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REPRESSION AND COGNITIVE STYLE*

PHILIP S. HOLZMAN, Ph.D.

The concept of repression has been the keystone of psychoanalytic theory since Freud clearly distinguished it from ordinary forgetting almost 70 years ago. Yet, the study of repression has suffered from a special kind of awe that has protected it from the experimental scrutiny afforded other psychological functions. Perhaps the phenomenon of repression, discovered in the psychoanalyst's consulting room, intimidates the more diffident investigator. Perhaps, too, the earlier studies purporting to validate the existence of repression provided such an unfruitful yield that investigators of cognitive processes find more fertile fields elsewhere. Today, few seriously question the fact of repression. But at a time when psychoanalytic ego psychology is seeking to explore nonpathological psychological phenomena, to link its insights with those of general psychology, it seems crucial to examine the mental processes involved in such motivated forgetting.

My primary aim here is to exemplify the kinship between defensive structures, particularly repression, on the one hand, and stable principles of cognitive organization outside the realm of conflict, on the other. A second aim is to illustrate a method of research into defensive structures that asks not, "does repression exist?" but "how does it work?"

It was in the last decade of the 19th century that Freud made his discovery of repression. He was treating patients who had hysterical symptoms with a modification of Breuer's cathartic method. Freud

* Reprinted with permission from *Festschrift for Gardner Murphy,* John G. Peatman and Eugene L. Hartley, editors. New York, Harper & Brothers, 1960.

invited his patients to tell him everything that crossed their minds. But, curiously, his patients seemed to have forgotten significant portions of their histories. When Freud insisted that the patient recall these events, many of the memories returned. These memories were of events that the patient would rather have not remembered; they aroused guilt or shame. Freud[1] concluded that these memories were kept out of consciousness by a force that was applied to them shortly after the events occurred. He called this process of expulsion from consciousness *repression,* and considered that the resistance encountered in unearthing the painful recollections was a reflection of the continuing force exerted against these memories by the process of repression.

Since these recovered memories generally led back to childhood sexual experiences about which memory was also unavailable to consciousness, Freud reasoned that a necessary condition for the operation of repression was the existence of an *already repressed* memory of an unpleasant sexual experience that could be activated by a new, but similar, experience. This activation had the effect of pulling the memory of this new experience out of awareness. The formal aspects of the repression process described by Freud anticipates to some degree the point I shall try to develop here, namely, that repression as a principal mechanism of defense occurs in those persons in whom there is a general cognitive disposition to organize stimuli in a way that least preserves the individuality or distinctness of the stimuli.

A few years later, another discovery led Freud[2] to consider repression as a part of normal psychological development rather than as a pathological mechanism. He discovered that the sexual memories of childhood were most often phantasies, and that sexual activity and wishes were inevitably present from very early childhood. These discoveries had two consequences for the theory of repression. First, repression was directed not against the memory of certain experiences, but against the mental representations of the sexual instinctual drive that was constantly striving for expression in thought or action. And second, whereas in the 1890's repression was regarded as a pathogenic factor, only 10 years later it had come to be regarded as crucial for normal maturation.

The theory of repression had then, in the early 1900's, to be coordinated with the general functioning of the mental apparatus. Three psychic systems, conscious, preconscious (corresponding roughly both to the later concept of ego and the descriptive unconscious), and unconscious were hypothesized. Repression occurred when an idea moved (the spatial model was a curious one) from the system preconscious to the system unconscious. But Freud retained the idea that the repression of early wishes, phantasies, and memories was a necessary condition for later repression. He later called this *primal* repression. These early experiences occurred prior to the development of the system preconcious. He reasoned that the aims of those early infantile wishes were inconsistent with those of the preconscious, *i.e.,* that part of the mind in stable contact with reality. The continued gratification of those infantile wishes and the recollection of their earlier gratification would now produce a painful experience. Thus, Freud assumed the existence of infantile experiences which were never preconscious and therefore never could be accessible to consciousness. This memory scheme, perhaps sensory-motor in nature, determines all later repression, since the pleasure principle requires that the preconscious remove attention from all descendants of such conflict-producing infantile memories. It is this subsequent turning away from the later derivatives of the infantile or primally repressed that came to be known as repression proper.

In his discussion of the Schreber case, Freud[3] clearly stated that repression is a two-part process. First, the system preconscious withdrew attention from an idea and repelled it out of the preconscious because it aroused aversion. Second, the idea was attracted into the unconscious from the preconscious by virtue of a connection having been established between the idea to be repressed and those already repressed.* Thus, the essential core of Freud's first theory of repression was retained. Active commerce—*i.e.,* a kind of assimilative pull—between what has already been repressed and what is to be repressed is a necessary condition for repression proper to occur.

This dragging down of an idea by impulse derivatives already repressed, and never having been conscious, seems to be an oversimplification. Freud conceived of the repressed drives as constantly seeking expression in consciousness or in action. But in order for this drive discharge to occur, a repressed impulse must, as it were, transfer its energy to ideas already in the preconscious, that is, to ride to expression under the disguise of already preconscious ideas. The preconscious ideas, then, by virtue of their connection with impulse derivatives, may now become

* A third stage discussed by Freud, the return of the repressed, need not concern us here.

as noxious as the repressed impulses themselves, and thus invite the withdrawal of attention from these preconscious ideas.

There is no need to follow closely here the further modifications in the theory of repression. The introduction in the 1920's of the structural hypotheses of ego, id, and superego assigned to the ego the defensive functions, among which is repression.[4] The principal change in the theory occurred in detailing the motives for repression rather than in the mechanism of repression.

The concept of repression and, indeed, of defense in general, developed as part of the theory of neurosis. Repression became a special function employed by the ego to combat pathogenic memories. Yet, Freud implicitly assumed that defenses—and in the present instance, repression—were products of a general ego development. For example, repression is only possible when there is a clearly developed differentiation between unconscious and preconscious systems. That is, repression is not present from the beginning; it develops relatively late in childhood. Some of the ego functions implied in repression are *memory, conciousness, judgment,* and *attention.* Thus, repression borrows its tools from ego functions that are not necessarily implicated in pathogenic conflicts;* and, further, repression may be thought of as a by-product of the development of two systems of awareness—unconscious and preconscious. Repression, then, apparently borrows its tools from psychological functions observable to any who care to study them.

The defensive activities of a country at war may offer some analogies to the development of psychological defenses. During a war, some of the country's functions are designed primarily for defensive or offensive purposes, such as munitions, tanks, and fighter planes. They have no other purpose than to do battle. Other equipment, however, originally designed for peaceful purposes, may be drafted or conscripted for wartime use. In this category we may, for example, put the majority of fighting men or the factories that during peacetime produced automobiles and now make tanks. Then, too, the general strategy of defense is dictated by the geography of the country invaded. A mountainous country like Italy defends itself differently from a country like Russia whose plains extend for hundreds of miles.

* Hartmann[5] has convincingly reasoned that defenses may have their origins in other than pathogenic conflict situations. The ideas expressed in this paper are based on his formulations.

These three possible sources of military defenses suggest analogous sources of psychological defenses: Defenses may, first, develop solely as a response to a threat stemming from impulse or reality, such as the flight reaction and its later forms, denial and avoidance. Defenses, moreover, may borrow their mode of operation from nondefensive thought functions. Thus, the defense of *isolation, i.e.,* the separation by thought of an idea from its ideational and affective connections, was thought by Freud to be a defensive use of the functions of attention and concentration, thought functions that have other than conflict origins. Finally, the style of defense may be dictated by the general life style of the person, as developed from the constitutional, maturational, and experiential vectors. It is this third aspect of defense that the following discussion turns toward.

In our laboratory we have been studying what we call cognitive system principles, that is, the principles under which our thinking and perceiving are organized.* We have concentrated on the individual consistencies in the way subjects approach neutral, simple problems, such as judging sizes, estimating weights, responding to contradictory cues. Several stable cognitive system principles have been isolated and previously reported.[7-10] We became curious about the relationship between these styles of thinking and defenses. Cognitive styles were conceived of as guiding the ways in which needs will be expressed in thought, and therefore as intervening between a motive, on the one hand, and response to an adaptive situation on the other hand. Thus, how a person performs a cognitive task depends in part upon the cognitive system principle—the organization of cognitive functions utilized in the solution. Defenses, likewise, have been conceptualized as mediating between needs or impulses and the pressures of reality constraints. A study recently completed in our laboratory links a particular cognitive style to the defense of repression.[11]

The particular cognitive system principle we studied is called *leveling-sharpening.* Leveling-sharpening refers to degrees of distinctness among elements in memory schemata. At the leveling extreme, memories seem to lack refinement and are apparently recorded and preserved in essentially vague and unarticulated schemata. Previous studies suggested

* The research described here was supported by a research grant (M 1182)[6] from the National Institutes of Health, Public Health Service, and represents a continuation of studies originally directed by Dr. George S. Klein.

that the undifferentiated quality of memory schemata is a reflection of relatively great assimilation to each other of memories of previous experiences.[12]

Levelers and sharpeners have been selected on the basis of performance on the schematizing test.[8] In this test subjects are asked to judge the sizes of 150 squares successively projected onto the screen. Compared side by side, the size differences among the squares are immediately appreciated. Viewed successively, however, the obvious size differences may be obscured. At the beginning of the test, the five smallest squares are presented in three different orders. The smallest square is then dropped from the series and a square slightly larger than any of the first five is added. This new series of five squares is then presented in three orders. In this way the squares projected gradually increase in size during the 35-minute test. This test is about as contentless and conflictless as one can make a test. Were it a shade more innocuous, it would run the danger of becoming a gruesome bore and arouse conflicts between the subjects and the experimenter.

Previous results with the schematizing test consistently established that some subjects, sharpeners, both accurately record the general trend toward increasing size and maintain the distinctions among the squares; and other subjects, levelers, tend both to lag behind the trend toward increasing size and to be unaware of differences among the squares. For example, at the end of the test many of these latter subjects judged a 13-inch square to be six inches, and from the very beginning of the test they blurred the differences between squares so that they, at times, judged a six-inch square to be the same size as or smaller than a four-inch square. Previous studies, showing clear relationships between leveling and large time-error assimilation effects, have suggested that leveling-sharpening may be regarded as a function of the degree to which the experience of a newly appearing square assimilates to the aggregate of memories of preceding squares.[12]

Recall that Freud assumed that repression proper is due in part to withdrawal of atttention cathexis by the preconscious system from an idea to be repressed and the cathexis of this same idea by already repressed impulse derivatives. That is, that idea will be expelled from awareness which fuses with or becomes assimilated to an idea already banned from consciousness. It is as if the preconscious system becomes

alerted to the idea's potential danger by the fact of that idea's fusion with previously repressed ideas.

We asked ourselves the question, "Does repression, as a typical way of coping with conflict, occur most easily in persons whose memory is so organized that ideas assimilate easily to each other?"

We selected two groups of subjects, 10 extreme levelers and 10 extreme sharpeners, from among a group of 80 subjects, using the schematizing test as the criterion instrument. Determining the degree of reliance upon repression as a principal defense mechanism posed a problem. It was clearly impractical, if not impossible, to observe incidents of repression of ideas in our subjects during a sample period of time. We, therefore, used as a criterion for repression the Rorschach test which is employed in clinical testing to determine, among other things, a person's adaptive and defensive repertoire. The chief defense mechanisms are usually inferred from the *effects* of these defenses on thought and affect organization, rather than from an observation of the actual operation of these mechanisms.

We administered the Rorschach test to each of our 10 extreme levelers and 10 extreme sharpeners. The 20 records were then rated on a four-point scale indicating the degree of repression. There were four raters, each of whom was an experienced tester at The Menninger Foundation. For inferring repression, each rater used a set of criteria that was based on rationales worked out by David Rapaport and his co-workers.[13] Of course, none of the raters knew who was a leveler or sharpener. The raters agreed very well among themselves as to who were the subjects who relied chiefly on repression.

There were six subjects among our group of 20 who relied primarily upon repression. And all of these six subjects were extreme levelers. Statistically, this is a highly significant relationship. According to Fisher's exact test, such a linking of repression and leveling could occur by chance only one time in one hundred. Since this result actually duplicates one done two years previously,[14] the result acquires firmer significance than were it a single occurrence.

But, although all repressers were levelers, the reverse was not true: All levelers were not repressers. It is as if the characteristics of the cognitive organization provide the conditions for the development of repression as a primary defense. No leveling—no repression, relatively speaking, of course. That is, if a person typically assimilates to each other

successively appearing stimuli in the absence of conflict, such a device may be employed to remove from his awareness an idea whose conscious recognition may cause pain. On the other hand, such a device is not likely to occur in those people who maintain the discreteness and individuality of memories as a general characteristic of their memory schemata. Thus, the formal functioning of the memory apparatus, the characteristics of the cognitive processes, are apparent in both adaptive and defensive performances.

In another study this leveling quality of memory organization was vividly illustrated.[15] Subjects were simply required to tell the story of *The Pied Piper*,* which presumably most adults in this country have heard at one time or another but have probably not intentionally committed to memory. By scrutinizing the recall of this story one can glimpse the way in which meaningful coherent memories are characteristically organized over a long period of time. Levelers' stories were, as expected, fragmented, and elements fused with each other; they recalled far fewer elements than the sharpeners; the vagueness of their story structure was striking. Compare the following two stories, for example. Note the cohesiveness of story details in the first story, told by a sharpener. The memory schema seems well structured, although the story obviously has not been committed to memory.

> "The people of Hamlin were overrun by rats and they had tried all sorts of remedies to get rid of the rats and nothing worked. So, one day they were discussing the rat problem as usual, and this man came to town. The mayor had just previously offered a bag of gold to anyone who could rid the town of rats. So, this man came to town. His name was Pied Piper. He told the mayor that he would rid the town of rats for the bag of gold. So he played on his little pipe and all the rats followed him out, down from the houses and followed him down the street, and he took them out of town and they disappeared. He came back for his gold and the mayor refused to give it to him on the grounds that he had never promised it. So, the Pied Piper told him he would be sorry if he didn't give him the gold, and that he would take away all the children. Well, the mayor just laughed at him because he didn't think he could do it. So, he still refused to give him the gold. So, the Pied Piper played the tune again and all the children followed him out of the town and he took them to the country where some mountains—supposedly the mountains opened up and the children went inside to this paradise. All the children—the mountain closed and the children were never seen again."

* This story-recall technique was suggested by Dr. David Rapaport.

The second story, told by a leveler, reflects a memory schema characterized by vague and uncertain details. The gaps and easy recombinations that cover the gaps are striking.

> "Well, I think there were a lot of rats in town or something—mice. And so the people didn't know how to get rid of them, so one day this Pied Piper came to town and played a little tune on his pipe and he told the king or mayor or someone like that, that he would be able to get rid of their mice by playing a tune and the rats would follow him. So, he started walking down the streets, and instead of the mice following him, the children followed him and they followed him clear outside the town."

The problem of how these structures developed is not answered. It is possible that leveling and repression are actually the same process, viewed from adaptive and defensive vantage points, or leveling may have developed as an adaptive use of repression. Equally likely is the possibility that repression and leveling descended from a common cognitive ancestor, differentiated into different processes in the course of maturation, but still bearing the stamp of their common ancestry. The most plausible possibility seems to be that repression makes use of leveling dynamics for part, but not all, of its operation. Repression takes its form from the way in which memory schemata are formed and stored. A memory system in which a high degree of assimilative interaction is characteristic, in which memory elements fuse with each other and lose their distinctiveness, seems to offer an effective vehicle for the defensive removal from awareness of painful memories.

This style of memory organization does not, however, have to be picked up and used by the defensive organization. There may be other thought modes or system principles which can be drafted into defensive service. Thus, the question, "What determines a person's choice of defenses?" is not answered, but the direction in which part of the answer lies may have been indicated in the point of view outlined here. Defenses are not necessarily processes that arise full-grown, spontaneously, from requirements to deal with conflict. They are thought structures, the study of whose origins and forms need not be shunned by psychological investigators. The methods for studying them challenge our imagination and force us beyond the frontiers of both the classical psychological laboratory and the analytic couch.

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GRAMMAR IN THE STORY REPRODUCTIONS OF LEVELERS AND SHARPENERS

WILLIAM PAUL LIVANT, Ph.D.*

The validity and stability of a leveling-sharpening dimension of cognitive control has been established by Gardner and his colleagues.[1] Levelers appear to assimilate successive events to each other more than do sharpeners; this makes for levelers' greater confusion among successive stimuli in tasks of detection and recall. Less certain is our knowledge of the cognitive *devices* which produce leveling and sharpening. Since most activities demand some regulation of the relations among successive events, it is likely that the cultural codes governing these activities contain such devices in their rules. Once such devices are found, differences in their use by different individuals can be studied.

Natural language, accessible to all, is one such code. Language contains rules governing order among events in two ways: (1) there are rather loose restrictions on the order in which a series of nonlinguistic events may be mentioned, and (2) there are more stringent restrictions on the order in which features of the language code itself—be they phonemic clusters, word classes, or phrases—may occur in a sentence. It is already clear, for example, that these restrictions are more stringent than those embodied in a finite-state Markov source[2] in which each symbol emitted depends only on the symbols previously emitted.

One important class of words in English which at once connect and differentiate successive linguistic events from each other are the "connectives," conjunctions and prepositions. If we confine our discussion to these connectives, it is clear that some, like "and," may be used much more freely than others, like "but" and "or." We know this in two ways: (1) It is an empirical fact that "and" occurs both more frequently and in more contexts than "but." It is also my anecdotal observation, which is being checked, that children in storytelling use "and" relatively more frequently than other connectives (*e.g.*, "I'm tired and my bear is tired, and tomorrow I go to school, and at school we draw, and Johnny fights with me, and I want a drink of water"). This suggests its developmental simplicity. (2) Logical studies of grammar find it simple to set up a conjunction rule which is applicable under a wide variety of linguistic con-

* Mental Health Research Institute, University of Michigan, Ann Arbor, Michigan.

TABLE 1
CONNECTIVES IN "THE PIED PIPER"

	Sharpeners	*Levelers*
Mean no. "and" per protocol	10.0	6.4
Mean no. all other connectives per protocol*	6.8	3.1
Proportion "and"	.594	.675
Proportion other	.406	.325
	t for proportions = 1.80 (one tail) $p < .04$	

* The most common other connectives were "but, so, if, since, because, or, nor, therefore, when."

ditions.[2] There appear to be fewer formal restrictions in English on the use of "and" than of any other connective.

Our present suggestion is that less restricted grammatical devices—in this case, connectives—ought to characterize the verbal production of levelers, whereas more restricted grammatical devices ought to characterize the verbal production of sharpeners. That is, in the continuous stream of natural utterance, successive portions of utterance are more clearly differentiated if a more restricted connective joins them.

This is obviously a matter of relative proportions. Using the study of Holzman and Gardner,[3] I compared the use of "and" and all other connectives by the subjects, 16 levelers and 25 sharpeners, in telling the story of "The Pied Piper." (See Table 1.)

The result of the comparison ought to be magnified if the stories were not independently elicited, if the stories of levelers depended on other stories of levelers and the stories of sharpeners depended on other stories of sharpeners. Fortunately, this condition is met in the study of Gardner and Lohrenz[4] in which the following folktale "The Son Who Tried to Outwit His Father" was transmitted serially through one chain of five levelers and another of five sharpeners.

> A son said to his father one day: "I will hide, / and you will not be able to find me." / The father replied: "Hide wherever you like," / and he went into his house to rest. /
>
> The son saw a three-kernel peanut, / and changed himself into one of the kernels; / a fowl coming along picked up the peanut / and swallowed it; / and a wild bushcat caught and ate the fowl; / and a dog met and caught and ate the bushcat. / After a little time the dog was swallowed by a python, / that, having eaten its meal, went to the river / and was snared in a fish-trap. /
>
> The father searched for his son / and, not seeing him, went to look at the fish-trap. / On pulling it to the river-side he found a large python in it. / He opened it, and saw a dog inside, / in which he found a bushcat, / and on opening that he discovered a fowl, / from which he took the peanut, / and breaking the shell, / he then revealed his son. / The son was so dumbfounded / that he never again tried to outwit his father.

TABLE 2
CONNECTIVES IN "THE SON WHO TRIED TO OUTWIT HIS FATHER"

	Sharpeners	*Levelers*	*Original Story*
Mean no. "and" per protocol	16.4	16.8	14
Mean no. all other connectives per protocol*	9.0	2.1	7
Proportion "and"	.645	.884	.67
Proportion other	.355	.116	.33
	t for proportions = 12.6 (one tail) $p < .001$		

* The other connectives were "that, which, so, then, after, on."

Table 2 shows the results of the transmissions, as well as a comparison with the original story, which, unlike "The Pied Piper," was administered in the laboratory.

As expected, the difference is greatly amplified. It also appears that virtually all the connectives forgotten from the original story are the ones *other* than "and." But it is unlikely that the original occurrences of "and" are literally reproduced. What may happen is that as the themes of the story merge and lose distinctiveness, the sharpeners maintain distinctiveness in their reproductions by the use of other connectives whereas the levelers do not.

A result which may seem puzzling is the greater absolute mention of "and" by both groups over the original story. However, there is an unusual kind of construction which occurs *six* times in the brief original and which was not shown as a connective in Table 2. Consider:

a. a fowl, *coming along.* . . .
b. a python, *having eaten its meal.* . . .
c. and, *not seeing him.* . . .
d. *on pulling it to the river-side,* he. . . .
e. *on opening it,* he. . . .
f. *on breaking the shell,* he. . . .

These are rather peculiar, Latin-type construction. They may be regarded, following Lees,[6] as transformed variants of simpler underlying constructions:

a1. a fowl came along, and (verb phrase)
b1. a python ate its meal, and (verb phrase)
c1. The father did not see him, and (verb phrase)
d1. He pulled it to the river-side, and (verb phrase)
e1. He opened it, and (verb phrase)
f1. He broke the shell, and (verb phrase)

In each case, a construction of the form

Noun Phrase + Verb Phrase$_1$ and Verb Phrase$_2$

is condensed and embedded within a larger sentence. Coleman[5] has presented some evidence to show that retention of constructions like *a.* through *f.* is poorer than retention of their simpler underlying construction (Chomsky[2]) like *a1.* through *f1.*

Now we may set out the reproduction of these six utterances, *a.* through *f.*, in the protocols of the *first* sharpener and the *first* leveler.

a.
(Original): a fowl, *coming along,* picked up. . . .
(S): a fowl came by and. . . .
(L): a fowl came along and. . . .

b.
(Original): a python, *having eaten its meal,* went. . . .
(S): the python *after eating,* he was full, so he went. . . .
(L): after the python had eaten its meal, he went. . . .

c.
(Original): father searched for his son and, *not seeing him,* went. . . .
(S): went looking for his son and couldn't find him and so he went. . . .
(L): father missed his son, and he looked for him. And in the meantime he decided he'd go down to the fish trap

d.
(Original): *On pulling it to the river* he found. . . .
(S): Well, he pulled out the python, and he opened. . . .
(L): (no mention of pulling in the python)

e.
(Original): bushcat, and *on opening that* he discovered
(S): bushcat; opened the bushcat, found. . . .
(L): (no mention of opening bushcat)
found the bushcat inside the dog; and inside the bushcat was. . . .

f.
(Original): the peanut; and *breaking the shell* he then revealed his son
(S): and he opened the peanut hull and found his son

(L): (no mention of breaking the shell)
and then he found his son in one of the kernels. . . .

Inspection suggests that the sharpener tends to turn the construction back into kernel form, using an additional "and." The leveler, however, tends to drop out construction *a.* through *f.* entirely. These data may show two stages in a progressive simplification of grammatical structure. Many other devices like *a.* through *f.* exist in natural language, which could function as tests to reveal the dynamics of simplification in memory.

This note suggests that the coding of verbal materials for linguistic structures as well as themes may discriminate cognitive styles and indicate natural devices in the culture by means of which these styles may operate in cognitive performance.

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TREATMENT MOTIVATION

FREDERICK J. HACKER, M.D.*

Treatment motivation is one of those psychiatric expressions that are widely used, but little studied. Virtually every case presentation contains some remarks about treatment motivation. The term embraces the patient's readiness to regard his personality manifestations as pathological symptoms, to consider psychotherapy the treatment of choice, to accept the therapist and arrangements regarding hours, fees and incidental inconveniences. The hesitation of the patient to comply, his doubts regarding the feasibility of treatment, his comparison of his therapist with others, are often interpreted as forms of resistance even though the patient is not always given the benefit of this interpretation at an early stage.

Often these early objections turn out to be resistances, indeed, at least in that the personality of the patient, his conflicts, anxieties, and defense mechanisms will, characteristically, express themselves in his reaction to the treatment situation and the therapist. This affirms the principle that personality disturbances affect the whole personality and reflect themselves in important and trivial reactions alike, if not similarly. This same assumption permits us to draw inferences from minor events in the consultation room to major events in the patient's life. Yet, this is as far as most observations or considerations about treatment motivation are conventionally permitted to progress.

If the patient does not return, or if he prematurely terminates treatment, it is said that his motivation has not been strong enough, that it was ambivalent, uncertain, not genuine, came from outside pressure, or from magical expectation. The pseudoscientific vocabulary used for excuses or explanations of therapeutic failure is almost inexhaustible. Psychotherapy thus is still, for some, the business in which the customer is always wrong. "Insufficient treatment motivation" is the convenient accusation which conjures up the ghosts of insufficient moral fiber, of weak will power, or incorrigible badness.

The traditional stance of blaming the patient has recently been reversed by focusing psychodynamic attention on the therapist and his structure. It was discovered that rigid fee demands and strict regulations about standard number and arrangement of hours are not necessarily based on

* The Hacker Clinic, Beverly Hills, California. Visiting Sloan Professor, October 15, 1960 through January 15, 1961 in the Menninger School of Psychiatry.

any particular insight into the optimal conditions for treatment, but sometimes reflect thought habits and conveniences of the therapist, and conceivably can be self-serving rationalizations of the therapist, or the therapeutic school to which he belongs. To shift the blame from the patient to the doctor represents no scientific gain. Name calling is no more productive when used against the healing profession than when applied to patients.

Indeed, by what criteria ought treatment motivation to be evaluated? Referring it to so-called reality testing is simple, but also unsatisfactory. The term "realistic" remains undefinable and arbitrary in this context and serves no useful, pragmatic purpose. What portion of income or capital should "realistically" be apportioned for treatment purposes? What and how many hardships should be suffered and for how long to qualify as realistic? What distances ought to be traveled and how often? Is the recent "realistic" downgrading of psychotherapy, in comparison with health factors other than formal treatment—family life, recreation, hobbies, occupational therapy—an improvement toward more realistic recognition, or does it border on indifference and, therefore, on lack of motivation? Is this changed "climate of motivation" in analysts and patients alike, significant for the shift of symptomatology and of character structure,[1] or expressive of a changed attitude toward heroism and the sacrificial temperament? Obviously these criteria are too uncertain and interdependent to serve as reliable yardsticks for even an approximate evaluation of treatment motivation.

Modern psychotherapy is based on the model that all treatment happenings are best understood as manifestations of an interpersonal process with many interlocking variables, which can be roughly subdivided into four sets: (1) Variables emanating from the patient and his psychological structure. (2) Variables emanating from the therapist, not necessarily on the same level as (1), being preferably rationally and empathically controlled reactions to the patient's actions. (3) Variables emanating from the therapeutic situation and its setting. (4) Variables resulting from the interplay of (1), (2) and (3), with the possible formation of various temporary or permanent constellations and structures, like transference, countertransference, or their resolution.

Unsystematic, old-fashioned psychotherapy focused only on category (1), considered factors (2) as systematically negligible, (3) as unimportant or self-understood and, therefore, could not develop any systematic conjectures, models or inferences about category (4). The exclusive em-

phasis on the patient and his reactions as the only meaningful set of variables necessarily either neglects the other sets, or demands optimal invariability of all the other elements involved in the process. The therapist should be a mirror, detached, and uninvolved, obscure to the patient. He should avoid being drawn into the patient's game, so as to retain objectivity and the untainted purity of his image to and for the patient. This "optimal" attitude becomes immediately inadequate with disorders like psychoses, character disorders, or borderline cases, or when adolescents or children are treated.[2-4] Refinement and sophistication of treatment techniques have theoretically and practically abandoned the earlier, simpler assumptions and take into account the complexities of interrelated and interdependent factors from many areas by outlining a great number of possible therapeutic attitudes and strategies. Yet, in so-called treatment motivation, we have hardly advanced from the naïve phase of therapeutic antiquity.

Treatment motivation is noted as a clinical phenomenon and registered descriptively. Its presence as a prerequisite of treatment is praised; its absence is criticized, or deplored. In the "good case," it is taken at face value and remains unanalyzed with the strong implication that it is unanalyzable. The neurotic individual with enough refinement and cultural background, tortured by symptoms so as to be driven into psychotherapy no matter at what expense or what sacrifice, still appears, to most therapists, the only valid model for the ideal patient. Any departure from this model is regarded not as presenting special difficulties but intelligibility for treatment. In psychiatric literature we find more warnings about the futility of treatment for inadequately motivated individuals than reports about how to overcome difficulties of motivation.[5] The necessity to modify conventional methods in hospital or prison settings combines with the reluctance of some psychotherapists to treat adolescents, character disorders or law breakers, to serve as evidence by circular reasoning that motivation is a primary requirement for psychotherapy. The remarkable psychological naïveté which regards consciously present, overt motivation as the only prerequisite for therapy, while absent or vascillating motivation only evokes therapeutic regret or anger about wasted time, has manifold determinants. The result is the exclusion from treatment of innumerable patients who demonstrably could be helped if as much therapeutic skill, time and thought were devoted to motivation as to other stages of the therapeutic endeavor.

Work on and with treatment motivation appears undignified. Medical

tradition has always prided itself on its detachment from the market place of supply and demand.[6] The ethical doctor does not advertise, etc. But this desirable, ethical attitude is not intended and should not be permitted to interfere with new insights and with the therapeutic process itself.

Psychotherapy is no longer an esoteric pursuit preserved for the initiate. The undeniable, sociopsychological fact of the Western world, particularly in this country, is that some simplified, possibly vulgarized and falsified view of psychiatry and of psychotherapy has penetrated into every aspect of contemporary civilization. Popular mass media—television, radio, newspapers, magazines, literature, art—clearly demonstrate the massive impact of psychodynamically oriented views.[7,8]

The attitude of the populace toward psychiatric treatment—magical expectations, suspiciousness, trust or skepticism, naïveté, sophistication, or any other attitude of the contemporary patient in regard to psychiatry—must be either the result of specific information, designated as psychological, of a propagandistic, educational or informative nature, or of unspecific psychological information disseminated under a diversity of artistic, advertising or educational labels. The professional insights of the psychiatric community, spread by propaganda and advertising media in obvious and hidden ways, have led to a revolutionary change of atmosphere and climate of opinion in our century. The newly created image of the psychiatrist, no matter how distorted, reflects different conceptions about mental health, availability of treatment, desirability of seeking relief by special psychotherapeutic methods, etc.

This conglomeration of information and misinformation, enlightenment and distortion, insight and resistance pre-exists in every patient. It regularly turns out to be not a random hodgepodge but is a highly selected and, hence, highly significant arrangement characteristic for the patient's general life situation, his personality and his personality disturbance. His idiosyncratic selection expressed in treatment motivation may be flexible, or a firmly established conviction, it may at times be peripheral to the disorder, just a copy of the predominant cultural attitude, or it may be central to his disturbance. In any case, consciously expressed and perceived motivation will always be a symptomatic expression that may be taken as the starting point of treatment and should be regarded as an important manifestation of the patient's present status.

Every psychiatrist has had experience with tremendous shifts in treatment motivation. We all know cases when the overt treatment motivation

appears overwhelming, urgent and explosive, yet often exhausts its force after one or two interviews. We also know cases when treatment began for some seemingly unimportant, "external" reason and with the development of transference the peripheral treatment motivation moved to the very center of therapy. The development and dissolution of the transference neurosis could also be described in terms of various aspects of treatment motivation.[9] Motivation is one clinical manifestation among others, sometimes relatively insignificant, sometimes crucial, following exactly the same general psychological laws as any other such clinical phenomenon.[10] As such, it is a proper subject for study, scrutiny and analysis regardless of whether it appears in a positive or negative form.

Decisive factors for determining treatment motivations are: the general, cultural, and social climate to which the patient is exposed; the specific conditions of this exposure that influence the patient's acceptance of his role as patient, his expectations of therapist, method and results. So-called positive motivation is frequently, if not regularly, the result of conscious or unconscious selling techniques that reflect the aspects of psychiatric services as merchandise on the market, with a certain market value and a certain image. Motivation has no greater or lesser dignity than any other complex sociopsychological or individual manifestation. Hence, motivation ought not be accepted as it presents itself but should be analyzed, scrutinized and, if necessary, modified.

Just as the positive treatment motivation is the result of successful preselling, negative attitudes represent a failure of such methods. Between positive and negative motivation there should be no more ethical difference than between techniques regarding positive and negative transference. Yet, there is an important practical distinction. Insofar as treatment moves regarding negative transference can depend on a previously established, firm treatment structure, absent or negative treatment motivation leads either to early interruption of treatment or no treatment at all. Therefore this situation deserves a special chapter in the discussion of psychotherapeutic techniques. Motivation techniques thus will be somewhat different than ordinary treatment techniques, qualitatively and quantitatively, because they have to become operative in a situation and at a time before meaningful treatment relationships have been established.

The attempt to discuss motivation systematically as part of the psychotherapeutic repertory does not require every therapist to become a "motivator." There can be no objection for anyone to confine his therapeutic

work to patients who display positive or even strongly positive treatment motivation. No therapist feels equally comfortable with every emotional constellation or is equally successful with every type of patient. The barring of patients who lack motivation falls in the same category as the exclusion of suicidal risks or of drug addicts or of patients below a certain income level. These practical criteria are sometimes administrative or emotional necessities and as such perfectly reasonable, advisable or even inevitable. Yet, they must be clearly and explicitly stated; generalizations referring to the patients must be confined to the group restricted by the selection principle and not extended to psychiatric patients or techniques in general.

The tendency of psychotherapeutic treatment is to build and rebuild, rechannel and modify internal and possibly also external constellations by a variety of tactics and strategies adapted to the individual case. The promotion of motivation will have to aim at a preliminary engagement or encounter. The patient has to accept himself, no matter how tentatively, as patient and the treatment situation as a commitment which then permits the accomplishment of more ambitious treatment goals. Hence, successful influencing of treatment motivation will depend on a necessarily quick estimate and a fast and appropriate reaction to the main personality structures and problems. Intuition, hunches and empathic participation will be at an even higher premium than in the course of well-established treatment. Quick perception of decisive trends in the patient's internal and external situation, by what is called "intuition" in psychological shorthand, has definite similarity to so-called practical knowledge of people (*Menschenkenntnis*) and the moves to establish immediate, even if superficial and tenuous interpersonal relationships are analogous to everyday, extra-therapeutic situations. Arrangement of motivation techniques some place along the axes of activity-passivity, or flexibility-rigidity is less important than to find some method or model by which these strategies can be conceptualized and scientifically applied.

Treatment motivation therapy never leads to the recommendation of any mechanized attitude, be it that of the propagandist, optimist, evangelist or any other. Insofar as powerful forces consciously and unconsciously determine motivation or resistance to motivation, the conventional attitudes of cautious pessimism, of preliminary passivity, of silent waiting, or the expectation of a sacrificial attitude on the part of the patient are only one possible set of therapeutic techniques which may be appropriate in some cases but cannot claim general, over-all validity.

The best model to conceptualize consistent, rational treatment motivation can be found in analogy to the psychotherapeutic philosophy of schizophrenia. At present, the various specific treatment suggestions in regard to schizophrenia and other parameters vary tremendously. The diversities are so wide that the one common denominator is not always easy to detect. Yet experts agree that in the psychotherapy of schizophrenic patients the level of regression of the patient has to be first determined to permit establishment of the therapeutic situation in accordance with the presenting stage of development or regression. All modern techniques[8, 11-15] accept the basic principle that, in order to treat the patient's system, it first has to be accepted and enlarged to include the therapist. The initial and sometimes most complicated treatment period consists in having the patient recognize and accept the doctor, assigning him a place in the patient's system. The same principle pertains to the treatment of children, adolescents or character disorders. The doctor who has undertaken to treat the patient has to accept him *as he is* in order to change him into something that he ought to become.

The various motivating techniques can be roughly subdivided into the following categories:

1. *Information or clearing up of misinformation*: The level of information varies widely among and within social and intellectual groups. Biased, one-sided, exaggerated or distorted misinformation can frequently be corrected and cleared up in one or very few interviews. Psychiatrists in metropolitan areas tend to make the mistake of anticipating and presupposing a greater degree of sophistication which is pretended initially by the patient in order to impress the therapist. At every intake interview an attempt ought to be made to elicit data from the patient about his information regarding psychiatry preferably with some indications as to source, firmness of conviction, possible doubts, questions and fears. Often it is surprisingly easy yet crucial to correct obvious falsification on a conscious level with appropriate explanations.

2. *Supportive measures*: Lack of information in most cases is not just due to blind spots; misinformation is not attributable to conscious factors alone, but indicates the workings of unconscious defense mechanisms that distort. In these cases a period of educational, supportive psychotherapy devoted to handling various defense mechanisms is indicated. Frequently it is necessary to connect certain specific distortions with various defensive maneuvers by techniques of confrontation, interpretation and education to prepare the patient for deeper endeavors.

3. *Role-playing*: In many, even in most cases the efforts described under categories 1 and 2 will not be sufficient if difficulties arise either from deep-seated character defenses and character distortions, or from equally deep-seated fears that are rationalized. In these cases the simple techniques of support, information and education will not succeed, but more complex role-playing tactics and strategies will be necessary. Role-playing as referring to motivation can be subdivided into: (a) Acceptance of the patient's position and regression, representing within his system an important figure.* If the patient has a masochistic character structure, submissive to authoritarian figures, the therapist may need to represent himself as an authoritarian figure rather than to point out and interpret this character trait which might destroy the only, momentarily possible, treatment motivation. (b) Substitution and filling in for an important lack: If the patient has been deprived of maternal love and care resulting in crises of primary trust relationships, the therapist should represent himself as able and willing to provide certain aspects of that maternal care till the deeper-lying reasons of the deprivation symptom can be further investigated. (c) If neither (a) or (b) are applicable, surprise or other psychological shock techniques may be in order.[16] In all cases of rigid character defense in which the patient produces and reproduces the same situation, expecting the same kind of response, an unanticipated and unexpected reaction by the therapist may establish the first viable treatment contact. The surprise factor can also act as an effective antidote against the unexpressed and unexpressible pessimism of the patient who may have no insight into the repetitious nature of his disturbance, but who has painfully experienced the equally repetitious responses to him that proved therapeutically futile. The unexpected response may stimulate the patient's interest more effectively than any persuasion will do. It also may arouse his fears that can be channeled into treatment motivation.

There are dangers to any and all these motivating moves. The foremost fallacy appears to be a confusion of successful motivation with suc-

* Aichhorn's book, *Wayward Youth*,[2] is a primer for the study of motivating techniques which he gives the name of "narcissistic transference," meaning that the therapist establishes himself as a narcissistific identification figure, possibly even as part of the patient's distorted ego ideal to start a meaningful treatment situation.

cessful treatment. Obviously treatment is evaluated by success outside of the therapeutic situation in the patient's accomplishments, achievements, his integration and adjustment. In this sense, therapy is a means toward an end. We recognize as major technical problems those situations when the patient attempts to substitute the therapeutic process for the accomplishment of those ends treatment is to promote. Clearly continuation of treatment is not the goal of treatment, but equally clearly the goal of motivating techniques is successful motivation. Treatment has, so to speak, a transcendental character pointing beyond itself while successful motivation is fully accomplished when treatment is firmly established.

For these reasons, motivation while properly dealt with as an initial part of treatment, ought to be separated from it in other respects. The so-called "corrective emotional experiences"[17] has its proper place as a motivating technique, but should not be confused with the desirable structural change. Treatment goals may never be reached if consent about and enthusiasm for treatment or its termination are mistaken for cure. Naturally the motivating phase is not always clearly delineated and confined to the start and might in some cases have to be woven into the further treatment program. In those cases, the motivating techniques will undergo a change and will be influenced by the course of treatment when they have to be reiterated on a different level and in different forms.

The necessarily superficial and even artificial methods of motivations are grossly contaminating factors. The subsequent treatment may to some extent be burdened and mortgaged by the original motivating methods. However, these major contaminating factors can be technically handled, interpreted and analyzed like other extraneous factors. Even the foreseeable difficulties ensuing from superficial and artificial motivation are by far preferable to leaving by default an ever-increasing group of patients without the benefit of therapy.

The transition difficulties from the motivating to the treatment phase proper often are extreme. The facilitating conditions of motivation regularly frustrate or delay the introduction of more painful and more demanding treatment techniques. Many therapists, excellent in establishing motivation, are less skilled in helping the patient in the transitional phase or in the treatment proper. In the same manner the inevitable countertransference difficulties become enhanced and increased. The personality structure compatible with the bringing about of good motivation is often

coupled with some tendency in the therapist toward magical omnipotence leading to the confusion of successful motivation with successful treatment or to the easy discouragement of the therapist resulting in anger reactions if the patient despite all therapeutic efforts does not get well quickly or completely. The *fervor motivandi* is subject to the same criticism as therapeutic overzealousness. The use of motivating techniques presupposes a much greater degree of skill and reflective insight in the therapist insofar as alternations and changes of motivating tactic and strategy are not only necessary for different cases but for every single case as it develops.

Assuming that the treatment process can be improved by considering all variables and all factors, no single expression like motivation should be exempt from psychological scrutiny and from psychological influence. The recognition of the invisible pre-selling in society resulting in greater acceptance of psychiatric techniques, greater trust in the effectiveness of psychotherapy by larger population groups, ought to lead to the development of techniques that include systematic attention to these factors as part of every treatment process. The evaluation and analysis of the original expectations, and the reasons for a persistence or change of these motivations ought to be a mandatory part of every treatment, whether the presenting motivation is positive, vacillating, weak or absent.

Summary

Treatment motivation has been neglected in therapy and research because it was taken for granted, *i.e.*, used if present or deplored as unsurmountable resistance if absent. It is a composite part of cultural and social influences, interpersonal relationships and intrapersonal structures and constellations, regularly expressing a large variety of heterogenous information, misinformation, fears, hopes, expectations and a mixture of rational and irrational elements. Present or absent, motivation is to be regarded and treated as a symptomatic manifestation whether it be of peripheral or central importance. The development of motivating techniques is a legitimate and obligatory part of the treatment process itself, ranging from educational to manipulative and role-playing methods, systematically determined by the general situation and individual psychodynamics of every given case. The acceptance of the patient's level of regression for the purpose of entering as a meaningful therapeutic factor into his system serves as a general principle from which follow the various

techniques and strategies. Confusion of successful motivation, as an initial facilitating step, with successful treatment must be avoided as well as similar other dangers necessarily originating from the extension of our therapeutic repertory. The criteria for optimal insight into treatment motivation in terms of recognition, emotional acknowledgment, working through, and so forth, are the same as for all other specific and unspecific transference manifestations.

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THE PATIENT'S RESPONSIBILITY: REASONS FOR ITS NEGLECT IN PSYCHIATRIC HOSPITAL TREATMENT*

HUGO J. ZEE, M.D.†

The psychiatric patient, especially if hospitalized, is often encouraged by his own and others' expectations to play too passive a part in the treatment process. This suggests that the patient and the illness are separate entities, which can be treated differently—one passively, the other actively. "Treating the patient as a whole," an almost trite statement nowadays, unfortunately still finds little application. At most we have progressed to treating a "disease" instead of a symptom, while the patient's active participation in the process of getting well may be discouraged through various maneuvers and for various reasons.

In order to get treatment, one ordinarily assumes the role of a patient, which generally means he could not help becoming ill (and that, therefore, he need take no responsibility for the illness) and that he must submit himself to a treatment program.[1-4] To do otherwise often means that he is getting by (malingering, irresponsible) and is resisting treatment. On the other hand, the doctor may have acquired the role of a near miracle worker, who is to bring about a magic metamorphosis, a cure—with a minimum amount of effort on the part of the patient. If this cure is not forthcoming, or if the behavior difficulty is too threatening, such as with criminals,[4] the problem may then be disposed of through various combinations of devices. Some of these are: labeling ("Your illness is so mild, don't worry about it," or "Your problem is of such a nature that I can do nothing for you"); transferring ("I think a home visit will do you good," or "What you need is maximum security"); and treatment ("I've done all I could," or "I'll do anything you ask me to, I'll give you medication, I'll protect you, I'll even defend your illness"). In brief, it means that the doctor's assumed responsibility is too great, while the patient's is too little.

The submission to treatment, though often a necessary phase, may seriously hamper recovery and create problems of its own.[1,5,6,8] Particularly it may lead to excessive dependence, chronicity, disorganization and, perhaps worst of all, a repudiation by the patient of any responsi-

* Accepted as a thesis in the Scientific Writing Course in the Menninger School of Psychiatry.

† Captain, Medical Corps, U.S.A.F.

bility for his illness. That this happens is, oddly enough, directly due to the extremes of the doctor–patient relationship, especially if augmented by the hospital setting and community attitudes.

Responsibility for one's own behavior is to be a self-governing entity, a self-piloting ego, an individual—slave neither to the environment (external or internalized) nor to one's drives.[7,8] Though the patient loses degrees of mastery, the limits of his responsibility may not be tested, but rather may be ignored or allowed to dwindle. That at certain levels self-piloting forces become automatic and biological givens, need not concern us here.[8] Nor shall I attempt to define the concept of responsibility or to explore fully its many implications for health and disease. Instead, I shall outline the various reasons why the assumption of responsibility for one's behavior is often ignored, rather than fostered, in the treatment of the mentally ill patient.

Four distinct components are involved in the treatment process: the medical doctor, the expert on the treatment of disease; the patient, who presents the problem; the hospital, where the treatment is to take place; and the community, in which the illness came about and to which it is hoped the patient will eventually return. Each influences the others strongly, but also each has its own special reasons to affect the degree of acceptance of responsibility for one's behavior.

I

A. The doctor traditionally does something to the patient. Originally a physician was considered to possess magic through which he freed the patient of whatever evils ailed him. With the advent of scientific medicine much of this magic was replaced by more exacting techniques, while the evils became more concrete entities such as bacteria, tumors, hormones or even toxic memories of traumatic experiences. Seguin[9] aptly called the bacteriological era of medicine the "Golden Age for the demoniac concept of disease, when the germs became the scientifically named demons." As our modern medical textbooks still testify, "Diagnosis becomes the foundation on which the art of medical practice rests. Diagnosis implies the discovery of all the various factors that are responsible for the illness."[10] These factors usually include the extent of the functional and anatomical changes produced by the disorder as well as the prognosis.

Eventually the illness must be combated in an effort to remove or alter

the disease. It is overlooked generally that what is seen as the illness is not only a *failure* of the patient to cope with the various stresses, which may or may not be of himself, but that also he has *succeeded* in finding a level of adjustment, though a less desirable one, to secure survival.[12] Any adjustment, whether called healthy or sick, is a dynamic balance which may move in one direction or another within a health-disease spectrum, and in which the person plays an active part. A treatment program, then, should aim not simply for cooperation from but active participation by the patient, for the illness is in large measure his own doing.

B. For objective appraisal of the patient's difficulty, certain isolation routines are usually set up. The locked door seems to anticipate his non-cooperation; his clothing and valuables are removed, possibly at the expense of his identity; his privacy is sacrificed, for the doctor must know everything, thus further impairing the ego's autonomy from the environment;[8] relatives are asked temporarily not to visit, potentially removing another anchor-point for the patient; and to make the transition as smooth as possible for everyone concerned, a laxative, a sedative, and a tranquilizer are prescribed. Thus much of the individuality of the patient can be sacrificed, and with the ensuing dependency that is created goes a lessening of that responsibility so necessary to enhance his self-esteem.

C. Unlike other areas of medicine, in psychiatry goals are less well-defined and several alternative solutions to the problems are possible. There are short-range and long-range goals; economics may determine the approach used; and availability of facilities for treatment must be considered. For example, hyperactive behavior may be dealt with in several ways, such as manipulating the milieu, using tranquilizers with or without psychotherapy, and giving electric convulsive therapy. As definite criteria for a treatment approach are not always apparent, the physician may tend to make decisions which may not always reflect optimum treatment for the patient. A decision may represent a compromise not always beneficial to the patient. This puts the psychiatrist in a vulnerable position, for, instead of being able to insist on a certain prescription of treatment, he may have to bargain for one and settle for less than what is optimum. This means that less may be demanded of the patient

than he can tolerate; and, in return, that less may be expected of the doctor than would be best.*

> One patient in dire economic circumstances had changed to a less remunerative job during the few months just prior to his seeking therapy. His therapy fee was based on his current income and took his many financial obligations into account. After several months, it became apparent that he saw the fee as an acceptance of his lowered capacity to manage his affairs. When this area was fully explored, the therapy progressed in a different direction.

D. There is an idea, based perhaps on the assumption that moral values should not be within the domain of our science, to condone behavior of the patient without questioning whether it may represent an area of friction with his system of values. This is especially so when the treatment program does not reflect those reminders of proper behavior the patient had in his own, more familiar surroundings. The patient who takes up smoking may, if it is noticed at all, be understood as more relaxed and modern in his attitude and as merely going along with the rest of the group. Yet, whether he is aware of it or not, his former inhibitions about smoking are still there to render their measure of guilt.[8] The changes that occur in the behavior of the patient are very subtle and, as in the example just given, can easily be overlooked as the possible sources that erode his energies by creating guilt.

On the other hand, quite the opposite may happen, *viz.*, we may impose upon the patient a moral value system, presumably based on psychological theories. The end result is similar to what occurs when we fail to consider his values, for again the patient may behave in disharmony with his reservations and needs.

Each individual has a given moral potential. Psychiatry does not provide us with a "philosophy of life" which can implement this potential. Rather, it has given us the means to better understand moral issues and help the patient to integrate them with the rest of his personality. On the part of the patient a greater commitment to his actions will be required, while the doctor assists in this process in a manner that will cause less strain on the mental economy.[14]

II

A. The patient expects to have something done to him in order to get

* Eighty per cent of hospitalized patients are treated in public institutions, of which only about 20 per cent are therapeutic.[13]

relief. In return he expects to do little else than pay his fee and, most important, to consent to be examined which, especially for the mentally ill, means to forego his personal privacy.[11] But the latter is extremely difficult, for it will reveal his contributing role to an illness which to him is frightening. He may confer upon the doctor such an omnipotence as to accept uncritically whatever is offered in the way of treatment (and there is much in the physician's clinical background to create too much acceptance of this role[15]), or else the patient may completely deny part or all of his illness. To learn that to fail does not necessarily mean to be bad, but rather is something unwholesome for which he must pay a big price, is among the first steps toward motivation for therapy.

B. The illness is not only a failure of the patient to cope with stresses, but also a success in finding a level of adjustment, though a less desirable one. Giving up his illness means finding a new level of adjustment, with all the anxieties that would go with this, as well as foregoing the secondary gain obtained from this illness. To be exempt from responsibility for being ill and helpless may avoid additional discomfort.

C. As Kai Erikson[2] pointed out, the role that the mentally ill patient assumes is usually a composite of his own and the community's expectations about what mental illness is like. In order to live up to this role, the patient may have to become sicker and disclaim responsibility for his illness.

> By accepting hospitalization, the person makes a contractual agreement to cooperate in a therapeutic partnership: he agrees to want and to appreciate treatment, to be realistic about his need for help, to volunteer relevant information, and to act as reliably as possible upon the recommendations of his therapist. Yet it is widely considered a condition of his illness that he is unable to make meaningful contact with any reality, therapeutic or otherwise . . . his behavior is likely to be a curious mixture of the active and the passive, a mosaic of acts which tend to confirm his competence and acts which tend to dramatize his helplessness.[2]

D. Some patients appear to experience no pain and are quick to blame others for their misfortune. These so-called "psychopaths" are becoming more common in psychiatric practice as the courts find more enlightened ways of dealing with them. Such a patient may, convincingly, assume no responsibility whatsoever for his actions or may be hyperagreeable, however insincere, about his role in the difficulties he has brought upon others and himself. The popular idea that psychiatrists encourage escape from personal responsibility by declaring such a person

ill rather than criminal is an oversimplification of the great difficulty involved in bringing about that change which will cause him to look more within himself for the causes of his troubles. Sometimes these patients feel that the sick role does not give enough recognition of their responsibility in their criminal acts and may attempt to force the doctor to see them as criminals by indulging in more delinquent behavior.

> A teen-age patient was committed for a heinous crime to the state hospital by the Juvenile Court because of her youth and the diagnosis of schizophrenia. In the hospital a serious effort was made to treat the patient according to the diagnosis, and an "understanding" attitude was taken by the staff about the crime. When one day the word "killer" was written with large letters on the patient's bed, everyone was perplexed as to who had been so rude as to do that. Only after every other possibility had been ruled out did it become clear that the patient had done it.

E. Alternative solutions to the problem are available to the patient as well as to the doctor. The obese patient often finds many ways to deal with his eating problems and may use them even if aware that emotional conflicts are at the bottom of his difficulty. That a patient may sway a doctor's decision into a less than optimum treatment course should not be forgotten.

III

A. Typically, the mental hospital is a state institution where a great gap exists between what is optimally needed for the patient and what the institution provides. As a state-controlled institution, there is a conformity of design which stagnates the development of a variability of treatment programs that would befit local needs and resources. Absent are such units as would be geared differently for urban and for rural people; of nursing homes near the family; of follow-up clinics in which the patient could work with the same people who had treated him as an inpatient; of day or night hospitals which allow close access to familiar community resources for work, entertainment and group meetings, thus giving the patient a chance to test and develop his strengths. Instead, there is a rigid compartmentalization of treatment based more on the diagnosis, age and sex of the patient than on his individual needs.

Usually remote in its location and oversized, the state hospital develops an inbred community of its own, no longer reflecting the social and vocational roles of the patient's society, nor, for that matter, reflecting the acknowledged best therapeutic atmosphere. Such a severe alienation

from his familiar surroundings, along with the marked readjustment that he has to make, gives the patient little chance to assert himself as an individual, healthy or sick, in the new setting. That this is true for private hospitals also is well documented,[1,16,18] but to a less extent than in state-owned institutions where lines of communication are so much more subject to distortion.[15,16]

In general, I believe that the hospital's greatest benefit to the patient still is his removal from an environment that fed into and encouraged his pathological adjustment. To observe the special meaning of *his* ill-adjustment and to provide a *unique* milieu that will both optimally undermine his neurotic coping devices while encouraging the development of better coping devices are services that are not yet well enough rendered. When we know and apply more of these individualized milieu devices, we can become more aware of where and why the patient is the responsible agent for his illness.

B. On the principle of what has been called the "self-fulfilling prophecy"[17] irresponsible behavior may actually be generated in the hospital. This principle, which holds that if one believes something may happen one tends to act in such a way as to eventually bring it about, finds many examples in the hospital setting. In one of the older buildings of our hospital the windows are small, few and well protected. Another, more recently built unit of similar size, has made much more use of window space in order to create a more pleasant atmosphere, and the windows are larger and less well protected. Surprisingly, the glass-repair bill has been many times higher for the older building than for the more modern one. This would indicate that constructing a building with the expectation of damage tends to bring about the damage. Fortunately the opposite can happen also; optimistic attitudes produce positive results. "There is nothing either good or bad, but thinking makes it so."

Often it appears that the behavior of the most disturbed patients is used as a common denominator on which ward rules and limitations are based. The use of locked doors, and the absence of jewelry, money, flammable objects, potentially sharp objects, etc., may serve to protect a few of the most severely disturbed patients, but does not give credit to the majority of those other patients to whom it means only another humiliation.

The example in Maxwell Jones's book,[5] *The Therapeutic Community*, in which the patients were made as responsible as the staff for dealing

with a theft from the patients' entertainment fund beautifully illustrates the therapeutic effect of making the patients the active participants in the treatment process.

C. The hospital staff usually comprises a medley of people with as many therapeutic attitudes, many disciplines (from the most sophisticated to the least), various races, nationalities and religions, and great differences in socio-economic classes. Moreover, the turnover of staff is great, creating much anxiety in the permanent staff and in the patients. No doubt, to bring about a unified, therapeutic approach with such a group is a most difficult task. The question of whether a teen-age girl should be allowed to smoke may be dealt with differently by each person working with her. Yet, there is another side to this great variability of the staff. Often it has resulted in a renewed optimism when different approaches have been tried. Not infrequently the newcomer starts the much needed changes in a chronic regressed ward.

D. There is always the danger when using volunteers in mental hospitals of patients being treated as charity cases. This is augmented by the fact that mentally ill patients are generally treated in public institutions, which are often called charity institutions. The concept of charity can have very humiliating meanings both to the patient and the community, and so may do little to help the patient to become an independent, responsible citizen.[4]

E. Finally, there is the effect of the hospital population on the individual patient. Not only will it expect the new patient to accept the groups' standards, but also it will provide convenient channels for the patient to project his guilt about having become ill.[1,2,5,18] Occasionally, a patient group may form which creates a distance between its members and the hospital staff. This is especially likely to occur when there is little interaction between the staff and the patient population, *e.g.*, when the staff–patient ratio is too small or when there is not a full-time treatment program.

IV

Parsons[3] describes how society, in order to deal with mental illness, which it sees as a form of deviant behavior, has developed a number of conditions which the patient assumes when he becomes ill. These conditions are: the exemption from normal social responsibilities, the exemption from responsibility for being helpless, the obligation to want to get well, and the obligation to cooperate with the technically competent help available. The dilemma in which the patient finds himself, *viz.*, the expectation of his being irresponsible and incurable on the one hand and yet being expected to cooperate and get well on the other hand, is described in detail by Kai Erikson.[2] By seeming responsible, the patient runs the risk of creating the false impression in his friends and relatives that he isn't "really crazy." "I don't see that they are sick," is the frequent remark from lay visitors to our hospital who, even though otherwise quite well-informed, still think that mentally ill patients must be violent, irrational, unpredictable and irresponsible.

Without going into the background for such attitudes, I shall mention one aspect of our society that may well make matters worse. As our community facilities and other aspects of our lives as well tend to become more specialized,[19,20] the distance between the members of the community and its problem-solvers becomes greater. This means that the relationship between what a citizen does and its ultimate effect on creating problems in society becomes less meaningful. When a community substitutes a direct relationship for an indirect one, distortions are likely to occur. Such a distortion, aside from affecting the mental health of the citizen, will also adversely affect his understanding of his role in the phenomena of mental illness. The "snake pit" appearance of mental hospitals, until recently so common, clearly illustrates the tragic gap that may develop between the public and those problem-solvers who are in charge of the care of mentally ill patients. Even now, after repeated sensational exposures, public mental hospitals are still far from being optimum treatment facilities. Our mass communication media, while a necessary link, always will be a poor substitute for that kind of close personal contact with our mentally ill fellow-citizens which will make us aware of our contributory role toward mental illness and mental health.

Summary

It is extremely important that the patient recognize a responsibility for his illness as a step toward motivation for his treatment. With the realization that the patient is in a constant state of interaction with his environment (external or internalized) and with his drives, responsibility is used here as the recognition that the patient is not totally at the mercy of these forces, but has potential, self-organizing structures which assure his independence from them. The extent to which the patient is

responsible for his illness (has actively contributed to the yielding to these forces, presumably to find a more useful adaptation) may be ignored because of some inherent attitudes about mental illness in the medical profession, the patient, the hospital and the community.

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READING NOTES

One of the fine, thoughtful writers of the country has stumbled. Friend John Fischer, Editor-in-Chief of *Harper's,* wrote an excellent editorial in his September 1961 issue regarding certain changes in industrial development and discussed the intangible assets of certain inspiring sites such as North Carolina, New England, Puerto Rico, the northwestern states, Wisconsin and Michigan (curiously omitting Colorado). But then it happens. Rhetorically he exclaims, "How could anybody create either a great university or an enticing environment in Kansas or North Dakota?"

President McCain of the State University comments sadly in the *Journal of the Kansas Industrial Development Commission* that this "reflects a widespread image of this state, although . . . a grossly distorted image." It probably is the image of our state accepted by the man of the street in Philadelphia, the factory worker in Rhode Island, the lobster fisherman in Maine or the sharecropper in Alabama. That's what we think, but now we learn it can be held by one of the most intelligent, educated and sophisticated men in one of the most metropolitan and broad-minded cities in the world.

We ought to do something about this. We ought to have a tour and take Mr. Fischer and some of his friends to see our several state universities, our many excellent colleges, our Lindsborg Festival and art center, the Eisenhower Library at Abilene, and just over our state line to see the William Rockhill Nelson Art Gallery and museum and the incomparable Linda Hall Library.

I should like to lead Mr. Fischer and his party up a beautiful hill west of Topeka, passing trees and flowers and woods, flocks of birds and occasional deer to our clock tower building. After they had looked at the sunset reflected on the river westward, and the city stretching out to the east, they might follow some of the invisible threads from this center leading to the state hospitals of Kansas and the state hospitals of twenty other states. They might proceed to the beautiful Topeka VA Hospital, long the pilot and leader in this great chain. He might follow threads to a score of hospitals, clinics and other institutions where psychiatry in a new key is taught, practiced and utilized. Some of their various research projects might inspire his hope for better use of the manpower in those states which he found so much more attractive.

Then I would take him to the Kansas Turnpike running from our cluster

of hills to the cluster known as Mt. Oread and show him the most beautiful university campus in the world, and on this campus Chancellor Clarke Wescoe would show him a panorama of buildings set in a panorama of scenery in which there is an expanding panorama of ideas and cultural examples which any state might envy.

Then we would turn around and go west to another range of beautiful hills where President Jim McCain would show him the first and the finest agricultural school in the land, part of a university, well deserving of that name in spite of Mr. Fischer's derogations.

But we would not stop there. We would go north through the beautiful Blue Valley or south through the incomparable Flint Hills (soon perhaps to be a national park). And we could turn east . . . or we could turn west . . . and we would find beauty everywhere.

A few days and a few thousand miles later Mr. Fischer might repent himself of his unkind words about a much maligned and long-suffering state in which—Mr. Fischer's despair notwithstanding—there are both great universities and enticements. If he elected to remain in Kansas, he would discover that he was the latest in a great train of distinguished persons from the east, who came, saw and were conquered.

* * * *

Several times I have referred to that psychoanalytic "character," Wilhelm Reich. He wrote one of our most valuable books on technique, correcting a serious error into which many had fallen. He had received world-wide acclaim only to dive off head first in the direction of Communism, and later in the direction of a delusion about "orgone" sex energy being accumulated from the ether by an empty crate. He was deadly serious about this and attracted quite a few disciples. He stubbornly refused to stand corrected even by the Federal government and installed himself in a strange fortress in the Maine woods, issuing threats and warning bulletins to the F.B.I. about "the Medical Trust." He died in a Federal penitentiary shortly after conviction for using the mail to defraud. His story is rather vividly reviewed by two writers, Brown and Cooley, in the magazine *True* for April 1962. I don't know anything about this magazine but the main outline of this story is not far off and is surprisingly rich in detail.

* * * *

I have just cited *True* magazine for an excellent article; this will be citation No. 2. In the June 1962 issue, former Warden Duffy of San

Quentin writes—from personal experience and participation—on the death penalty, entitled, "88 Men and 2 Women."*

"I hate the death penalty because of its inhumanity . . .

"I hate the death penalty because it is a brutal spectacle . . .

"I hate the death penalty because it is a terrible waste of human energy . . .

"I hate the death penalty because it does not allow for examination, mental aberration or psychological disturbance . . .

"I hate the death penalty because it makes mockery of our moral code . . .

"A man does not die for the crime he commits; he dies because he committed it in the wrong state or in the wrong county or at the wrong time or because he faced a tough judge or because he couldn't afford adequate counsel. . . ."

If a warden who has killed 90 people for us, one by one, can say all that about the wretched business, why does the public (or at least our legislative representatives) still demand it?

* * * *

According to *The Wells Newsletter* for April 1, 1962, the antireligious activity of the Kremlin "is dwarfed by declarations of the most famous Russian physicists, mathematicians and astronomers who are openly stating their belief that there is a force superior to man which dominates the creative energies of the universe. This force, they urge, must replace the mechanical concepts of previous days if Soviet science is to advance." ". . . This renewed religious interest among scientists cannot long be confined to science alone, for poets, writers, painters and musicians in Russia have all been active in promoting a new mysticism in Russian life."

* * * *

Last year I distributed to a few of my friends a pamphlet which we had received in the mail bearing the startling title, *"Have you been in jail lately?"*

This is a Quaker publication which refers to the visitation of prisoners—an injunction by Jesus which is rarely followed by good Christians these days. This pamphlet contains suggestions for occasional visits. It has in mind less the comfort of the prisoners than the education of the visitors regarding the conditions of the prisons to which our judges

* This is also the title of a new book by Warden Duffy, published by Doubleday.

mechanically direct offenders day after day. It suggests the visitors look into the general atmosphere, the overcrowding, the ventilation, the cleanliness, the vermin, the separation of juveniles and first offenders from old timers, attention given the ill—including the mentally ill—the "character of the staff," the way in which the prisoners are permitted or expected to spend their time, the amount of exercise permitted, the availability of personal counseling, the availability of medical examinations, the concern for the religious life of the prisoners, the methods of discipline used, the sort of preparations made for release, especially the questions of friends and jobs.

° ° ° °

Atlas is a monthly containing selections from the foreign press. To see ourselves as others see us is always healthy, even if (frequently) painful. In the May 1962 issue I was most interested in reading numerous German commentaries on the William Shirer book *Rise and Fall of the Third Reich,* which is a best seller there as well as here.

Shirer did pretty well, they think, in many respects, but his narrow-mindedness, his blind hatred of certain individuals and his lack of preparation in historical research resulted in many misleading "half-truths." The Germans do not deny the major allegations; they feel that it is good for them to face their guilty past. But they think that Shirer misjudged and misreported some important things.

One of the leading newspapers of Europe, published in Milan—*Corriere della Sera*—published an Italian "judgment of Germany" written by an Italian correspondent in Germany, Montanelli. Part of it is extraordinarily keen:

"The miracle of Germany is purely economic. Literature, cinema and theater are a desert because in the spiritual field any examination of conscience that has been avoided or shunted aside irrevocably condemns a people to sterility. Italy is alive, though in a state of chaos, and is perhaps the most alive country in Europe because it has accepted this examination of conscience and even wallows in it. Only fools would consider this acceptance to be defeatism or masochism. Creativity is always denunciation and protest, rebellion against oneself and society, beyond which lie only empty academics. . . ."

The "Buy-American" policy recently pushed in this country is very painful to the Japanese, both economically and psychologically. In recent months exports to South Korea dropped 33 per cent, to Formosa

35 per cent, Pakistan 68 per cent, Cambodia 85 per cent. And in a recent "international" bidding for a supply of fertilizer to India with the U.S. aid, Japan has again been excluded.

A most devastating picture of the sterility and starkness of the Marxist regime is by an Italian reporter who visited Leipzig, Dresden, Karl Marx-stadt and other towns in East Germany. Listless, cold, dreary, stark, spiritless, tired, squalid . . . drudgery . . . unreconstructed rubble . . . wooden faces . . . routinized life—these are a few of the adjectives and phrases that I pick up at random.

° ° ° °

I have recently had a letter from a nurse long experienced at Rochester, Minnesota and elsewhere, whose youngest sister died of cancer of the colon, "which developed after a terrific disturbance of several years." The writer next recalls a patient dying of cancer who was most distressed by the fact that for more than thirty years his wife had borne him no children. The next patient she describes was the mother of a deaf mute; the next a man who had lost all earthly possessions in a fire and not long after died of cancer, after which his wife developed it. The nurse's letter goes on in page after page of accounts of patients she has nursed or friends she has known with cancer immediately following some loss and in connection with great emotional stress.

° ° ° °

I can well remember when Oswald Spengler's *Decline of the West* appeared in 1926. It was customary for all those who considered themselves thoughtful, literate and socially concerned to bring it up for discussion at every informal meeting. The inevitability of cycles and the impending doom of our civilization were arresting and disturbing ideas. Toynbee revised Spengler a bit and brought in the hope of spiritual development and growth through Christianity. But in the back of many minds, there is still that gloomy prophecy of Spengler, and the book has recently been reissued in an abridged edition by Knopf.

K.A.M.

BRIEF BOOK REVIEWS

Group Psychoanalysis: Theory and Technique. By NORMAN LOCKE. $6.50. Pp. 253. New York, New York University, 1961.

The book describes an attempt to adapt the techniques of individual analysis to expressively oriented therapeutic groups. The dreams of one member, for example, are used as a springboard for eliciting associations of other group members, which in turn become the basis for individual interpretation. The method is somewhat more radical than that used by most analytically oriented group psychotherapists and adds to the wide array of group approaches. The sections on theory and rationale are perhaps the least valuable parts of the book inasmuch as they are often equally applicable to individual treatment. Also, the author at times betrays a lack of psychiatric sophistication, particularly with regard to concepts of ego psychology. But the book contains many valuable suggestions about the technical handling of groups where expressive work is indicated. The annotated transcript of one treatment hour is particularly interesting. (Leonard Horwitz, Ph.D.)

Learning Theory and Behavior. By O. HOBART MOWRER. $6.95. Pp. 555. New York, Wiley, 1960.

The nearly one-thousand references in this book and the lengthy quotations indicate that the author's major concern is with systematization of learning theory, while the exposition is instrumental, and often forbiddingly complex. Though the book is highly instructive and in many respects quite rewarding, the reader feels like a rat in a series of experiments, running maze after maze, now deprived, now rewarded; now shocked, now left in peace; contemplating valleys and fields, often pending between hope and fear. Such is, at least to this reviewer, Mowrer's didactic procedure, demonstrating his new two-factor theory of learning *in vivo* to the student. While this is certainly not a pleasant and elegant learning process to the reader, it may be far more effective than he is aware. (Paul W. Pruyser, Ph.D.)

Death and the Supreme Court. By BARRETT PRETTYMAN, JR. $4.95. Pp. 311. New York, Harcourt, 1961.

Here a scholarly lawyer turns his attention to the way in which six crimes were committed, detected and "punished" with particular reference to the role of the United States Supreme Court, to which all of these cases were, for various reasons, referred. It is superb writing and it is highly informative, less about criminality than about the operations of legal machinery, especially the Supreme Court. (K.A.M.)

Encounters: Two Studies in the Sociology of Interaction. By ERVING GOFFMAN. $1.95. Pp. 152. Indianapolis, Bobbs-Merrill, 1961.

Goffman's sophisticated view of human relationships, reflected here in discussions of "fun in games" and "role distance," places him in the select company of those sociological observers such as Georg Simmel who possess both analytic ability and a lively, persuasive literary style. These essays, and his earlier *The Presentation of Self in Everyday Life*, are highly recommended to

anyone interested in the sociology of interpersonal relations and small group behavior. (Charlton R. Price, M.A.)

Sons of the Shaking Earth. By ERIC R. WOLF. $5. Pp. 303. Chicago, University of Chicago, 1961.

A scholarly and well-illustrated history of Mexico and Guatemala from prehistoric times up to the present is here offered by the associate professor of anthropology at the University of Chicago. I read it all through, and when I go South again I shall take it with me. (K.A.M.)

The Nature of Man in Theological and Psychological Perspective. SIMON DONIGER, ed. $6. Pp. 264. New York, Harper, 1962.

The 19 essays in this volume constitute a contemporary approach to the age-old problem of reconciling science and religion. Agreeing on man's fulfillment through wholeness, they differ widely in approach, from the pedestrian through the technical to a transcendental point of view. Among the most significant contributions are Paul Tillich's philosophical discussion of existentialism, psychotherapy, and the nature of man, Karl Menninger's stimulating call to hope, Seward Hiltner's practical criticism of a case in pastoral theology, Paul Pruyser's treatment of the relatedness of theology and psychiatry, Noel Malloux's reasoned distinction between the neurotic and the rational conscience, and Franz Alexander's original concept of a biological foundation for Christian morality. Like most anthologies, the book suffers from lack of flow, but variety and thoughtfulness measurably atone for this lack. (Nelson Antrim Crawford, M.A.)

Schizophrenia as a Human Process. By HARRY STACK SULLIVAN. $6.50. Pp. 363. New York, Norton, 1962.

Sullivan's unusual skill with schizophrenics—in 1934 80 per cent social recovery while other practitioners were having discouraging results—is reflected in this book containing his major articles from 1924 to 1935. He early felt that schizophrenic phenomenology required for complete exposition nothing different in essence from the elements of commonplace human life. Recognizing the importance to the adolescent of the eruption of sexual impulses, he maintained that if a person could effect a meaningful relationship with a member of the opposite sex, schizophrenic illness would not occur. Some of his skill Sullivan attributed to his own early encounter with the schizophrenic process and his recognition of the repeated frustrations that lead to the schizophrenic's low self-esteem. Avoidance of any serious mistake with schizophrenics is essential, he held, because of their having learned long ago that nobody in the world can be trusted to value and love one. (Herbert Klemmer, M.D.)

Psychology of Judgment and Choice: A Theoretical Essay. By FRANK RESTLE. $6.95. Pp. 235. New York, Wiley, 1961.

A lucidly and concisely written book about the use of mathematics in psychology. Mathematics, serving as a structure for valid deduction, permits us to deal with quantitative relationships and to arrange psychological data in the form of frequencies of particular events. Analyzing the theories of set, measures, and probability, Restle shows how to translate logically expressed hypotheses into mathematical structures, such as those of union, intersection, and comple-

mentation, how with the introduction of measures set theory goes beyond ordinary logic, becoming specifically useful for the complex psychological facts, and how it can be transformed into probability theory for tackling the crucial problems of applying psychological theory to data. Step by step the relevant mathematical concepts are introduced, clarified as to their conditions, effects, and applicability and finally shown in action by the demonstration of specific research tasks related to choice and judgment. (H. M. Graumann, Ph.D.)

The Doctors' Dilemmas. By LOUIS LASAGNA. $4.95. Pp. 306. New York, Harper, 1962.

Doctor Lasagna, well known in experimental and clinical pharmacology, displays his versatility in a book about doctors from antiquity to the present, covering topics from medical quackery, old and new, to the selection and training of physicians. This is a virtuoso performance by a clever and well-informed physician with convictions on most of the controversial issues which currently touch on the medical profession. The author's judgments on many of these questions are courageous and fair but he can also be as arbitrary and severe as a police magistrate. He is scornful of psychoanalysis and looks down upon the majority of its practitioners as either fools or knaves. He builds up Freud as one of the "tall men" only to demolish him. The quality of the essays varies from undistinguished to excellent. By and large the writing has shape and style; it is often engaging and breezy, but not infrequently prolix and punditic. The publishers call this a startling book; this reviewer does not know why. (Nathaniel Uhr, M.D.)

A Model of the Mind. By GERALD S. BLUM. $6.95. Pp. 229. New York, Wiley, 1961.

A psychologist and his brother-in-law, an engineer, set out during one Christmas holiday to "systematize psychoanalytic theory." "An electronic scheme spelling out in detail the functions of Id, Ego, and Super-ego suddenly seemed attractive." From this beginning grew a series of experiments in which they used hypnosis to "deposit traces according to our own specifications" and investigated the fate of these traces. The aim of the experimental work was to devise and test a "model of the mind." The tentative model constructed has little to do with psychoanalytic theory. The work is interesting, inventive, and girded with the requisite trappings of scientific rigor. The serious student of models and metapsychology should read this closely. (Richard S. Siegal, Ph.D.)

Exploring the Base for Family Therapy. NATHAN W. ACKERMAN and others, eds. $4. Pp. 159. New York, Family Service Assn. of America, 1961.

This collection of papers is a contribution to the growing literature about "the family." While considering the attempts of social work, psychiatry, sociology, psychology and anthropology to understand family interaction, the 14 authors do not develop an integrated approach to family diagnosis. The papers lend themselves to the further development of a base for family theory and are recommended to those interested in exploring the various disciplines' understanding of "the family." (Minnie Harlow, M.S.W.)

Learning Theory and the Symbolic Processes. By O. HOBART MOWRER. $8.50. Pp. 473. New York, Wiley, 1960.

The author calls his book "exploratory." His explorations cover a large territory, while he applies his two-factor theory of learning (See Mowrer: *Learning Theory and Behavior,* 1960) to the phenomena of symbolism in behavior, from animals to man. Starting with latent learning as a primitive form of symbol activity, attention is given to processes of imitation, sign learning and various other aspects of language behavior, thought, imagery, memory and scientific thinking. While trying to preserve as much as is salvable of a rigorous S-R scheme, the last chapter on Social Learning and Human Personality ends on a quite mentalistic (and even moralistic) note. The last quotation (and quotations constitute a sizable portion of this as of Mowrer's previous books) is a passage from Erich Fromm on mental health. (Paul W. Pruyser, Ph.D.)

They Shall Take Up Serpents: Psychology of the Southern Snake-Handling Cult. By WESTON LA BARRE. $3.75. Pp. 208. Minneapolis University of Minnesota, 1962.

A historical, anthropological, and psychoanalytic study of a bizarre religious practice. Doctor La Barre traces the symbolism of snake cults among primitive peoples in various parts of the world and elucidates their religious and psychiatric meaning. His studies show an apparently spontaneous origin of the snake-handling cult among Southern Fundamentalist Christians in 1909, carrying unconsciously the prehistoric significances in an underprivileged society of "poor whites" and, in some regions, Negroes also. Considerable of the book is devoted to an individual leader, who is analyzed as a psychopathic character. At the same time, Doctor La Barre offers the conjecture that "this man, who, for his own reasons, breaks through punitive cultural fictions and leads his people, however stumblingly, away from them, may be rendering his parishioners a therapeutic service." (Nelson Antrim Crawford, M.A.)

Man and Civilization: Control of the Mind. SEYMOUR M. FARBER and ROGER H. L. WILSON, eds. $6.50. Pp. 340. New York, McGraw-Hill, 1961.

The present study is a heartening example of the efforts to overcome the threatening breakdown in communication between the sciences and the humanities. It would seem no accident that C. P. Snow was Regent's Professor at the University of California when this symposium brought together leaders of religion, law, history, government, and philosophy as well as members of the various sciences. Sir Charles, of course, in his excellent sequence of novels, *Strangers and Brothers,* has been vastly important in expressing this contemporary problem. The symposium, held at the San Francisco Medical Center of the University of California, was organized around the following topics, with papers by such men as Aldous Huxley, Seymour Kety, Arthur Koestler and Herbert A. Simon: The Mind and Its Integration, The Influence of Drugs on the Individual, The Mind and Society, The Impact of Technology on the Mind, and Restriction and Freedom of the Mind. (Lewis F. Wheelock, Ph.D.)

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