one interested in either encephalography or behavior can read this book without being impressed with the exquisitely lucid presentation of highly technical material, with highly provocative reports and commentaries on the pertinent research presented by Doctor Glaser's collaborators. Particularly effective are Charles Wells and Karl Pribaum on the sensory systems in learning; the new contributions of neurochemistry to the understanding of the function of the brain; and finally, the contributions from the convulsive disorders to the understanding of behavior. This is an outstanding contribution to the literature on electroencephalography as well as behavior. (John Segerson, M.D.)

*Adolescent Personality and Behavior.* By STARKE R. HATHAWAY and ELIO D. MONACHESI. $5.75. Pp. 193. Minneapolis, University of Minnesota, 1963.

The authors studied approximately 15,000 adolescent students, then reexamined them after some had become delinquents or school dropouts. Through this approach they avoided the common pitfall of studying children only *after* they have committed such acts. The study has several problems which the authors acknowledge. They were forced by the statistical requirements of their research design to blunt the sensitivity of their measuring instrument, the Minnesota Multiphasic Personality Inventory, and to use it in a coarse way. The book also suffers from a lack of theoretical orientation; there are many isolated findings which are loosely tied together. (Allen Willner, M.D.)

*Perception of Causality.* By ALBERT MICHOTTE. $10. Pp. 424. New York, Basic Books, 1963.

In Hume's observations, causality was reduced to repetition and habit formation; he denied that causal connections can be directly perceived. He declared that even the immediate naïve impression of power which we have when we act muscularly on others (causality of the self) is a fallacy. Over the years, Michotte of Louvain (steeped in the Wuerzburg tradition and a Nestor of European psychology) has proved in a series of brilliant experiments that Hume did not really "look" at his world, but proceeded so analytically that he only saw single pieces on an empty screen, without immanent (and perceptible) relations. Michotte's work is linked with the work of Maine de Biran, who always stressed the reality of felt effort, and of Piaget who sees the idea of causality arise by progressive differentiation of external and internal situations in reciprocal action. Using ingenious optical (later tactile) methods, mostly lines on discs revolving behind a screen with a small opening, it was possible to simulate such phenomena as impact, launching, bumping, movement, between objects. This book, which is a greatly amplified translation of the French text of 1946, presents Michotte's theory, with minute attention to the conditions under which causal impressions are found to occur. This is no doubt one of the great psychological studies of the century. (Paul W. Pruyser, Ph.D.)

*Theory and Research in Projective Techniques.* By BERNARD I. MURSTEIN. $8.50. Pp. 385. New York, Wiley, 1963.

The author has synthesized and evaluated the vast TAT literature from the point of view of objective-quantitative science. The literature survey itself is of great value to the clinician, and the author's appraisal of various systems of analysis is thorough. He criticizes the psychoanalytic system for its lack of operational clarity, yet espouses a view which is central to recent psychoanalytic ego theory: namely, that the TAT is a cognitive task which calls ego-controlling devices into operation. The bulk of TAT research relevant to ego theory is being done, the author states, by students of learning and decision theory. (Stuart Wilson, Ph.D.)

*The Perceptanalytic Executive Scale.* By ZYGMUNT A. PIOTROWSKI and MILTON R. ROCK with JOHN J. GRELA and others. $6. Pp. 220. New York, Grune & Stratton, 1963.

Top business executives, divided into groups who maintained their status and those who did not, were examined with Piotrowski's Perceptanalytic Rorschach Test method. Fifteen test signs were associated with the "successful" executives, 17 signs were associated with "failures," all of them then being incorporated into the Perceptanalytic Executive Scale, a measure which the authors hope will aid in the selection of executives. This work flies in the

face of the dangers of predicting specific behavior, and of working with a restricted range of subjects. It eschews personality theory, relying instead upon literal translation of assumed response process and face-value content into personality traits, *e.g.*, "Since the S ascribes the belligerence not to male figures which are more nearly like him than are female figures, we infer that belligerent competitiveness is a somewhat embarrassing attitude for him to assume." (Stephen A. Appelbaum, Ph.D.)

*Narcotic and Drug Abuse: Final Report of The President's Advisory Commission.* $0.55. Pp. 123. Washington, D.C., U.S. Gov't. Printing Office, 1963.

This report recommends that the medical functions of the Narcotics Bureau be transferred to the Department of Health, Education and Welfare, and its judicial aspects to the Department of Justice. Despite the United States Supreme Court's decision that the Harrison Act, "says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment," the Bureau of Narcotics disagrees. The result is that physicians are less free to use their judgment in prescribing narcotics in the treatment of addicts than are British colleagues. The reasons for repudiating the British system are not convincing. (Alberto Montes, M.D.)

*Group Psychotherapy and Group Function.* MAX ROSENBAUM and MILTON BERGER, eds. $12.50. Pp. 690. New York, Basic Books, 1963.

This collection of some major articles on group psychotherapy includes its relationship to social psychology, historical developments, theory and technique, special applications, and training of psychotherapists. Gardner Murphy has an excellent opening chapter on man's social needs which find expression in therapeutic groups. Although the authors make clear their effort to further a liaison and cross-fertilization between group dynamics and group psychotherapy, neither the articles nor the editors' brief commentary at the beginning of each section reach this ambitious goal. The authors present a good cross section of the major approaches to group psychotherapy, including the orthodox, neo-analytic, Rogerian, and eclectic points of view. A more explicit statement of both the Bethel and Tavistock points of view would have been appreciated. The volume contains an excellent sampling of the diverse currents in the field, but this is not a book for the beginning student seeking a consistent orientation. (Leonard Horwitz, Ph.D.)

*The Science of Human Communication.* WILBUR SCHRAMM, ed. $4.50. Pp. 158. New York, Basic Books, 1963.

It is reassuring to discover in this book, based on a series of talks for the Voice of America, that communication experts from the behavioral and social sciences can communicate well. Someone concerned about attitude formation and change in groups of people, adoption of new practices in communities, influence of mass media, and ways to conceptualize how people's expectations influence their reactions to communications will find this book of considerable interest. It is particularly worthwhile for those with a theoretical interest in community and social psychiatry. (Harold J. Mandl, Ph.D.)

*Forensic Medicine.* By LEWIS J. SIEGAL. $12.50. Pp. 354. New York, Grune & Stratton, 1963.

This encyclopedic volume contains a wealth of detailed information about the law as it applies to medicine. Legal case citations accompany each bit of fact presented. The subjects covered are the doctor as a witness, privileged communication, malpractice, statute of limitations, X-ray practice, right to privacy, workmen's compensation, and fees. Many references to psychiatric practice are included, as well as a glossary of legal terms. The style, vocabulary and content of the book are legal, not medical; therefore it is not easy reading for the doctor. Most of the chapters are poorly organized, with some unnecessary repetition. The psychiatric portions of the book are old-fashioned and nondynamic. (Herbert C. Modlin, M.D.)

*Guide to Psychiatry.* By MYRE SIM. $11.50. Pp. 868. Baltimore, Williams & Wilkins, 1963.

A British psychiatrist organized this guide like a desk reference with subheads, center heads, heavy print and italics to facilitate scanning and checking. Because of these features, it may well be used for review before examinations. Its goal to give medical students, general practitioners, social scientists and psychologists a handy text with "more than a superficial knowledge of certain aspects of psychiatry," makes for strength as well as weakness. It is strong in its survey possibilities; the author has chosen boldly and concisely from classical and modern sources. Its weakness, to the professional and parapsychiatric reader, is the fact-oriented neutrality, the rampant eclecticism and a swiftness of presentation not commensurate with the current status of psychiatric theory and practice. The latter are full of ambiguities and unsolved tensions of which the author seems to be aware, but cannot do justice to in a book of this intention, scope and format. Accordingly, some weighty problems are dealt with slightly which may be an inherent fault of a book intended only as a guide. But in a guide of 795 pages, may not the reader expect more discernment? (Paul W. Pruyser, Ph.D.)

*Progress in Neurology and Psychiatry,* Vol. 18. E. A. SPIEGAL, ed. $14.75. Pp. 605. New York, Grune & Stratton, 1963.

The section on psychiatry covers all the major fields relating to clinical psychiatry in 1962 with authorities from each giving terse summaries of the significant articles and books. Particularly outstanding is the chapter on drug therapy which is an excellent summary of the first decade of experience in the field of psychopharmacology. Each chapter lists an extensive bibliography for the interested reader or researcher. (Jack Ross, M.D.)

The sections on basic sciences, neurology, and neurosurgery are chiefly useful as an annotated bibliography. Well-selected bibliographical references permit a time-saving headline type of summary of recent literature. (D. B. Foster, M.D.)

*Meeting the Increasing Stresses of Life.* By EARL A. TAYLOR. $6.50. Pp. 193. Springfield, Ill., Charles C Thomas, 1963.

The author covers a wide range of topics either directly or tangentially related to his thesis that the "Multiple Therapy Approach in Education" can best meet the increased stresses of life. He questions present methods of evaluating and treating school children; instead he suggests the use of the Functional Readiness Inventory which includes the Visuascope, the Junior

Metronscope or the Prism Reader and the Ophthalmograph or Reading-Eye Camera. If these instruments identify functional impediments, they are then eliminated by visual training, controlled reading techniques and (where necessary) through cooperation with physicians and vision specialists. "Injections of chorionic gonadotrophin not only assist in the physical maturation of the individual but also—and this is of great importance—seem to increase his stability by increasing his emotional maturation." In addition, the use of sympathetic teachers, tutors, and changes in attitudes toward learning are included. The seven successful case reports are too sketchy to give a clear picture of what actually was accomplished by his techniques. (Edward D. Greenwood, M.D.)

*Symbol Formation.* By HEINZ WERNER and BERNARD KAPLAN. $11.50. Pp. 530. New York, Wiley, 1963.

The authors present a major and original contribution to the theory of verbal and nonverbal language. Although abundant references are made to other writers in this field, the material is not intended as a critique or as a review of the various theoretical positions. Rather, the writers focus on their own theoretical and experimental efforts at developing "an organismic-developmental approach to language and the expression of thought." Readers of Werner's earlier book, *Comparative Psychology of Mental Development*, will appreciate the broadened discussion of "physiognomic language" in the present work. A notable section deals with the authors' view of inner language when contrasted with the formulations of Piaget and Vygotsky. (Clyde Rousey, Ph.D.)

*Geriatric Psychiatry.* By KURT WOLFF. $5.75. Pp. 125. Springfield, Ill., Charles C Thomas, 1963.

Doctor Wolff has devoted himself to the older psychiatric hospital patient since he was a Fellow in the Menninger School of Psychiatry ten years ago. He organizes the literature and his observations well. This small book provides a glimpse of what he considers to be most pertinent or useful in treating older patients. He emphasizes the importance of groups, the value of mixing men and women, and the usefulness of the adjunctive therapies. Above all, he convincingly points out how much it is possible to help many of those who are called hopelessly confused, psychotic, irascible, or senile. (Prescott W. Thompson, M.D.)

## BULLETIN WINS AWARD

The National Federation of Press Women, on June 9, 1964, awarded second place to the *Bulletin of the Menninger Clinic* in the category of professional and technical journals edited by a woman. The award was presented to Mrs. Jeanetta Menninger, editor. The *Bulletin* had previously won a first place award in the same category from the Kansas Press Women's Association earlier this year. The National Awards were given in 15 categories and were chosen from 1041 entries of newspaper, magazine, radio and television material submitted during 1963.