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MENTAL HEALTH PROGRAMS IN AMERICAN COLLEGES AND UNIVERSITIES*

By SIGMUND GUNDLE, M.D.** and ALAN KRAFT, M.D.†

The traditional goals of education have been to disseminate knowledge and to stimulate its development in each generation. Modern educators have felt increasingly a responsibility for the development of the student as an individual component of society. Because of the close relationship between the learning process and individual development, it has become a goal of modern education to facilitate maximum maturation and self-realization. Late in the nineteenth century many colleges developed their own health services for students, and gradually added special facilities to promote mental health. Probably the earliest of these was that developed at Princeton in 1910 by Dr. Stewart Paton.[1] The first college known to employ a full-time psychiatrist was West Point Military Academy. In the 1920's, lecture courses in mental hygiene were offered in a number of schools. One of the earliest such courses was one instituted by Dr. Karl Menninger at Washburn College. Gradually in the intervening years many mental health facilities have developed in universities and colleges on either a part-time or full-time basis.

It was the wish to know the extent of mental health resources in our universities and their availability to students in the nation that moved us to undertake the survey described here. One of us (S.G.) had been a full-time psychiatrist in a midwestern university for several years and knew a number of colleagues who were engaged part time or full time in universities. But the lack of data about these facilities as a whole and the comparative isolation of the numerous campus units seemed to indicate a need

* From the Student Health Service of the University of Kansas, Lawrence, whose director, Dr. Ralph Canuteson, was very helpful to the authors in the course of this study.

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for a study of the present situation. In 1953†† we set out to obtain a more accurate picture of the resources available to college students and, if possible, to collect exact figures about these services.

Previous Surveys

In 1936, Raphael[2] undertook the first survey. With the questionnaire method he surveyed 865 colleges and universities in the United States, obtaining replies from 53 per cent (479). The answers showed that special courses in mental hygiene then were available in 39 per cent of these schools. Less than half (41 per cent) had some kind of consultation service, but only 142 schools (about 30 per cent) had "some kind of organized service." The remainder was classified by Raphael as "irregular services" because they were not continuous. Only 43 schools had a consultation service under psychiatric direction.

Another survey was conducted in 1948 by Clements Fry[3] who polled 4,765 members of the American Psychiatric Association of whom about 50 per cent replied. He found that 30 psychiatrists were engaged on a full-time basis in organized programs in various universities and another 63 on a part-time basis. Because Fry's survey was addressed to individual psychiatrists, one can draw no conclusions about the number or kind of programs which existed at that time.

The only other data were from a recent comprehensive survey of college health services in general by Moore and Summerskill[4] which, however, was not specifically concerned with mental health facilities. It should be noted that this survey occurred at about the same time as ours and was based on the same list of American universities. They found that 98 institutions, about 10 per cent of the number where data were available, retained the services of one or more psychiatrists and 125 schools employed psychologists. More than two-thirds of these were found in urban college communities. The authors acknowledge that their data are not too conclusive because their questionnaire was not specific enough, and they have no data about part-time or full-time facilities or the number of psychiatric teams. Nevertheless, there is a remarkable agreement between their survey and our own findings which were obtained independently.

Method

In November 1953 we distributed a questionnaire to 1,141 colleges and universities in the United States, Canada and United States territories. This represented two thirds of all institutions of higher learning listed in the U. S. Educational Directory for 1952.[5] The basic criterion for selecting this particular sample was size of student enrollment. The 1,141 schools selected included all four year colleges and universities with more than 250 students and all two year colleges with more than 500 students. The questionnaire was sent to the director of the student health service when his name was listed in the roster of the American College Health Association or, when the name was not available, it was addressed to the president of the institution.

†† In preparation for the Fourth National Conference on Health in Colleges.

TABLE I

Distribution by Size of Enrollment

Size	Number	Per Cent
*0–249	19	2.6
250–999	409	56.0
1000–2999	200	27.5
3000–4999	40	5.5
5000–9999	44	6.2
10,000– and over	16	2.2

* According to figures of the 1952 U. S. Education Directory these schools had enrollments of more than 250 and thus were recipients of our questionnaire.

The questionnaire was designed to learn which schools did or did not have special mental health facilities available as part of their student health service. Those that did not were asked to describe what resources they had for students who needed help. Schools that had special mental health resources were asked to give details such as the composition of personnel, the kind of services offered, the activities of the unit, the total number of students seen, the amount of work load and the operating cost.

Our sample on which our findings are based, consisted of 728 completed returns which represents a response of 64 per cent. The distribution of our sample by size of enrollment parallels the general distribution of these schools and on that basis is fairly representative (Table I).

No attempt has been made to evaluate any particular facility, and the questionnaire was not designed for this purpose. The findings are only useful in giving quantitative data. No conclusions can be drawn as to results, or as to whether schools which have such special facilities are actually improving the mental health of the students, though it is generally presumed that they do. The data allow a comparison of groups of schools as to the extent of the services offered, as to cost, and certain aspects of their function.*

The findings to be discussed here are in two parts: (1) a breakdown of our figures into schools with and without special mental health facilities, and (2) the nature and extent of services in those schools which maintain mental health facilities in their student health services.

Schools Without Special Mental Health Facilities

By far the greater number of institutions polled had no special mental health resource within their health service: 86 per cent of the returns (629

* This will be the subject of a separate paper to be published.

TABLE II

Breakdown of Schools by Enrollment According to Presence or Absence of Mental Health Service

Size	*With* Mental Health Service		*Without* Mental Health Service	
	Number	Per Cent	Number	Per Cent
0–999	22	6	379	94
1000–2999	30	15	170	85
3000–4999	13	30	28	70
5000–9999	21	52	21	48
10,000– and over	13	81	3	19

TABLE III

Resources Used in Schools without Special Facilities

Resource	Number
None Available	19
Separate School Psychologist	80
Faculty Advisers	447
Dean of Men or Women	432
Psychology Department	289
Guidance Clinic	167
Private Psychiatrist	103
Health Service M.D.	54
Clergy	37
Others (mostly nurses)	80

schools) were in this category. Only 14 per cent (99 schools) maintained special facilities within their health service to deal with emotional problems. However, it may be assumed that those schools which maintain such a service would be more likely to answer our questionnaire on the basis of greater interest in such a survey. If this assumption is justified, the 99 probably represent the total number in existence. The figure of 99 institutions in our survey is remarkably close to the 98 found by Moore and Summerskill. Identical figures from two independent surveys makes the conclusion more justified that all those schools which maintain special facilities have responded to our questionnaire.

Whether or not a school maintains a special resource, other factors being equal, seems to be determined by its size. Schools with larger enrollments are more apt to maintain such a resource, while those with small enrollments are less likely to do so. Table II shows this relationship very clearly.

Only 22 schools in the lower enrollment category had such services. On the other hand, only three schools with an enrollment of over 10,000 students did not have such facilities. These three schools were all located in large metropolitan areas where other psychiatric resources existed.

Schools which did not have special mental health facilities available were asked what resources they used, and Table III shows the number of reporting schools which used each of the listed resources. Each school used more than one of these and therefore the total in Table III is more than the number in the sample.

It can be seen that 80 schools maintained the services of a separate school psychologist. The exact nature of the work of such a person probably varies and was not investigated in this survey. On the basis of our personal experience, the work of a school psychologist ranges from formal psychotherapy to counseling to vocational guidance. A large number of schools, 281, reported that they used the college psychology department as a facility for students with emotional difficulties, while not as large a number, 167 schools, had a guidance clinic, usually in addition to a psychology department. A little over 100 colleges reported that private psychiatrists were available for their students. When psychiatric services were available in the community, some schools considered these an adequate treatment resource for the student. These private psychiatrists were not affiliated with the university or with the student health service. Almost two thirds of the schools in our sample used faculty advisors or the dean of men or women to deal with emotional problems.

It appears that of those schools which do not have any special mental health facility, a small number maintain a special agency on the campus in the form of a guidance clinic, or a separate school psychologist who can deal with emotional problems, primarily with the less severe ones. However, two thirds of these institutions, one must conclude, use whatever facility happens to be available, such as the faculty advisor system, primarily created for the purpose of academic counseling, or a personnel system which includes a dean of men and a dean of women. The psychology department is less often used, probably because students do not readily go there. Only a small number of our universities have a psychology department that includes training facilities for clinical psychologists who might be equipped to handle some emotional problems. The majority do not have any staff experienced in clinical psychology. It seems that the psychology department is used as a resource because it happens to be there, not because it is equipped to handle such problems.

We grouped the schools in a classification which we arrived at by individual evaluation of the information received from each school.

Forty-five per cent had to be classified as having "no organized program," or were using simply whatever facility happened to be available. About 48 per cent of the schools surveyed maintained some program, varying from what could be called "some organized program" to a "well organized program" (both outside the health service) to special facilities within the student health service, usually meaning the presence of specialists in psychiatry or psychology. Seven per cent of the schools maintained a referral system to agencies outside the campus or to their own medical school.

TABLE IV

Mental Health Facilities in 728 Colleges

Program	Number	Per Cent of Total
No organized program. Facilities include faculty advisers, deans, psychology department.	322	45
Some organized program outside the health service, including such facilities as a dean who has experience in guidance, a guidance clinic, or a school psychologist.	220	30
Well organized program outside the health service, including those schools having an organized counseling service available.	56	7
Specific referral system to clinics outside the school or to a medical school.	31	4
Special facilities within the health service or closely associated with it.	99	14

It is interesting to compare our figures of 1953 with the ones obtained by Raphael seventeen years earlier. We are aware that Raphael's sample and questionnaire were different, and that not all data are exactly comparable. However, Raphael organized his replies in a fashion similar to ours. In 1936 only 30 per cent maintained some kind of organized program which was concerned with emotional problems of students, and this included the few schools which maintained specialists on their staff. Our figures indicate that 51 per cent of the schools in our sample have some sort of facility nowadays (Table IV). This increase is in proportion to the increased enrollment and proportionate to the increased number of individuals who have received training in clinical psychology or in psychiatry or in counseling during the last 17 years.

Each school which did *not* have special mental health facilities was asked whether they felt any need for such services. Of the 629 schools replying to this question, 51 per cent said they felt a need for one, while 49 per cent said they did not feel any need. The reasons given varied a great deal. A small number of schools felt they had no problems. Many recognized they had emotional problems in their students, but felt their school was too small to maintain such a service. Others said they were located in an urban area where outside facilities were available, or they had primarily non-resident students, or they could refer their problems to local or state clinics or hospitals.

In the group which felt a desire for services but had none established yet, there were two main reasons given: one was that no qualified personnel was available to fill positions and the other was a lack of funds. Only a small number, fourteen, mentioned strong opposition on the campus which prevented establishing such services.

Of the individual comments, we are quoting some of the more common replies, because they reflect a sentiment in a large number of institutions. One college replied, "Last year, we had one student who needed help. His problem was taken care of by the Dean of Men and the college physician." Another college wrote, "Educators are too inclined to think of everyone as a mental case." One reply was, "We have staff members who can detect cases needing professional care, and they can be handled by referral." This was a fairly common reply. Another comment, "We have very few severe psychiatric problems, but many emotional problems, most of which can be handled by an understanding physician. The few severe problems, we refer to a psychiatrist; we would have one if funds were available." Some small colleges replied, "We need indeed very much to recognize the need for this type of therapy and it is highly critical." Another frequent reply was, "Selective admission policy eliminates most such problems. We try to avoid admitting potential emotional and mental problems, because we cannot afford to care for their needs. When a case develops, we refer it and, if necessary, ask the student to withdraw." Another reply was, "The health certificate required for application is a rigid one. Hence, in nine years, we have had one student who was emotionally disturbed." A common comment was: "Our need is great and our response much too weak."

Institutions with Special Mental Health Facilities

Personnel (by schools): There were 99 schools which maintained special facilities dealing with emotional problems in students.* As shown in Figure 1, one third of these schools had only a part-time psychiatrist as a resource. The number of hours given by these psychiatrists varied greatly from four hours a month to three or four days a week. About an equal number of schools had a full or partial psychiatric team.

Sixteen schools maintained the services of a psychiatrist, psychologist and a social worker, the usual psychiatric team. Criteria for a full team were that all three categories must be represented, and at least three people must be maintained full time. A similar number of schools maintained what was classified as a partial team. This category was used for those schools where only two of the three categories of the team were present. The majority of these 15 schools maintained only a full-time psychologist and a full-time social worker. A few of them maintained a full-time psychiatrist and a full-time psychologist. These three categories were by far the most frequent combinations.

If broken down by schools, 87 schools used psychiatrists, 52 schools employed psychologists, and 17 utilized social workers. Table V summarizes this information.

* Two more replies were received late which actually brings the total to 101.

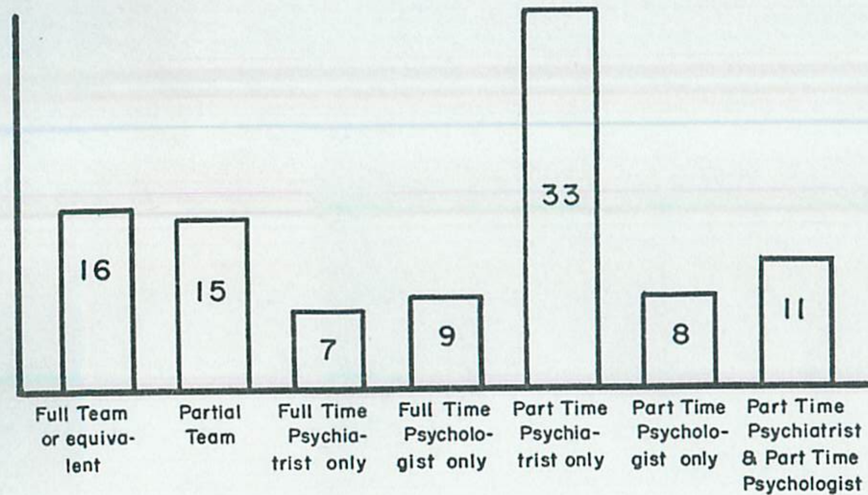

FIG. 1. Personnel available in 99 schools

TABLE V

Personnel in Universities with Mental Health Facilities—Breakdown by Schools

Psychiatrists, full-time	22
Psychiatrists, part-time	71
Psychiatric Residents, full-time or part-time	8
Total: Psychiatrists, full-time or part-time	87*
Psychologists, full-time	23
Psychologists, part-time	35
Total: Psychologists, full-time or part-time	52*
Social Workers, full-time	12
Social Workers, part-time	6
Total: Social Workers, full-time or part-time	17*
Graduate Students, full-time	2
Graduate Students, part-time	11
Total: Graduate Students, full-time or part-time	13
Other Personnel (Counselors mostly)	10

* The apparent discrepancy in the totals is due to an overlapping of personnel at schools, some schools having more than one category.

TABLE VI

Personnel in Universities with Mental Health Facilities—Breakdown by Individuals

	Part Time	Full Time	Total
Psychiatrist	131	35	166
Psychologist	71	44	115
Social Worker	10	22	32
Graduate Student	44	5	49
Others*	11	13	24
Total	267	119	386

* Mostly counselors working under medical direction.

If the same data are organized, *not by schools but by individuals*, one obtains the breakdown of personnel shown in Table VI.

In 1936 there were only 10 units which utilized something like a psychiatric team; 17 years later we find 31. In 1936 there were only 43 units which were under psychiatric direction; 17 years later we find that this number has more than doubled with 87 units. One might almost say our universities are getting a fair share of the available psychiatrists. Since 1948, when Fry conducted his survey, changes have not been too profound. Fry found that there were 30 psychiatrists engaged on a full-time basis in organized programs in our universities. In 1953, we find there were 35. However, the number of psychiatrists engaged in college work on a part-time basis has exactly doubled during the last seven years, but we cannot be quite sure whether there really has been such an increase. It is possible that the present survey is more inclusive because the survey was based on schools, while Fry queried individual members of the American Psychiatric Association. On the other hand, it could reflect the postwar growth of psychiatry in general.

The questionnaire inquired into the level of training of the psychiatrists. Of the 35 full-time psychiatrists, 16 were certified by the Board of Psychiatry and Neurology, 11 were eligible for certification and five were full-time psychiatric residents. It was noteworthy that there were only three psychiatrists who were neither certified nor eligible for the certification. Of the part-time group in college psychiatry, 83 were certified.

The questionnaire inquired in some detail into the kind of activities the staff of each unit engages in. These varied a great deal, ranging from consultations to counseling (this was not accurately defined in our questionnaire and it was left to the discretion of each unit what counseling meant). Short term psychotherapy was practiced widely, but only a small number of units were able to afford the expense of long term psychotherapy (more

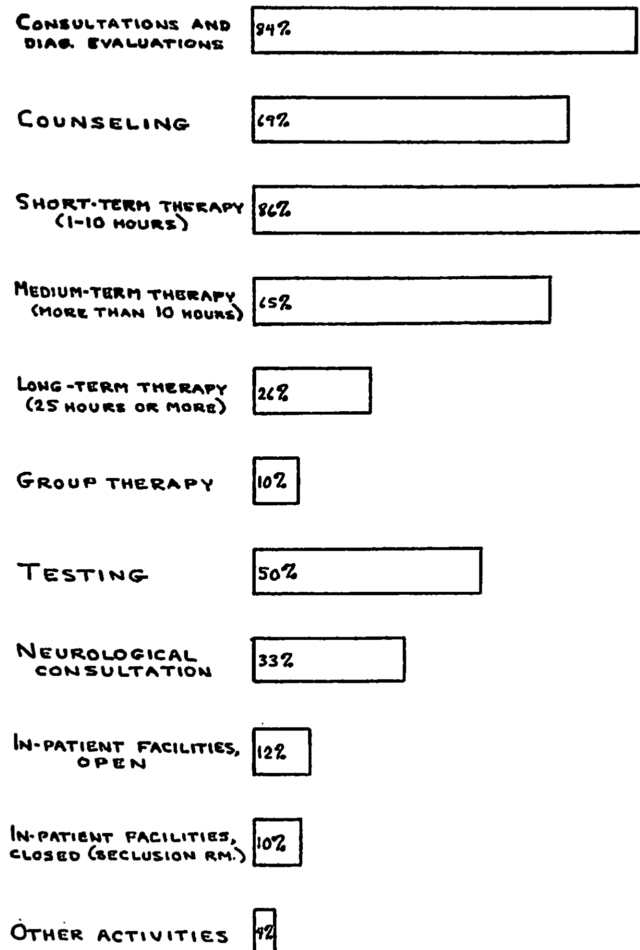

FIG. 2. Variety of activities and services in universities with mental health facilities (93 replies).

than 25 hours) for their students. The variety of activities can be seen in Figure 2.

In addition to these regular activities, inquiry was made into other functions such mental health services have assumed. As could be expected, a number of schools engaged in training psychiatrists and psychologists and had on their staff psychiatric residents or graduate students in psychology. A few schools also had trainees in social work or were engaged in training counselors. It was surprising to learn that 29 schools reported they were engaged in student selection and screening. Selection projects

at the present time are not too encouraging, particularly those which rely only on a brief interview. Our own experiences while engaged in this work have been very disappointing. We were therefore quite surprised to see that a great number of schools feel that selection and screening of students is a useful activity. Twenty-three schools reported they were engaged in some kind of research. Other functions of the staff included medical school teaching or academic teaching. Sixty-five schools, two thirds of our sample, reported a part of their regular function was to maintain liaison with deans and faculty members. It was encouraging to see that such a great number of schools have recognized this as an important part of their program, and realize that it does not suffice to render service to a few individual students. Thirty-five schools still were engaged in using mental hygiene lectures in one form or another. Quite a few units made their staff available to provide clinic service to the local community. A certain number of units permit their full-time psychiatrist to engage in part-time private practice in the community in order to augment his usually moderate salary. This practice seems to be quite wide spread. Perhaps it indicates how necessary this practice has become in maintaining a psychiatrist on the staff. Of 35 psychiatrists employed on a full-time basis, 21 do part-time private practice. This represents 70 per cent of the full-time psychiatrists employed (exclusive of psychiatric residents).

Availability of service: In addition to being available to students, we learned these services are made available to faculty (32), to employees of the health service (25), and at some schools, to families of students (18). It appears that these practices are not too common, probably because it increases the cost considerably.

Confidentiality of communication: We wanted to obtain some picture of the kind of relationship which exists between such units and the individual student, who as a rule does not remunerate the therapist directly. We felt a question about the degree of confidentiality of the communication would allow some inferences about the kind of relationship which exists. It was noteworthy that 88 schools reported that the material is kept strictly confidential. Seven schools practice a limited sharing of the information with the health service staff only. Five schools stated that communications from the student were shared with the school administration upon request, a practice which seems dangerous, indeed.

Separate fees: University health services in general are financed by a fee system, the health fee, which is paid by the student in addition to his tuition when he enrolls. This practice has been traditional and has gained wide acceptance. In some instances the fee is stated separately, in other instances the student does not know how much it is. This fee, which covers all health services whether earmarked or not, includes also whatever mental health

services are available. We were not concerned in this survey with the method of financing health services. Moore and Summerskill[4] have detailed data on this. We were interested, however, in how many schools had additional charges for psychological services or charged for psychotherapy. We found that only 12 schools made separate charges to the individual student when they received long term therapy. Eighty-four schools made no additional charges to the individual who received psychiatric service. In other words, the practice of making the few individuals who receive such service responsible for part of the great expense, as opposed to the total student population paying for it, has gained acceptance in only 12 schools.

Operational data: Our questionnaires provided data pertaining to the number of patients seen and the number of interviews per patient. From these figures other values could be calculated. The figure which particularly interested us was the percentage of the total student enrollment seen. When the values for all 99 institutions were averaged, the mean was 4.7 per cent. The median, 5.2 per cent was close to it. The range was from 0.61 per cent to 40 per cent. We were surprised that there was such a wide range, but the 40 per cent figure was an exception and for one small institution. From the questionnaire we deduced that these were primarily screening interviews where a large number of individuals were seen one time. Most institutions were reasonably close to the mean. This figure is interesting in view of the assumption that has frequently been made that a well run service will see about 10 per cent of the student population. This is clearly formulated in a report on college psychiatry in 1950 by the Group for the Advancement of Psychiatry.[6] In the light of our findings this figure may have to be revised; five per cent seems to be more reasonable and accurate. Aside from a few small colleges where as much as 15 to 40 per cent of the student population is seen in one hour screening interviews, our questionnaires reflect that even in well organized and adequately staffed services, the percentage of enrollment seen may be only as high as 6.5 per cent. Any higher figures reflected primarily screening practices. It appeared that the greater the enrollment, the smaller the percentage of the enrollment which was seen, even though the units in larger universities have a larger staff.

We were able to calculate the number of interviews per patient, and the mean was 4.8 interviews per patient (median = 3.4) with a range from one to nine. The larger the school, the greater was the mean number of interviews per patient. Figures about the cost of operation showed a wide range from $300 to $93,000 a year. The latter figure should be qualified because it is an exceptionally high figure and from a large Eastern school which has a special endowment for this purpose. The mean cost of operating a mental health unit yearly was $11,200 with considerable variation up and

down. More significant, perhaps, is cost per enrolled student which varied much less and was $2.50 (median $1.90, range from 17¢ to $12). Such figures may be useful when plans for new units are made by school administrators. One could estimate that the yearly cost of a mental health service at a school with 5,000 students would be around $12,500 or higher. One can generally expect that about 5 per cent of the student body or about 250 students would make use of these facilities in an average school year and that the average number of interviews per student would be five.

Summary

While mental health facilities in colleges and universities have existed for several decades, there has been no complete survey made of them since 1936. In an effort to assess the present available facilities, their staff and operation, this survey was undertaken in 1953 when a questionnaire was sent to 1141 colleges and universities in the United States and Canada.

There were 728 replies. About half of them stated they had some kind of resource available on the campus ranging from "some organized program" (30 per cent) to a "well organized counseling service" (7 per cent) to specific mental health facilities which included a psychiatrist or psychologist or both on the staff of the Student Health Service (14 per cent). The other half had either no facilities whatsoever or were using various resources which were not created for the purpose of dealing with emotional problems in students.

The report of this survey discusses all the available resources and, in detail, those special units which are a part of a student health service and are under psychiatric direction. Detailed data about the personnel, staff activities, cost of operation, kinds of services, proportion of student enrollment seen, and number of interviews per patient are given. Comparisons are made with data obtained in 1936.

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MENTAL HEALTH RESOURCES IN CHURCHES

By THOMAS W. KLINK*

Churches are increasingly concerned about the mental health of their parishioners. This concern is attested to pre-eminently by the steady increase of supervised clinical pastoral training for seminary students and pastors—a movement whose beginnings were formalized in 1925 by the organization of the Council for Clinical Training of Theological Students, and whose purpose is to provide an institutional "internship" for would-be pastors.[1]

The profusion of literature on pastoral psychology is a further indication of the current interest of the churches. The techniques and theory of psychological treatment have become a major stimulus for theological writings.[2-4] Concepts of group work, reinforced by a theological framework of concerns, are applied increasingly within the churches.[5] And, in the traditional "life-crisis" functions of the clergy—baptism, marriage, burial—dynamic psychological concepts are being studied for new light on the conduct of ancient offices.[6-8] Finally, in a few interesting but atypical churches, therapeutic or counseling services are provided on a professional basis in church sponsored clinics or through specially trained ministers of counseling.† Although some description of this type of church service agency will be offered here, it cannot be noted too emphatically that *the principal service of the churches to mental health is through the normal ministries of* parish pastors. Further, such service is to be found not only in self-conscious "pastoral counseling," but in the enlightened use of the milieu of the church with its opportunities for service, recreation, group life, and its unique resources of worship, liturgy and sacrament.

As a sample of the setting for such services is the following abstract made by a pastor in a small (275 member) Protestant church in a stable single-home neighborhood of a metropolitan Western city. The abstract represents situations of chronic or acute personal distress noted at the end of two years as pastor:

> Two members in a state hospital. One having been in and out of the hospital for a number of years with a chronic functional psychosis. The second having

* Chaplain, Topeka State Hospital.

† Indirectly but intimately connected with the concern of the churches for mental health is the growing practice of psychiatric screening of candidates for ordination as pastors. This has been a practice of some of the missionary agencies of the churches in selecting candidates for foreign service for almost two decades, *c.f.* Christensen, Paul W.: The Role of the Psychiatric Consultant to a Seminary. *J. Pastoral Care* 9: 1-7, 1955.

> just been admitted after increasingly withdrawn behavior had suggested to the pastor the value of professional consultation. The suggestion for professional help was relayed to the parishioner's family at the pastor's initiative and led, upon a psychiatrist's recommendation, to commitment.
>
> Two members receiving professional psychotherapy. One with an anxiety tension state that had taken her to the physician with heart complaints. Another suffering from feelings of failure and incompetence shortly after her 44th birthday.
>
> One adolescent girl, acutely disturbed and on the verge of a schizophrenic break, receiving the attention of the public school "visiting teacher" in cooperation with the pastor. She came to the pastor's notice following a temper outburst when a very close girl friend began dating boys.
>
> An overprotected only son (a "momma's boy"), a college junior, mutely devout in the regularity of his church attendance with a chronic disabling mucous colitis.
>
> An elderly woman of talent and professional training facing loss of sight with as yet inoperable cataracts. This same woman had nursed her own aged mother for six years while the mother was blind with a similar condition. Neighbors spoke of her "acting queer" following her mother's death at which she had been noticeable for her lack of apparent grief.
>
> A Sunday school teacher of Greek Orthodox background, an enthusiastic convert to her new church, being sued by her husband for divorce on ground of infidelity.
>
> A 16 year old boy of well-to-do parents acting out his feelings toward his divorced parents by wild driving which brought him into contact with the courts and led him to "escape" a court action by arriving unexpectedly at a week of church summer camp.
>
> A brother and sister in their early 20's, closely attached and beginning to be irritated by the joking comments from contemporaries about their closeness.
>
> A 17 year old boy slipping into a pattern of vagabondage, disappearing from home for days and weeks without notice. He reported to the pastor at his mother's insistence and described his experiences with strong suggestions of his acceptance into a homosexual "society." This boy, with one eye permanently damaged by a boyhood accident, was the older child in a family where the father was in a state hospital, the mother a driven, dominating leader in women's activities and the step-father, a kindly but ineffectual putterer around the garden.
>
> A Japanese-American business man struggling with the problem of his father's senility in business decisions and his race's traditional respect for age.
>
> A four year old boy of a mother who had lost a husband through death (the boy's father), then divorced a second husband; the boy acting out his feelings in acts of unusual destructiveness and aggression in the Sunday school.

These situations were in addition to the usual round of marriages, baptisms, and funerals. They are listed here without elaboration of their management by the pastor because, in most cases, they were never brought to the pastor as problems—they merely furnished the backdrop of awareness against which the pastor's work of visiting, religious education, and youth leadership took place.

One pastor completing a period of clinical pastoral training noted with

some accuracy, "The pastor is the last amateur in a world of specialists. In my church I am counselor, business manager, occupational therapist, group therapist, psychiatric social worker, priest, vocational rehabilitation aide and referee all rolled into one." His remark testifies not only to the exasperations of the ministry but also to the varied nature of the church's resources for mental health.

Specialized Church Services to Mental Health

In a very few places churches have provided more specialized services, in addition to the normal pastoral ministries. These situations appear to fall into three groups: the minister of counseling, the pastoral counseling agency, and the church-supported multiprofessional clinic employing psychiatrists, psychologists, social workers and ministers on a treatment team. One of each of these is described as follows:

The Minister of Counseling. In a number of churches, usually large "downtown" congregations, a specially trained "minister of counseling" has been added to the staff. The following excerpt is from a letter to the writer by the minister of counseling in a large suburban Protestant church:

> The counseling service here originated three years ago because of the obvious and growing need. At that time there were three full time ministers on the staff of this church, ministering to a congregation of nearly three thousand members. In addition, this is a "downtown" church in a large suburb, and almost daily the church is called upon for some kind of help from strangers who have no connection with the church. So, a psychologist was hired to do counseling. This man was not an ordained minister, and his experience had been largely in school guidance work. After one year he left the church and went back into school work. At this point I was hired to be part time counseling minister on the staff. I am an ordained minister with some training in psychology and counseling. . . .
>
> The intention of the church was to provide a counseling minister to relieve the load on the other ministers, although they continue to do some counseling too. I do not think it has ever been part of the church's intention to establish a large clinic. However, the work load slowly but surely increases. I have established contact with various psychiatrists and psychologists and welfare agencies in the community to whom I can make referrals as necessary. We turn no one away; we either try to help them ourselves, or refer them to more appropriate sources of help. My work includes counseling with people who have some particular problem they wish to work through, with people who have definite neurotic patterns, and occasionally someone who might be classified as prepsychotic. In cases of severe anxiety or depression, or an obviously psychotic pattern, I make referrals. I feel that more and more my work should include preventive therapy through groups and programs in the church. To this end I am working very closely with a newly organized "Family Life Committee." I also handle most of the premarital counseling here. . . .

Pastoral Counseling Service. Associated with Boston University School of Theology is the Pastoral Counseling Service, established in 1952. This center is staffed by clinically trained pastors enrolled as candidates for the

doctoral degree in pastoral psychology at Boston University. Small folders, freely distributed in churches and to social agencies offer the facilities of this center in the following terms:

> Have you ever wished that you could sit down with someone you trusted and talk over your problems?
>
> There might be an annoying little fear that others think silly, a decision that you have to make, a difficulty that you have in getting along with others, a question about the meaning of life, or your relationship with God.
>
> Whatever the concern if you would like to talk about it with an understanding clergyman you can find him here. . . . Each counselor believes in religion and in the resources it has for troubled persons, and each one accepts people just as they are. . . .
>
> One interview may be of help to you, or a series of weekly visits may be found to be more helpful. It may be, as you and the counselor work together upon your problems, that somebody else in the Greater Boston Area can be of help. All matters you discuss in the interviews will be held in confidence. . . . There is no charge for interviews, but those who wish to do so are encouraged to give voluntary contributions.

The 1954 annual report of this center includes the following statistics:

Total Number of Persons Interviewed		216	
From the Community	180		
From the University	36		
Referrals from:		No.	Per Cent
Clergy		101	47
Self		59	23
Friends, Relatives		18	8
Center Staff		11	5
University Personnel		11	5
School of Theology		10	5
University Chapel		3	1
Physicians		2	.9
Newspapers, Radios, etc.		1	.5
Referrals to:		No.	
Private Psychiatrists		12	
Psychiatric Clinics		5	
Family Service Assn.		2	
Child Guidance Clinics, Legal Aid, Student Health, Pastors		12	
Classifications of Problems		No.	Per Cent
Marriage		94	44
Anxiety and Guilt		33	15
Self-Emergence		28	13
Parent and Child		21	10
Vocation		15	7
Psychoses		8	4
Sexual Deviations		5	2
Grief		4	2
Health Problems		4	2
Social, Economic Problems		4	2

The Church Clinic. Typical of the few church professional clinics is the American Foundation for Religion and Psychiatry founded by the Rev. Norman Vincent Peale, pastor of New York's Marble Collegiate Church, some 15 years ago. Currently licensed by the state of New York as a mental health clinic, it was reported in 1953 to have a staff of sixteen psychologists, psychiatrists and ministers. Two of the staff, Kew and Kew[9] analyzed some 3700 interviews and summarized the first 260 consecutive cases seen:

Epilepsy	1
Simple Adult Maladjustment	2
Pseudoneurotic Schizophrenia	4
Psychosomatic Complaints	5
Hysterical Anxiety	5
Involutional	7
Psychopathic Personality	8
Requesting Information	9
Character Neurosis	10
Anxiety State	10
Alcoholism	12
Situational Problem	12
Schizoid	14
Reactive Depression, Manic Depressive	17
Obsessive Compulsive	18
Anxiety Neurosis	27
Schizophrenic, Latent	28
Psychoneurosis, Mixed, Paranoid, etc.	54
Miscellaneous	17
Marital Problems (not included in total of 260 cases, but classified according to psychiatric diagnosis)	61

No charges are made for services but clients are encouraged to make donations to the budget of the clinic.

Conclusions

The concern of the churches for mental health is of pre-eminent concern to the writer and one cannot help being impressed by some of the developments. However, in the midst of enthusiasm, a certain degree of critical detachment and historical perspective can be sought. Thus, one notes the historic fact that the role of the priest or pastor in any religion is not only determined by the education and intent of the clergy but by the needs and expectations of the people. This stubborn, irrational element will not be set aside by a couple of generations of clinical enlightenment as any acquaintance with TV healers makes clear. Further, the writer is impressed by the peripheral status of health in the concerns of religion, historically. Religion's basic concerns are theological and medicine's empirical notion of health as

absence of crippling symptoms is of only secondary importance in the eyes of religion when set against the central goal of salvation. It would be misleading to confuse any partial therapeutic alliance with ultimate identity of purpose.

Finally, it should be noted that the concern of pastors for mental health has moved in a full developmental curve from initial resistance, through wholesale adoption of psychological goals and techniques, to an increasingly discriminating application of psychological insights and methods to the peculiarly religious tasks of the church. Unfortunately, in the view of the writer, there are too many instances in modern church life where, as in individuals, this development seems to have been fixated at a "gulping" stage or has moved onto the last stage of enlightened self-consciousness too quickly, before essential developmental tasks have been completed. The only available remedy for such problems known to the writer is supervised clinical pastoral experience.

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EMPLOYEE COUNSELING IN INDUSTRY: OBSERVATIONS ON THREE PROGRAMS*

By HARRY LEVINSON, PH.D†

In the course of the Menninger Foundation Survey of Industrial Mental Health,[1] there have been frequent questions about the details of various kinds of "emotional first-aid stations" in industry. In response to these queries, two leading psychiatric programs[2] and a psychiatric clinic for the treatment of alcoholism[3] were described previously. This paper describes and discusses three formal counseling programs in industry which are "psychological" in orientation, in contrast to "psychiatric" or "social work." The three programs have in common an emphasis on nondirective counseling, commonly identified with psychology, rather than on treatment or casework.

These programs were selected first, because their respective companies, organizational structures, methods and objectives are sufficiently varied that together they represent a broad sample of such counseling practices in industry; and second, because of their historic, pioneering roles in industry. One of the three, that of Prudential Life Insurance Company, is now defunct. The other two, those of the Western Electric Company and the Caterpillar Tractor Company, are currently in operation.

The Three Programs

Western Electric. After interviewing some 20,000 employees in the course of the now classical experiments[4] at the Hawthorne (Chicago) plant of the Western Electric Company from 1927 to 1932, the investigators reported two discoveries,[5] both significant although elementary knowledge to anyone with clinical training: (1) The complaint, as stated, was frequently not the real source of the individual's difficulty. Consequently, action based on the *manifest* content of the complaint did not assure that the underlying difficulty would be eliminated. (2) With the opportunity to express themselves freely, the employees were able to more clearly formulate their complaints, and in many cases the complaints disappeared entirely. In addition, many employees developed a new enthusiasm for their work as they talked out their problems and lost some of their tensions.

These considerations led to the development of the Western Electric counseling program, formally organized in 1936 as part of the Industrial Relations Branch, which became the precursor of all other nonpsychiatric

* A brief report from the Menninger Foundation Survey of Industrial Mental Health.

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industrial counseling programs. Inasmuch as the interviewers who had participated in the research were supervisors and other plant employees, it was perhaps only natural that those who became counselors should also come from the ranks. Forty such persons, 20 men and 20 women, made up the original counseling force. Contemporary counselors are specifically employed for the job, but, like their pioneer predecessors, have no formal preparation as counselors. They are supervised and given in-service training by six supervisors under the direction of the Chief of the Personnel Counseling and Training Division.[6]

Employees are counseled by persons of the same sex. Each counselor is assigned a given territory within the plant where he serves between 300 and 400 employees. He seeks to integrate himself in the work group, relating himself to everyone in the same impartial way, but remaining outside the social relationships which are organized around the work itself. He is deliberately not given any formal authority lest, on one hand, such authority become a barrier to free communication between counselor and counselee, and, on the other hand, lest an authoritative person outside the immediate work relationships undermine the position of the supervisor.

Thus the counselor becomes familiar with the employees, the shop processes, the social relationships in the shop, and supervisory and administrative practices, but he does not enter into the power relationships of the shop. He makes himself available to the employees and supervisors in informal contacts on the floor of the shop or in a small interviewing room where the employee can talk in privacy. Most counselees are seen from one to five times. Some are counseled for a year or more.

Counselors are concerned exclusively with "bringing about adjustments and changes in employee (and supervisory) attitudes through the interviewing method itself."[5] Interviewing in this case means to maintain a neutral, confidential listener's role. The orientation is nondirective, no probing, no implication of analyzing the employee. But the counselor may, by asking questions, "direct the employee's thinking into those areas which he needs to take into account in order to achieve an adequate adjustment."[4] The counselors do not diagnose, give advice or prescribe. W. J. Dickson, who set up the counseling program, felt that, "This procedure avoids many of the problems of transference which arise in clinical interviewing which would be difficult for a layman to handle."[4]

Being neutral means absolute confidentiality. All the records which the counselor keeps are his property, not that of the company. It also means that he can in *no way* take action upon any difficulties, complaints, or grievances which he learns about in his interviews, seek to create changes within the organization, or make referrals.

In attempting to bring about adjustment, the "counselor's sole object

is to lead the employee to a clear understanding of her problem such that she herself comes to realize what action to take and then assumes responsibility for taking it."[4] He enhances the employee-supervisor relationship when either the employee, or the supervisor adjusts more effectively to the work situation,[6] or when both employee and supervisor, after talking to the counselor individually, find their relationships more congenial. Through his teaching contribution to supervisory training, through generalized "feed back" on employee's reactions to policies and practices, and through interviews with management representatives as they come to his section, the counselor communicates problems of the social structure. The major focus, however, is on the adjustment of the employee.

Dickson claims[5] the following advantages for this kind of counseling: emotional release and relief of tensions; stimulation of the employee to reexamine his ideas, beliefs and fantasies with a view toward reappraising them; creation of a stabilizing force for the employee in the employee-counselor relationship; avoidance of attaching a stigma to the employee who seeks counsel by relating the counselor to an entire work group; provision of counsel without disrupting normal work routine; early detection and dissipation of emotional disturbances.

Prudential Life. In October, 1948, twelve years after the Western Electric program had been initiated, the Prudential Life Insurance Co. established a counseling center in its Newark home office.[7]

The Prudential program differed in several ways from that of Western Electric. Its staff was made up of "people with prior specialized and professional training in interviewing conducted for the purpose of helping clients solve problems" because "it is easier to take professionally trained people and teach them something about the company than it is to draw employees from the ranks and try to teach them the techniques of counseling."[8] Dr. John A. Bromer, a psychologist, was director of the center. Two other psychologists and a social worker comprised the staff. There was only one center for counseling. Counselors did not initiate contacts with employees. Clients were not necessarily assigned to counselors of the same sex. The counseling center was avowedly and publicly a mental hygiene service.

The goals of the Prudential program were improved morale, greater job satisfaction, and increased friendly relations between the company and its 11,000 home office employees.[7] "When members of the home office feel the desire or the need to discuss something in their day-to-day work situations or anything else that troubles them, we want them to be able to do so," the personnel vice-president wrote the employees.[9] All employees were eligible to use the center. The focus was on normal people who were "interested in improving their understanding of themselves and others or in learning how to get along better with their fellow men."[8]

The counseling center was responsible to the vice-president in charge of personnel, but was separate from personnel administration. It had neither administrative responsibility nor authority.

As at Western Electric, the center kept no formal records and such notes of its interviews as it did keep were strictly confidential within the center itself. It had no contact about the employee-client with anyone else in the company.

Although its orientation was basically nondirective, direction and interpretation were sometimes used, following the methods suggested by Super.[10] It was Bromer's thinking that nondirective counseling avoided the anxieties and hostilities which he felt were likely to be aroused by more clinically oriented diagnostic and evaluative programs conducted by clinical psychologists and psychiatrists.[8] Persons whose problems might be dealt with more adequately by psychiatric or case work services were referred for such services. Employees who sought answers to specific questions about community resources, training opportunities, or administrative routines within the company were given direct answers. Budget planning and financial advice were given, as well as vocational guidance and counsel on emotional problems. The counseling staff administered and interpreted interest and aptitude tests. Results of these tests could be referred to the personnel department upon the request of the employee if he were seeking a job change.

In its first full year, 331 clients visited the center for 983 counseling sessions, ranging from 1 to 20 consultations per client.[7] More than half of those who sought the center's help were men, although two-thirds of the employees in the home office were women. Although most of the clients who used the center were rank and file employees, managers and supervisors, proportionally speaking, made greater use of it. More than half of the problems brought for discussion involved the job or the work situation. By the end of 1952 the counselors had seen 1,500 people representing one-sixth of the working group. In addition, the staff was frequently consulted by executives on ways of handling personnel problems.

Caterpillar Tractor. The Caterpillar mental health program grew out of the interest of Dr. Harold Vonachen, medical director of Caterpillar Tractor Co., and Dr. M. H. Kronenberg, manager of medical services at the Peoria plant. The program was designed jointly by these men and a team of psychologists and psychiatrists from the Cornell Medical Center.[11] A mental health section was created in the medical department.[13, 14] From its inception in 1945 it was conceived as "a comprehensive program endeavoring to cover all phases of human behavior for the improvement of mental health."

The present staff of the mental health section includes the director, an industrial psychologist, two other industrial psychologists and a clinical

psychologist. Each of the industrial psychologists has also had some training in nondirective counseling and has some acquaintance with projective techniques. Counseling techniques range from the permissive and nondirective to authoritative advice. Local psychiatrists serve as consultants. The contemporary work of the section falls into three major areas—selection and placement, employee counseling, and supervisory development.

The current functions of the counseling service are: (1) to administer minor psychotherapy; (2) to consult with supervisors on the management of employee problems; (3) to furnish psychological test data with interpretations to company physicians; (4) to assist in arranging transfers, job changes, and medical leaves of absence for persons with emotional difficulties; (5) to assist employees and management in referrals of severe emotional adjustment problems to private and community care; (6) to consult with physicians and supervisors relative to post-treatment rehabilitation and adjustment of employees who have undergone severe mental and emotional disturbances; (7) to maintain case records on all reported cases of employee adjustment problems.

All interviews are confidential. All test information and all counseling information is regarded as medical information and accessible therefore only to persons in the medical division. Only progress and behavior on the job are discussed with supervisors.

Employees may go to the mental health section for counseling of their own accord, or they may be referred by physicians, supervisors or their personnel office. In 1954 there were 4,239 consultations with employees or with management about employees. No counselee has to appear for interviews after the initial contact. He may terminate counseling at any time. All kinds of company records are used to guide the counselor: safety, personnel, medical and foremen's. With the employee's knowledge and consent, contacts are made with the plant and family physicians, social agencies and the counselee's family, if the counselor feels it necessary. Severe emotional problems are referred to the family physician first with the recommendation of additional referral to a psychiatrist. Employees who demonstrate psychotic disturbances on the job are escorted home, or, with the help of the family, to the hospital.

The unique aspect of the work of the mental health section is its collaboration with the personnel office. Every applicant is routinely given psychological tests by members of the mental health section. These include the Cornell Word Form and a modification of the Cornell Selectee Index.[15] If there are indications from the latter test that the applicant has severe psychological problems which might make him unemployable or which would require that his placement be given more consideration than usual,

one of the psychologists in the mental health section sees him in a personal interview. About fifteen per cent of the applicants are so seen for an evaluation of the severity of their problems and for recommendations regarding their placement. Applicants who are thus interviewed may be recommended for general placement within the organization, for a limited placement, or not recommended at all. If the mental health section decides that Caterpillar should not employ the applicant, this decision is regarded as a medical decision and interpreted to the applicant as such. He is then advised, on the basis of his test results and interviews, about the kind of work he might profitably seek.

A study[11] of more than 500 case histories of persons referred for consultation from January 1, 1948 to May 15, 1953 disclosed that out of 130 cases which were sufficiently detailed for analysis and evaluation, 82 per cent of the persons improved in various degrees and in the remaining 18 per cent there was no evidence of improvement in the employee's emotional health.

Discussion

The historic contribution of the Western Electric program was that this company was among the first to recognize the importance of the personal tensions and feelings of its employees. Furthermore, the company recognized the importance of providing an avenue for the discharge of tensions and for the expression of feelings. This implied that such feelings were regarded as natural, that they were accepted as the usual customary behavior of all human beings and that they were of such importance that the company was willing to provide for their relief as it would provide for the relief of medical emergencies. Taken together, all this tended to create a greater feeling of dignity on the part of the employee.

The merits of the Western Electric approach, as with any other approach, depend upon the situation to which it is adapted. The counselor in such a situation thoroughly knows the work environment and everyone in it. By enabling employees to ventilate their problems, he makes it possible for many to better mobilize their own strengths. At the same time the limitations of his listening technique preclude his getting into dangerous areas beyond his competence. The technique itself militates against any manipulation of the employee and this readily apparent advantage must make the employee feel quite comfortable about talking to a person whom he perceives much as "a friend in need." Seeing the counselor for help becomes a matter of casual everyday talking as one would talk to any interested friend. Another advantage is the opening up of an additional anonymous channel of communication with management.

Western Electric has a medical department and a personnel department

which carry the responsibility, respectively, for treating and referring persons who are ill and for evaluating and placing job applicants and employees. Western Electric does not want its counselors to have anything to do with these other aspects of the company functioning because a counseling service in that company which operated differently than the present method would tend to create other problems. To expect diagnostic and referral services, vocational guidance or other clinical activity from the Western Electric type of program is to expect something for which the program was not designed.

To the Western Electric precedent Prudential added the status and proficiency of a professional staff. The implication here was that not only were an employee's tensions or feelings important enough to warrant the company's providing a way for their expression, but they were sufficiently important to provide a person professionally skilled in understanding and eliciting feelings. Furthermore, the Prudential program gave recognition to the fact that, often despite its therapeutic advantages, the expression of thoughts and feelings alone was not enough to solve a given problem. Two things were added therefore. First, the Prudential program brought the social resources of the community to bear on the problem. Second, it provided an objective evaluation of the employee's aptitudes and interests, when needed, so that he might better determine the direction in which he would like to go. Finally, the Prudential program gave full recognition to the fact that people's everyday tensions and feelings are related to their health, by clearly defining its work as mental hygiene.

As at Western Electric, there were certain things which the Prudential company handled outside the counseling service such as morale studies and medical problems. Prudential clearly defined the role of the counseling service as dealing with employees' emotional problems in a counseling relationship. They did not envision a more broadly clinical kind of situation, preferring that clinical problems be dealt with by the medical department.

The Western Electric and Prudential programs operate almost as autonomous units within the respective companies. That is, in contrast to most other operations of the business organization, their highly confidential relationships together with their limited contacts outside their own services preclude any detailed supervision of or knowledge of their work on the part of management or other departments in the same organization. This kind of autonomy is extremely important to counselors and those who are being counseled. Yet there are certain dangers. For example, it is easy for such a department to become isolated, and isolation can mean the gradual withering and ultimate death of any program. It is critically important that continuous efforts be made to acquaint the rest of the or-

ganization with the work of the counseling service and with its contribution to the mission of the business organization.

The structure of the Caterpillar program provides another avenue for avoiding the danger of isolation, through its integration of medical, personnel, training, and supervisory functions. As was the Prudential program, it is directly tied to the community and thereby able to coordinate company and community facilities in the interest of the employee with problems. It also has constantly available to it, as tools in the counseling process, all the objective measures of job adjustment and job potential, both physical and mental, that the company provides.

The Caterpillar approach has two other major advantages: 1) Direct contact between the counselors and supervisors, where there is an exchange of information about any given problem (without violating confidences) and cooperation in its solution, permits a certain amount of environmental manipulation in the interest of the troubled employee. 2) By being a part of the medical department, the counseling service has the advantage of the traditional acceptance of the medical department by the employees as a source of help.[16]

Transcending the major advantages and limitations of the three programs is the degree of daring required of the three corporations in establishing their programs. Certainly the industrial relations climate of 1936 was not one conducive to a departure such as Western Electric's program. Nor had the climate improved by 1945 and 1948 to the point where either Prudential or Caterpillar would feel compelled to institute counseling services because others were doing so. The experience gained by the three corporations has helped provide important guides for those who will follow.

Summary

The pioneer counseling programs of the Western Electric Company, the Prudential Life Insurance Company and the Caterpillar Tractor Company are described and discussed. These programs differ widely in scope, method, degree of integration within the parent organization and in the type of business they serve. They have in common a primarily nondirective approach to the adjustment of the employee to his work.

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EXPERIENCES IN A PRISON HOSPITAL*

BY NORMAN GRAFF, M.D.†

Can a therapeutic environment†† be developed in a prison hospital? The answer is Yes, but there are many problems and pitfalls, as might be anticipated. In the literature[7-11] are certain discussions which emphasize the conflict between custody and therapy viewing the goal of custody and the therapeutic goal of the psychiatrist as diametrically opposed and irreconcilable. The conflict is a real one but it has been my recent experience that the problems are more complex than is expressed in the generalities of the controversy.

I was assigned as a staff psychiatrist to the Medical Center for Federal Prisoners at Springfield, Missouri in July 1953. This institution has been assigned the care and treatment of sick men who have been incarcerated for violation of federal statutes since September 30, 1933. Patients are received from all other federal penal institutions as well as directly from court. The afflictions from which these men suffer include all the most serious physical and mental disorders.

The medical staff is provided by the U. S. Public Health Service, with a consulting staff of local specialists. The Medical Center is essentially a thousand bed prison-hospital, which is divided into medical, surgical and psychiatric sections. The latter section is further divided into an acute and chronic section, with a total inpatient population of about 500. My specific assignment was staff psychiatrist in charge of the closed or acute intensive treatment unit consisting of 117 rooms, isolated from the rest of the prison. The rooms are divided into three wards, which are graded custodially into (1) maximum security, (2) medium security, and (3) an "improved" unit.

The maximum security ward is distinguished by having more officers and greater restriction in the freedom of the inmate-patients. It is a re-

* The views expressed in this paper are those of the author, and do not necessarily reflect official opinion of the U. S. Public Health Service, or the Federal Bureau of Prisons.

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†† Milieu therapy has been recognized as a method of making the total hospital experience of patients of some therapeutic value. Work at the Menninger Clinic[1-3] recognized quite early that the inter-relations between members of the staff and the patients could have positive or negative therapeutic implications. Accordingly, a program of in-service training and orientation in the principles of psychoanalytic psychiatry, and the application of these principles to the concrete problems of treating residential patients was begun. Formal as well as informal meetings and conferences have evolved in order to study the effect of intra-staff attitudes on patients and are discussed more frequently in the recent literature.[4-6]

ceiving ward for acutely disturbed patients, but is also utilized for punishment purposes when patients classified as "psychotic" (for administrative reasons) commit infractions of prison discipline. The security aspects of the unit make it convenient to house inmates who are escape risks, and inmates who are hazardous to the general welfare of the institution because of their poor judgment and lethal propensities.* Ten rooms are referred to as "strip" cells, since they are barren except for a mattress or steel bed. A hole in the floor serves as a toilet facility.

The patients occupying these facilities are totally dependent upon custodial personnel for food and water, and even to flush the drains (controlled from outside the room), not to mention for less basic but equally fundamental requirements of life such as tobacco and reading material. The medium security unit and improved unit have a dormitory-like atmosphere, but provide individual rooms for the patients which are furnished with a hospital bed and mattress, steel bedside table, lavatory and toilet. The men in these units are in general recovering from acute psychoses, or they are patients who are chronically ill and unable to make a satisfactory adjustment in the general prison environment which is referred to as "population."

The personnel assigned to the acute unit from the medical staff, include two full-time psychiatrists and a medical technical assistant who supervises the administration of insulin therapy. The custodial branch of the prison assigns a complement of ten correctional officers for each eight hour period. The education training branch of the prison, is also under the administrative echelon of custody, and provides the services of an occupational therapist for the unit. A senior custodial officer, called the desk officer, is responsible for the administrative work of the unit as it pertains to custodial matters and it is through him that the psychiatrist in charge of the medical mission of the unit must work. In this way, the desk officer has a dual function, in that he implements the therapeutic objectives of the unit, and at the same time is responsible for its security. He must have the respect and confidence of the officers who work in the wards. Without his effective cooperation, the therapeutic program cannot succeed.

The relationship which develops between the inmate-patient and the custodial personnel (functioning in the dual capacity of psychiatric aide and guard) is highly important and may influence the patient's mental illness and his total adjustment to imprisonment. The newly admitted patient is not only suffering from his illness but is defensive about his social status, concerned about the length of his sentence, fearful that shock treatment will be used to punish him and suspicious of the motives of personnel as they represent society.

* Nosologically, this group of patients falls in general into the paranoid personality category with occasional transient acute psychotic episodes in response to increased intra-psychic pressures, or pressures from the general prison population.[12]

The psychiatrist in charge of the unit has a regularly scheduled weekly appointment with the occupational therapist, parole officer, medical technical assistant, and his assistant psychiatrist, to expedite supervisory functions, and to consider intra-staff as well as staff-patient relationships. He meets daily with the desk officer to consider the problems of the unit as a whole as well as the welfare of individual patients. In addition, the psychiatrist has the responsibility for directing the organized recreational program, and prescribing therapeutic activities for patients. These activities include library, movies, church, organized athletic competition with other units, educational training, and occupational therapy. He also administers the electro-convulsive therapy, and prescribes somatic therapy* when indicated.

Even though I was familiar with locked wards, I felt very uncomfortable as I walked to my unit through the maze of tunnels in the prison. I felt the inquiring, measuring stare of the inmates and the officers as I walked down the corridors. I was frightened, anxious, and reluctant to be assigned to this unit, and just as determined to conceal these feelings from myself, as well as the personnel. As I entered the unit, the officer announced, "Doctor's coming in." (I felt very small to be heralded in such a loud voice.) I glanced around the ward, noticing the concrete floor, the double tiers of steel cell doors looking out on the enclosure where the patients are housed. The upper tier had a catwalk and was enclosed by a wire mesh. Each door had four window-panes, but three of them were covered with opaque green paint and the faces of my patients peered at me through the remaining quarter panes.

The conducting officer told me about various patients, with careful attention to their respective merits as human pulverizing machines. He related with some concern how the last psychiatrist had had his nose broken and suffered minor lacerations by not heeding his advice. I went forward numbly to meet my patients. As the doors were opened, I was flanked by four officers, and as I stepped forward with outstretched hand to greet the

* The insulin coma and subcoma program utilizes standards acceptable to the American Psychiatric Association. Approximately eight patients receive insulin coma at any given time, this being the maximum number which can be handled safely with existing facilities. Similar standards are maintained for electro-convulsive treatment. Provision is made for observation during the post-convulsive recovery period by a member of the nursing staff. This program has varied from as many as 30 patients receiving electro-convulsive therapy, to as few as two to four patients. Criteria for treating any individual patient with somatic therapy are evaluated by the neuropsychiatric staff of the institution. Hydrotherapy in the form of continuous flow tubs and cold wet sheet packs is utilized when indicated.

patients and introduce myself to them, they returned my handshake somewhat mystified. I was informed that I had broken with tradition by entering the room without the officers, calling the inmates "Mister" and by shaking hands. I was immediately aware that the officers regarded my behavior with some dismay and suspicion. I was on trial by my patients, and the officers as well. That afternoon, I received several notes from patients who resided in other areas of the prison, congratulating me upon what I had done.

At this point, I found I was identifying myself with the patients, having more in common with them at this moment (psychologically), than with the custodial officers with whom I was to work. I had expected to be on trial with the patients but not with the officers, and the schism was broadened subsequently by other events.

The following day, a young man serving a 15 year to life sentence became disturbed, broke the lavatory bowl with his bed, and hurled pieces of porcelain through the windows and at the officers who came to subdue him. During the ensuing melee, his hands were cut and bleeding. I was called by the desk officer, and found the patient standing in the corner of a strip cell, naked, and shouting vile imprecations at the officers, and at officials of the Bureau of Prisons, and Public Health Service doctors, whom he blamed for his plight. I walked into the room, and asked him why he was frightened of me. He was startled, and denied vehemently that he was frightened of anyone. I pointed out that it was my experience that when people stood in a corner, with their backs to the wall, that it usually meant that they were afraid. I commented further that it was unlikely that I could harm him, since he was twice my size. I asked then if I could examine his hands, and help him with his injuries. For a moment he hesitated, then laughed, and permitted me to examine and treat his lacerations. While the officers commented favorably about the incident, I felt that they resented the contrast between their handling of the patient and mine, since their initial suggestion had been to enter the room and forcibly subdue him.

As the patients sensed the stiffness of my relationship with the custodial personnel, the turbulence in the wards increased, culminating in another episode when a patient became disturbed and attempted to assault a guard with a mop handle. This was reported: "The patient went berserk, destroying Government property, and said it was the fault of that damned psychiatrist." When it was discovered that the patient had suffered injuries which were greater than should have been necessary to subdue him and an investigation ensued, my relationship with the custodial personnel bogged down completely. The guards felt hostile toward me for the pressure which was brought to bear upon them during the investigation, and complained that I was "on the side of the inmates."

The "cold war" which followed resulted in the pharmacy doing a brisk business in sedatives, as the patients responded to the stalemate between the figures of authority with increasing agitation. At this point, I tended to accentuate the wide gap between the way they were treated by me and by the other personnel. I was unaware of my own role in stimulating this turbulence and self-righteously noticed how antitherapeutic the custodial personnel were.

The in-service training program,[18] involving all of the personnel working in conjunction with the unit gradually became the place where the areas of disagreement could be brought out into the open and discussed. At first, the ward meetings dealt with administrative matters affecting custody, and excluded all medical problems of the patients, except custodial hazards. This emphasis changed slowly to a consideration of the patients' illnesses and the effect of the ward personnel on the patients' course in the hospital. In these meetings, the staff became acquainted with the psychiatrist as a person, and I became aware of them as individuals, instead of regarding them collectively. The clarification of our respective roles, resulted in such tangible features as the reduction in the use of physical restraints to a total of three times in 18 months.

Fortuitous circumstances were utilized for teaching purposes. For example, when the occupational therapist was accidentally locked in a room with one of the patients, he was able to provide the group meeting with a vivid account of his feelings of anxiety. He recalled how at first, he gazed out the window, and studied the room carefully, particularly the door. The patient in the room broke into his reverie, saying solemnly, "It helps to look out the window." He tried to appear unconcerned when he knocked on the door, hesitantly at first, and then with increasing violence, finally kicking at the door with his heels to attract attention. The patient watched the therapist's increasing desperation and remarked, "All new fish feel like that when they first hit the tank." When the therapist was released, the other employees laughed at his discomfiture at first, and then examined his reactions seriously in the light of similar behavior on the part of newly incarcerated patients.

As time passed, the personnel rotated and our relationship improved as we worked together, and tried to understand each other. I found that the custodial officers have the same prejudices as other uninformed laymen regarding the manifestations of mental illness. They are perplexed by patients who distort reality as a symptom of their illness, and are disturbed when their attempts to be solicitous are met with rebuff. They hold strong moral convictions regarding the individuals' social offenses. They have to sail between Scylla and Charybdis continuously, if they are to satisfy their superiors, the higher echelon of custody (who hold the opportunities of

increase in grade), and the psychiatrist who represents the echelon of ther-
apy and who functions most frequently in an area which is mysterious to
them. As our separate responsibilities and areas of symbiotic functioning
were clarified, the patients reflected the improvement with better ward
behavior. For a time, I found myself over-identified with custody, and
concerned with contraband items coming into the unit. This has been
described by Powelson and Bendix[10] as "Making compromises for the sake
of teamwork," which in its essence, is placing the retention of the patient
in primary focus, and his needs for treatment in a secondary position.

The custodial personnel manifested their change in attitude in the fol-
lowing ways: Electro-convulsive therapy was no longer suggested as a
control measure for a disturbed patient. Patients were not hauled like
limp sacks of flour to their rooms and dumped on their beds, in full view of
the other patients, to recover from the effects of their treatment. The
paint was removed from the windows, and patients were no longer stripped
of their clothing and left to sleep on concrete floors when they were dis-
turbed. The change was epitomized ironically, "The fellows that used to
work here tell us that it's not like the old days, when they had all those
dangerous and assaultive patients."

The "climate" of the ward changed, despite a residue of chronically ill
patients. The unit won the softball league championship. The year before,
they were not permitted to use a full-size bat because it was considered a
lethal weapon. The unit became cheaper to operate because of the de-
crease in breakage. For example, an electrician formerly worked full-time
to keep the radios in order as they were being destroyed by patients. Only
three radios out of 78 had been damaged in the past year by acutely dis-
turbed patients. No lavatory porcelain had been smashed or hurled as a
weapon in 20 months. The officers working in the units now made sugges-
tions for improving the ward, or for the handling of a disturbed patient so
that he could remain on an improved unit and benefit from the program
available, instead of bundling him off to the maximum security section the
moment his behavior appeared unusual.

These changes have had a drastic effect on some of the patients. For
example, the patient whose hands I had dressed following his injuries, be-
came quite friendly and complained if I did not see him frequently. He had
intermittent episodes in which he became acutely delusional, begging that
he be killed quickly instead of being tortured to death and saying that he
knew that the officers planned to burn him alive. During one such episode
he was in a sedative tub on his birthday, and I arranged for a birthday
cake to be brought to him. He broke down and wept, saying that it was the
first birthday cake he had ever had, and here he had received it in prison
from people whom he felt showed him no sympathy or understanding. It

would have been impossible to carry through such a therapeutic gesture
without the cooperation of the custodial personnel. His adjustment to the
hospital had been satisfactory for the past 10 months, the first peaceful
period in his lengthy history of incarceration including Alcatraz.

Areas of conflict still exist. For example, officers working with regressed
patients complain about their untidiness and urge deprivation of simple
pleasures (such as smoking) to coerce recalcitrant patients to clean their
rooms. There is a resistance toward accepting patients' behavior as a
manifestation of illness, and a tendency to explain bizarre behavior as con-
scious willfulness, or "putting on an act." It is difficult for them to refrain
from suggesting punitive attitudes as being potentially therapeutic. (This
is in keeping with the basic philosophy of imprisonment.) Sometimes, the
activity program grinds to a halt, unless the desk officer and ward doctor
are vigilant, the patients somehow do not get out to the "yard" (recrea-
tional area), or their period of recreation is cut short. It is much easier to
keep men locked up than to work with them when they are out of their
rooms, and there are many adherents to this philosophy who are not vocal
but persistent.

Conclusions

The fundamental lesson to be learned from this experience, in the opin-
ion of the author, is that the basis of the therapeutic program of such a
unit stands or falls on the relationship which develops between the psy-
chiatrist in charge of the unit and the officers who translate his ideas into
action. The prison environment exerts a subtly corrosive effect on the psy-
chiatrist's professional judgment. He becomes accustomed to having his
opinions go unchallenged. The in-service training program helps him
maintain a critical introspective eye on his tendency to consider his opinion
infallible. This is true for both custodial officer and psychiatrist. A schism
between the goals of custody and therapy is not inevitable if the attempt
is made to educate custodial personnel to the value of an active therapeutic
milieu in terms of greater job satisfaction for them.

To establish an effective therapeutic program in a prison-hospital, the
psychiatrist must understand the dual function of the custodial officer,
and similarly, the officer must be educated to accept his responsibility for
treating the sick inmate as a patient, as well as being his custodian. Such a
program cannot succeed without the cooperation of the administrative
echelons of custody and therapy at higher levels. To maintain the efficacy
of a program which develops from the joint efforts of the psychiatrist and
the supervisory custodial officer, a continual in-service training program
for the staff of the unit is mandatory.

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BOOK NOTICES

The Collected Papers of Otto Fenichel, Vol. II. Hanna Fenichel and David Rapaport, eds. $6.50. Pp. 374. New York, Norton, 1954.

The second volume of Fenichel's collected papers, which cover his work during the last 24 years of his life, carefully edited again by Drs. Hanna Fenichel and David Rapaport, completes this monument dedicated to the memory of a creative psychoanalyst. The papers and reprints from different psychoanalytic and psychiatric journals include also some translations of papers that were published in German periodicals. It is impressive to see how much of modern ego psychology these papers contain and how much they predict, or rather condense, present theoretical and technical interests within psychoanalytic science. Students and scientists alike will find this and the original companion volume invaluable source books which stimulate one to explore new paths, the beginnings for which were hewed out so carefully and skillfully by Fenichel. (Rudolf Ekstein, Ph.D.)

Female Sexuality. By Marie Bonaparte. $4.50. Pp. 225. New York, International Universities, 1953.

The many intricate problems of female sexuality are studied in this book by tracing their beginnings in infancy through all phases of development and in adult life. The biological, psychological and social aspects of femininity are carefully reviewed in a manner which greatly enriches psychoanalytic theories of female sexuality. The vicissitudes of male sexuality are much better understood than those of female sexuality; therefore, a careful study of this book is essential to all students of psychoanalysis. (Lewis L. Robbins, M.D.)

The Clinical Interaction. By Seymour B. Sarason. $5. Pp. 425. New York, Harper, 1954.

Interpersonal and situational factors in diagnostic testing and psychotherapy are discussed and well illustrated with clinical and experimental examples. The bulk of the book is a replication of the Rorschach test as administered and interpreted by the author, with references to recent experimental and theoretical contributions to Rorschach rationale and significance of specific vectors. It is a useful text for graduate students of clinical psychology. (Walter Kass, Ph.D.)

The Urge to Persecute, By A. Powell Davies. $2.75. Pp. 219. Boston, Mass., Beacon Press, 1954.

This book is another in the growing literature of protest against the erosion of civil liberties. The author, a Washington minister, has produced an entertaining, emotional and literate analysis of McCarthyism (or "bullyism" as he calls it). Mr. Davies is concerned not only with McCarthy and his imitators but also with the "little people" who cheer their performance. Davies uses psychoanalytic, psychological, sociological and moral concepts in his analysis. The results, as one would expect, are heavily weighted on the moral side. To sum up, this is a one-sided analysis of a modern controversial problem—not a scientific study. (William H. Key)

Therapeutic Abortion. HAROLD ROSEN, ed. $7.50. Pp. 348. New York, Julian Press, 1954.

This symposium with twenty-one articles includes discussions of the medical, psychiatric, anthropological, legal and religious aspects of the highly complex problems of contraception and therapeutic abortion. Most of the chapters are written by psychiatrists, including one by Dr. Karl. Among the other authors are an anthropologist, several rabbis, ministers and a priest, and two obstetricians and gynecologists. This book provides the reader with a broad background against which he may review his own opinions on these controversial subjects. (Lewis L. Robbins, M.D.)

Principles of Industrial Psychology. By THOMAS ARTHUR RYAN and PATRICIA CAIN SMITH. $5.50. Pp. 534. New York, Ronald Press, 1954.

"Motivation can be considered as a central problem of industrial psychology," according to the authors, but by the time they have come to this statement they have already written 350 pages in the traditional statistical vein of industrial psychology. Theirs is "conscious psychology"; the unconscious is denied. The newer contributions of social psychology are passed over quickly. Little attention is given to the emotional problems of the workers as such. The authors demonstrate a healthy skepticism of much of the data of industrial psychology and a commendable sense of responsibility with respect to the use of personality tests in industry. (Harry Levinson, Ph.D.)

The Origins of Psychoanalysis, Sigmund Freud's Letters. MARIE BONAPARTE, ANNA FREUD and ERNST KRIS, eds. $6.75. Pp. 485. New York, Basic Books, 1954.

In Freud's letters awaits a rich mine for the student and scientist interested in the origin of psychoanalytic science and in the development of it and of its founder who there permits (originally against his intentions) insight into his creative work. The slow development of psychological theory, freed from the straight jacket of the 19th century physiological concepts, is exemplified by the "Project For a Scientific Psychology," precursor that it is for the seventh chapter in *The Interpretation of Dreams*, and nuclear ideas that it contains for the development of modern ego psychology. It suggests the enormous problems involved in freeing man from customary patterns of thinking which have become sterile as new observations require new conceptualization and new theories. The facts of Freud's relationship to Fliess, if used as a model for interpersonal conditions for creative work and of learning, will prove important. The impact of this excellent English translation will increase, as will the impact of psychoanalysis itself, with time. (Rudolf Ekstein, Ph.D.)

The Only Child. By NORMA E. CUTTS and NICHOLAS MOSELEY. $3.50. Pp. 245. New York, Putnam, 1954.

The belatedness of this review stems partly from the time required for resolving certain ambivalences in the reviewer provoked by the earnestness of this effort to study an important problem by two competent educational psychologists with an almost complete omission of any psychodynamic considerations. It was for him like reading a guidebook about California written before automobiles were invented. It brings home to some of us how naive we are in assuming that *our* conceptions of child psychology are generally known or generally accepted. The book is good normative sensible parental counsel on an important topic; as the authors point out in the foreword, there are over 200 articles on this subject but only one book and it is in Dutch. (K. A. M.)

Stuttering: A Psychodynamic Approach to Its Understanding and Treatment. By DOMINICK A. BARBARA, M.D. $5. Pp. 304. New York, Julian Press, 1954.

From his own stuttering, personal analysis, and clinical work with the problem, a psychoanalyst surveys the subject of stuttering. The discussion, based on the views of Karen Horney, is eclectic, lacking comprehensive psychoanalytic formulation. An informative chapter reporting an original "Study of Stuttering in Psychotics" suggests equivalence of pathogenic processes in psychosis and stuttering. Evidence cited from Jelliffe and others concurs with Menninger Clinic observations of stuttering masking an underlying schizophrenia which may be unleashed by removal of this symptom through speech correction or psychotherapy. (Walter Kass, Ph.D.)

Psychosurgery and the Self. By MARY FRANCES ROBINSON and WALTER FREEMAN. $3. Pp. 118. New York, Grune & Stratton, 1954.

In this small but well-focussed book, the authors report new and interesting data in support of the hypothesis that "psychosurgery alters the structure of the self through reduction of the capacity for self-continuity." The concept of self-continuity, and the several ingenious tests for its assessment, should remove this book from shelves limited only to the psychology of prefrontal lobotomy and place it among contributions to personality theory and measurement. Psychologists in particular, will be interested in Robinson's appendix "For Other Investigators," in which the Self Regarding Span Test, the Test of Self Concern, and the Sensibility Questionnaire are carefully and lucidly described. (Helen D. Sargent)

The Technique of Psychotherapy. By LEWIS R. WOLBERG. $14.75. Pp. 896. New York, Grune & Stratton, 1954.

Dr. Wolberg has attempted in this almost encyclopedic volume to cover virtually every aspect of psychotherapy. His approach is eclectic including contributions from all schools of dynamic psychiatry. Included are comments on the types of psychotherapy, general principles of psychotherapy, the different phases of treatment and the special problems that may be encountered in each, supervision of psychotherapy, recording. At the end there is also a detailed case history and the appendix contains a number of outlines and forms which the author has found useful. Because of the wide area which Dr. Wolberg has covered it has not been possible for him to discuss any topic in great detail; however, the book is a useful reference. (Lewis L. Robbins, M.D.)

The Practice of Dynamic Psychiatry. By JULES H. MASSERMAN. $12. Pp. 790. Philadelphia, Saunders, 1955.

Masserman presents us with a textbook of psychiatry of great breadth and length—39 chapters and numerous appendices. It is by all means the

most ambitious text ever published in America, and bears the stamp of his individualistic approach and his wide erudition. Something is said about almost every aspect, relationship, and viewpoint of psychiatry, and there are numerous historical and philosophical inserts. (The use of the letters written to referring physicians and others regarding certain patients is an unusual method of presentation.) Sometimes there is a little too much condensation; for example, religion and civilization and the concept of self do not quite fill one page, to which another partial paragraph on primal narcissism is given. There are over 150 case reports. I do not agree with some of the rather dogmatic conclusions and generalizations, but in the main it is a good, if rather big, book. (K. A. M.)

The Psychoanalytic Study of the Child. Vol. IX. RUTH S. EISSLER and others, eds. $7.50. Pp. 369. New York, International Universities, 1954.

The high standards set by the editors have been kept up in this volume which contains three large sections: Problems of Infantile Neurosis; Problems of Normal and Pathological Development; Technique. The first section contains the Anna Freud discussions on infantile neurosis and presents an attempt to bring clinical views in line with modern theoretical development. The second section has a variety of contributions on developmental problems ranging from the development of the self concept, problems of motility, play patterns, to problems of intellectual development and perception. The third part is concerned with technique, one of the contributions describing work from one of our own local departments: The Southard School. I do not know if my repeatedly expressed wish for an index will influence editors and publishers. Because the issues covered are of such a wide range, the index would permit the less acquainted reader and student to find specific problems that are of special interest to him. (Rudolf Ekstein, Ph.D.)

Neuropharmacology. Transactions of the First Conference. HAROLD ABRAMSON, M.D., ed. $4.25. Pp. 210. Packanack Lake, N. J., Josiah Macy Jr. Fdn., 1955.

The Macy conferences, bringing together annually groups of distinguished scientists of disparate disciplines for free discussion, have brought to readers of the published transactions illuminating insights into current research and the qualities of original scientific thought. This volume is the first of a new series on neuropharmacology, with ten scientific disciplines represented among the discussants, Hudson Hoagland serving as chairman. Topics discussed in this conference include pharmacologic effects on brain circulation and metabolism, introduced by Kety, functional organization of the brain, introduced by Scharrer, electroencephalography in relation to anesthesia, the ascending reticular system, and new convulsants. An index is included. (Samuel Zelman, M.D.)

Techniques that Produce Teamwork. By WARREN H. SCHMIDT and PAUL C. BUCHANAN. Pp. 75. New London, Conn., A. C. Croft, 1954.

This primer of group leadership should be a useful text for supervisory training programs. It is written simply, but does not "talk down." The major points are clearly outlined and well illustrated. Emphasis is on democratic group sharing. Self-examination and readiness on the part of the team leader to change himself are advanced as the basic premises on which democratic team functioning is built. (Harry Levinson, Ph.D.)

Holiness is Wholeness. By JOSEF GOLDBRUNNER. $1.75. Pp. 63. New York, Pantheon Books, 1955.

Influenced by Jung's psychology, the author, who is a philosopher and theologian, formulates in this small volume some rich and drastic thoughts on the plight of man in his striving for holiness. The "cure of souls" is sought in a new anthropological "holism" in which body and soul are synthesized under the guidance of the three virtues: faith, as the creative attitude towards fear; hope, as the principle of spiritual renewal; love, as the meeting of Eros and Agape. This is not just an abstract outline of a program, but a scholarly essay full of critical notes on traditional Christian attitudes towards asceticism. (Paul W. Pruyser, Ph.D.)

Administration, Supervision and Consultation—National Conference of Social Work. $1.50. Pp. 114 New York, Family Service Assn., 1955.

Papers from the 1954 Social Welfare Forum are evidence of efforts in social work to integrate content in the further refinement of methodological skills. These papers on social work practice raise some provocative questions in relation to the conceptual framework in the areas of practice and teaching. Such efforts should be encouraged not only to analyze present practice, but to further re-examine the basic hypotheses of social work in relation to the current social structure. This selection of papers on administration, supervision, and consultation are worth the attention of those interested in these dynamic processes. (Mildred T. Faris)

The Study of Personality. By HOWARD BRAND. $6. Pp. 581. New York, John Wiley & Sons, 1954.

Intended as a source book of original papers on theory, methods, and significant problems comprising a "cross section of research in personality," the present volume falls short of providing a representative selection of work in the field. Although Sullivan, Mullahy, and Alexander, as well as such academicians as G. Allport, Cantril, and Eysenck find a place (and deservedly so), the contributions of writers like Erikson, Kris, and Hartmann—not to mention both Freuds—are conspicuous by their absence. Several papers by less widely known authors, however, provide pleasant and stimulating surprises; notably, Brian A. Farrell's paper on the testing of psychoanalytic theory. (Howard Shevrin, Ph.D.)

Clinical Psychiatry. By W. MAYER-GROSS, ELLIOT SLATER and MARTIN ROTH. $10. Pp. 652. Baltimore, Williams & Wilkins, 1955.

The reader who goes beyond the introduction of this English book, with its diatribe against American psychiatry, will find a broad, nonspecific discussion of the standard syndromes based primarily on "constitutional and physiopathological causation." There are no case histories. There are long chapters on geriatrics and forensic psychiatry, the former presenting chiefly neuropathology. (Herbert C. Modlin, M.D.)

Woman's Mysteries, Ancient and Modern. By M. ESTHER HARDING. $4.50. Pp. 256. New York, Pantheon Books, 1955.

This study about women is a woman's attempt to interpret femininity from a developmental point of view in terms of analytical psychology. Myths and ancient and modern rituals are the source materials for the book. The author finds the essence of feminine psychology to be relatedness or what Jung called the principle of Eros. She asserts that in modern times

allegiance has been given too exclusively to masculine forces but that the ancient feminine principle is beginning to reassert its power, not in the old guise of projection into the form of a goddess but as an unconscious psychological force. (Dean Johnson)

Making the Most of Marriage. By Paul H. Landis. $5.50 Pp. 542. New York, Appleton-Century-Crofts, 1955.

This book has a strictly functional approach to marriage and the family. It is similar to many of the other functional books in that it uses extensively the traditional research studies. However, it differs from many books in that it places more emphasis on the interrelationship of men and women and parents and children. The book places less emphasis on the mechanical aspect of finances, sex, in-laws, and more consideration is given to the ego and affectional needs and the role, expectations, and aspirations of each person. Because of this latter orientation, the book makes an important contribution to the literature in this field. (Robert Foster, Ph.D.)

Progress in Neurology and Psychiatry, Vol. 9. E. A. Spiegel, M.D., ed. $10. Pp. 632. New York, Grune & Stratton, 1955.

This new yearbook covers the literature of 1953 in five chapters on the basic sciences, nine on neurology, six on neurosurgery and 15 on psychiatry. There are several excellent essay-type chapters which go beyond a mere abstract of papers or an enumeration of facts. An interesting new feature this year is a review of five years progress in experimental psychology. (Paul W. Pruyser, Ph.D.)

Adjusting to a Competitive Economy—The Human Problem. M. J. Dooher, ed. $1.25. Pp. 48. New York, Amer. Management Assn., 1954.

This series of papers, presented at the Manufacturing Conference of the American Management Association, is concerned with techniques for managing people. The warm and informal paper by Paul D. Arnold on the way in which human needs are recognized in the Arnold Bakeries stands in sharp contrast to the remaining papers which are preoccupied with how to do things *to* people. (Harry Levinson, Ph.D.)

Casework Papers—National Conference of Social Work. $2. Pp. 150. New York, Family Service Assn. of America, 1955.

A compilation of fourteen selected papers given at the 1954 National Conference of Social Work by social workers, psychiatrists and related disciplines is presented. The first eight of these papers from a unit devoted to the subject of helping and understanding the child, with a good deal of useful and stimulating discussion of the dynamics of parent-child relationships. Other topics included are group treatment of the unmarried mother, medical services in rehabilitation, problems in case recording, and evaluative research in social casework. (John F. Roatch)

Truants from Life. By Bruno Bettleheim. $6. Pp. 511. Glencoe, Ill., Free Press, 1955.

The second volume in a planned series which describes the Sonia Shankman Orthogenic School of the University of Chicago continues a description of residential treatment through case histories of four children who needed a total therapeutic environment. This volume, like the first, is imperative reading for those who help people, adults or children, through the resources of a residential treatment institution. From the case histories, the fragmented, distorted, disorganized life of disturbed children is vividly portrayed against the background of an institution which serves as a consistent, absorbing, therapeutic force in the child's integration and growth. (Arthur Mandelbaum)

The Clinical Interview, 2 Vols. By Felix Deutsch and William F. Murphy. $17.50. Pp. 948. New York, International Universities, 1955.

The senior author of these two big volumes has maintained for many years that patients can be interviewed in a certain way which will permit a psychoanalytically trained interviewer to detect unconscious problems, which he can then re-introduce to the patient in an acceptable form and with a therapeutic effect. The first of these two volumes has to do with the diagnostic aspect, the second stresses the therapeutic aspect.

Verbatim interviews are (bravely) recorded with patients who have depressions, chronic headaches, phantom limb pain, asthma, convulsions, arthritis and other things. The reader is then introduced to what is called "clinical sector psychotherapy," which seems to mean electing a critical area of attack.

This reviewer cannot entirely follow either the theory or the interpretation of these authors, and although he is one who thinks highly of charts, he was disappointed to find himself unable to understand numerous case charts and diagrams offered. One of the first patients described is a woman brought in on a stretcher because of a post-lumbar headache. After this had been explained to the doctor twice, he asked why it was that she was on the stretcher. He faithfully records that she told him for a third time that she had been sick. When he replied to this information by repeating the word "sick" with a rising inflection, she patiently explained again that she had vomited and had a headache. The authors pick up the word "headache" and again throw it at the poor patient with a questioning inflection, commenting to the readers that this is a suggested threatened loss of the head and is a key word! When the patient explained for the fifth time that she had had a lumbar puncture, she was asked why she thought the headache came from the lumbar puncture.

This sort of thing, however well intended, can understandably alienate neurologists and internists from any sympathy with psychoanalytic interpretations. Nevertheless, eminent colleagues praise the usefulness of the method described in the book as a teaching device for psychiatric residents. I do not concur with that point of view. (K. A. M.)

Clinical Neurosurgery. Vol. 1. Congress of Neurological Surgeons. $8. Pp. 201. Baltimore, Williams & Wilkins, 1955.

The Congress of Neurological Surgeons is justly proud of the acclaim granted to its first four meetings. At each of these meetings a senior neurosurgeon presents a paper in a field of his own particular interest on each of the three days of the meeting. "Clinical Neurosurgery" consists principally of the masterful presentations made by Sir Geoffrey Jefferson of Manchester, England, at the meeting of the Congress in New Orleans in 1953. It thus establishes a precedent for future editions of these transactions. The

author of these papers is mellowed with experience, practicality, good judgment, and a sense of humor. Of particular interest is the chapter on "Compression of the Optic Pathways by Intracranial Aneurysms." (Robert P. Woods, M.D.)

Memoirs of My Nervous Illness. By DANIEL PAUL SCHREBER. (Ida Macalpine, M.D. and Richard A. Hunter, M.D., trs. and eds.) $5. Pp. 416. London, Wm. Dawson & Sons, 1955.

Ida Macalpine and her son have put us all in their debt by this carefully prepared translation of Judge Schreber's memoirs. The introduction states that this retranslation has discovered numerous errors in the official translation of Freud's study. I confess great personal satisfaction in the authors' emphasis on the artificiality of the existing divisions of mental disease, even the division into neuroses and psychoses. I find satisfaction also in the complete concurrence of the authors' definition and historical review of paranoia with one which I recently prepared. Many weaknesses in Freud's analysis, some of them pointed out by himself, are listed, and the authors' own theory of the Schreber illness as a reactivation of unconscious archaic procreative fantasies is developed. (K. A. M.)

An Outline of a Comparative Pathology of the Neuroses. By LUDWIG EIDELBERG, M.D. $4.50. Pp. 263. New York, International Universities, 1954.

Apparently this book is designed to meet the needs of students of psychoanalysis. In spite of its limited size, it attempts to present in a simplified didactic form a very wide range of topics: from the theory of instincts, the unconscious, defense mechanisms, and dreams, to symptom neuroses, neurotic character traits, perversions, psychopathy, addiction, and psychoses. The author's interest in studying and reviewing psychoanalytic terminology and his ambition to advance what he calls the quantitative approach in psychoanalysis seems to have been sacrificed for the sake of clarity, categorization, and conciseness. (Ishak Ramzy, Ph.D.)

Delinquent Boys, the Culture of the Gang. By ALBERT K. COHEN. $3.50. Pp. 202. Glencoe, Ill., Free Press, 1955.

The author, a sociologist, submits a theory that most male delinquents are from the "working class" subculture found in sections or neighborhoods of large cities. This theory, however, does not attempt to explain all types of delinquent behavior. Amongst other things he emphasizes that the delinquents' "choice of symptoms" is often based on their associations with other boys who are having similar difficulties in adjusting to their communities. The research in social psychology offers more leads to understanding the delinquent than research based on "psychogenic theories" since the author's orientation is sociological. The annotated bibliography at the end of this stimulating, provocative book provides some excellent research material for further investigation of this complex problem. (Edward D. Greenwood, M.D.)