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PROBLEMS OF NARCISSISM

H. G. VAN DER WAALS, M.D.*

Author's Note: Baffled by the ambiguity of the term "narcissistic" and the controversies to which it gave rise, this author, some 25 years ago, undertook a study of the development of the concept of narcissism as it appeared from the literature up to 1939. From this originated an essay, published in Dutch, entitled "'Narcissistic' Problems of Narcissism" (*Psychiatrische en Neurologische Bladen*, Vol. 43, 1940, pp. 537–628), establishing that defining narcissism in terms of the libido theory (*i.e.*, id terms) does not meet the requirements of an understanding of narcissistic phenomena from an ego-psychological point of view. In a paper "Narcissism and Ikarism" (*Psychiatrische en Neurologische Bladen*, Vol. 44, 1941, pp. 613–634) the author contrasted normal and pathological developments of narcissism. Part of the author's conclusions were presented in a report to the Douzième Conférence des Psychanalystes de Langue Française, Paris, 1949: "Le Narcisme: Étude Théorique" (*Revue Française de Psychanalyse*, Vol. 13, 1949, pp. 501–526). The prominent place accorded to ego-psychology in present-day psychoanalytic theory encouraged the author to a review of his ideas in light of the literature of the last 25 years, some aspects of which are presented in this paper. It was read at The Hampstead Child-Therapy Clinic in May, 1965, and is a modification of a paper presented to The Topeka Psychoanalytic Society, November 19, 1964.

The theory of narcissism, in spite of its importance, has been a source of confusion and controversy from its inception to the present day. Even a correction of the history of its development occurred, if unintentionally and not as an improvement of the past, in the Russian manner. Both Waelder[1a] and Jacobson[3] recently stated that it was the behavior of paranoid schizophrenics which incited Freud to introduce the concept of narcissism. As a matter of fact, Freud[4] in his main essay on the subject distinguished neatly between "the strongest of the reasons which have led us to adopt the hypothesis of narcissism" (the "narcissistic" object-

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choice of homosexuals) and "a pressing motive for occupying ourselves with the conception of a primary and normal narcissism" (the attempt to subsume what we know of dementia praecox under the hypothesis of the libido theory).

We had better not overlook this first part of the history of the concept of narcissism, for taking it into account protects us against some misconceptions which hinder the full understanding of the concept. Following the path indicated by observations of Havelock Ellis,[14] Näcke[15] and Sadger,[16,17] Freud[5,6] arrived at his first concept of narcissism as a normal, perhaps unavoidable phase on the way from autoerotism to object-love, in which one's own body is made a love-object as a synthesis of initially isolated autoerotisms. A complete dissociation from narcissism was deemed necessary, which shows that Freud at that time had not yet recognized normal narcissistic phenomena in later life.

This concept of narcissism is predominantly a *psychological* one, derived from the phenomenological sphere. Narcissism was considered to be a transient stage of self-love, starting sometime after birth and disappearing completely in normal development; according to this concept, narcissism resembled a temporary perversion. As narcissism was either a transient normal or a pathological condition, there was sense in calling an individual "narcissistic." Narcissism was believed to be antithetical to object-love. According to this conception, narcissism in the course of psychic development diminished quantitatively, but did not change qualitatively. A paper by Rank,[18] still close to Freud in these years, reveals how relatively late in development self-love was thought to come into being, *i.e.*, introducing puberty, or at least becoming more clear then. The self-love of this first concept of narcissism is object-directed, the object being the self, or part of the self, obviously requiring mental representation of the self and parts of it. Freud, of course, was well aware of this; in recent years, however, it had to be rediscovered.

In "On Narcissism," Freud[4] established that narcissism constitutes a far more general problem. Libido concerns not only the objects, but also the self all through life. Although never stated by Freud in this way, on the psychological level man all through life aims at acquiring and maintaining a positive self-feeling, of which an appreciative attitude toward the self is an important part. To use the words of Joffe and Sandler:[10] "The striving to attain a state of well-being . . . exists as a biological goal." I would prefer to formulate it thus: The ability to enjoy life is biologically determined, man being a pleasure-seeking creature, enabling him to get satisfaction out of living in spite of minimal feelings of well-being and safety. Narcissism in the sense of the first concept, disappearing completely in the course of development, is replaced by a wider concept: narcissism which develops simultaneously with object-relationships.

In this essay Freud maintains the view that autoerotism precedes narcissism. Not until the "Introductory Lectures"[7] was the beginning of narcissism relocated toward the beginning of life: the child is born in a primary narcissistic condition. This is, of course, no longer a psychological concept, but a deduction from the libido-theory, which does not fit the original psychological concept of self-love. Psychologically there is not yet a self, nor a nonself. Whatever sensory-affective awareness the neonate may have, the immediate data it provides "have no owner yet" (*Wittgenstein*).

This libido-theoretical notion of a primary narcissistic condition needs some psychic content, in order to become of psychological importance. The answer to the question as to what this psychic content may be is still as controversial as it was some 30 years ago. In defining loving as "the relation of the ego to its sources of pleasure," Freud[8a] makes us understand how autoerotism, "the sexual activity of the narcissistic stage of allocation of the libido," is the source from which love of the self originates, and of course not only love of the self, but love in general. "Love is derived from the capacity of the ego to satisfy some of its instinctual impulses autoerotically by obtaining organ-pleasure."[8b] Love derived from autoerotism provides a link between the fully developed metapsychological concept of primary narcissism and the psychological one of self-love. Sandler[20] pointed to the feelings of well-being and of safety the infant probably experiences as another link.

The autoerotic phase, originally not belonging to narcissism, has now become the primary narcissistic phase, in which the libido still seems completely bound to primitive bodily gratifications, rightly called autoerotic if only in the sense that the newborn infant does not yet know objects dissociated from himself which he can connect with this libidinal gratification. This seems to be the meaning of Freud's[9] remark, "What psychoanalysis regards as the essential point is not the genesis of the excitation, but the question of its relation to an object." This interpretation assumes that Freud had a *psychological* relationship in mind in

using the words "relation to an object." Nagera,[24] in his interesting study *Autoerotism and Ego-development*, does not share this assumption. He believes that with the words "relation to an object" Freud refers to an actual physical-biological relationship to an object (from the viewpoint of an observer), which determines whether a given sexual activity is autoerotic or not. His conclusion, that sucking at the mother's breast is consequently not an autoerotic activity, in contrast to sucking one's own finger, which is an autoerotic activity, does not seem to be of particular psychological importance. It has been observed that a neonate almost immediately after birth started to suck his thumb before having had any contact with the nipple. Thumb-sucking, according to this observation, seems to be based on an inborn mechanism, and therefore, too, biologically determined. Is this thumb-sucking to be considered autoerotic or not; and, if so, what is the psychological difference between it and sucking at the mother's breast?

From primary narcissism, ego-development leads to a condition approaching what was originally called narcissism, the direction of the libido toward the own person as a somatic and psychic entity. This is clearly dependent on ego-development, which enables the child to add to his *being* a self, a *having* a self as an object by means of psychic representation. A next step in the development of self-love as conceived of by Freud is the formation of the ego-ideal, due to which narcissism, in a progressive sense, obtains a lasting place in the individual life. Freud introduced the ego-ideal as a stage in the development of narcissism, enabling the child to go on loving himself in the sense of the original narcissism, and stressed the primitive narcissistic nature of the ego-ideal, the wish to maintain an unrealistic self-love. In later formulations Freud made it perfectly clear that, by means of the ego-ideal, the child also tries to find a form of self-love compatible with positive object-relationships. Sandler and his co-workers[21] brought together the evidence regarding this point.

Within the framework of the later concept of narcissism, the term "narcissistic" has become extremely ambiguous. The fact that the concept of narcissism was introduced into psychoanalysis in connection with severe pathological conditions made it difficult for many authors to conceive of mental health as having anything to do with narcissism. Waelder,[2] 10 years after the appearance of Freud's main essay, did not think it irrelevant to argue at some length that a narcissistic man is not

necessarily psychotic. More recently Waelder[1b] found reason to point out that it is a mistake to believe that narcissism is in any form or degree a pathological phenomenon. Normal narcissism, he states, is a basic prerequisite of psychic health, meaning "a basic acceptance of oneself and love of oneself regardless of one's shortcomings. . . ." This sounds a little like advocating an unconditional self-love, but I cannot believe Waelder to be of the opinion that unconditional self-love is the essence of normal narcissism.

When we speak of a "narcissistic personality," what do we have in mind, in view of the later concept of narcissism? Obviously, we mean that there is some peculiarity in the way a person tries to maintain a positive self-feeling. What we actually refer to is the structure of his narcissistic organization, determining his object-relationships and his attitude toward the world and himself. Freud was also a pioneer in the distinguishing of types of narcissistic organizations or structures. The narcissistic woman, labeled by Freud as the "most pure and genuine" type of woman, and his narcissistic-libidinal type of personality are both called narcissistic, in spite of the fact that as far as their object-relationships are concerned they are opposites. The narcissistic woman wishes to be loved passively, the narcissistic-libidinal type wants to love actively. Maybe the most valuable thing in Freud's later conception of narcissism is that he opened our eyes to these great and important differences in narcissistic structures, showing us various ways along which man can aim at maintaining a satisfactory narcissistic equilibrium in his dealings with the object-world. It hardly needs mentioning that these various ways can be more or less well adjusted to inner and outer reality.

Narcissism and Object-Love

Let us consider the consequences the widening of the concept of narcissism has for our understanding of the relationship between narcissism and object-love. The mysterious transition from presumably objectless primary narcissism to the first object-relationships, I will pass over for the moment. Within the framework of Freud's later concept of narcissism it is patently out of the question to see in the relationship of narcissism and object-love no more than a quantitative problem of libidinal cathexis. Freud's theory of the ego-ideal implies that qualitative changes arise in narcissism hand in hand with the developing and changing object-relationships. His *amoeba pseudopodia* image does not

adequately represent the changes in narcissism in the course of ego-development. Nevertheless, I believe that Freud's *reservoir* image retains a limited validity for each stage of narcissistic development. Working on this paper required a shift in my cathexes. Enjoying doing it brought me somewhat closer to Narcissus, at my wife's expense.

Some authors use the terms "narcissistic-libido," "ego-libido," and "object-libido," introduced by Freud, in a way suggesting that there are qualitative differences between the three as forms of energy. We read, for example, of a cathexis of objects with narcissistic-libido, in contrast with other cases in which this is done with "real" object-libido. We are also faced with the surprising opinion that at a certain stage of development the narcissistic-libido has largely changed into object-libido. To speak of object-cathexis with narcissistic-libido suggests that "true" object-love is completely free of any narcissistic trend. This idea is a remnant of Freud's original notion that narcissism is antithetical to object-love and ought to disappear completely in the course of psychic development. A closer look at adult object-relationships reveals their roots in the narcissism of the later concept, for it shows the narcissistic aspects characterizing every object-relationship, although the narcissistic phenomena involved may belong to different levels of development.

The same may be said of the narcissistic factors determining particular object-choices. No matter what differences in quality are shown by the wishes and desires for which gratification is sought in the love-relationship, they are certainly "narcissistic" in the wider sense of the concept. I have not even touched on the narcissistic desires that are not satisfied, leading to the failure of so many love-relationships. People whose egos are well matched seem to satisfy each other's secondary narcissistic needs reciprocally in the manner described by Ferenczi[28] as typical for a mutually satisfying sexual relationship: giving satisfaction to one another by actually pursuing personal egoistic wishes. Ferenczi calls these wishes "egoistic"; I see no objection to calling them "narcissistic." The wider narcissism concept not only refers to what is primitive in man, but also comprises what is noble and sublime.

To me it seems undeniable that in the later stages of development, narcissism and object-love are not rigidly contrasted. In normal development, narcissism modifies itself in such a way that it becomes compatible with full object-love. Even though a completely tensionless condition will never arise, as the narcissistic needs of an ego can never be completely satisfied by an object, this does not change the fact that in normal development narcissism and object-love become more and more dependent on one another. Object-love, and therefore "object-libido," has its narcissistic aspects, and is even inconceivable without these unless the ego is willing to discard completely its interests, needs, values, norms—briefly, its way of living. Also, in the field of love, charity begins at home; he who has no charity for himself will not have charity for others.

This conclusion seems to me in good agreement with a later development in Freud's theory. Freud[7b] originally termed the energy of the sexual drives "libido," that of the self-preservative drives "interests." Calling narcissism the libidinal complement to egoism, he held it possible "to be absolutely egoistic and yet maintain powerful object-cathexes, insofar as libidinal satisfaction in relation to the object forms part of the ego's needs . . . ," and also "to be egoistic and at the same time to be excessively narcissistic—that is to say, to have very little need for an object . . ."

As a consequence of the later theoretical assumption that the self-preservative instincts are also of a libidinal nature,[10] egoism gets equated with narcissism and "interests" become narcissistic cathexes. When the self-preservative instincts are of a libidinal nature, too, we have to consider whether it is possible "to be absolutely narcissistic and yet maintain powerful object-cathexes." It all depends on the specific meaning of the term "narcissistic" in this sentence, whether one admits or denies this possibility. Concerning the group leader's narcissism, Freud[11] states in *Group Psychology*: "The fixation of the libido to the woman and the possibility of satisfaction without any need for delay or accumulation . . . allowed his narcissism always to rise to its full height." It is clear that the narcissism meant in this sentence is not at all antithetical to object-love, at least not to one of a cruder variety; on the contrary, object-cathexes have become essential elements in the leader's narcissistic organization. The corresponding wording of the second possibility presents us with another striking illustration of the ambiguity of the term "narcissistic." Can one "be narcissistic and at the same time . . . excessively narcissistic"? I admit this possibility, having in mind a representative of Freud's narcissistic-libidinal type who is very much in love with himself.

A further implication of the new theoretical assumption is that all types

of object-choice can rightly be called "narcissistic." This, however, does not eliminate in the very least the clear psychological difference between the anaclitic type of object-choice and, *e.g.*, the "narcissistic" one of homosexuals.

It goes without saying that these considerations do not strengthen our confidence in the efficacy of the terms "narcissistic-libido," "ego-libido," "object-libido," or of the "reservoir image" to describe psychological conditions adequately. The uncritical use of these terms led to far too schematic ideas on the relation between narcissism and object-love, wrongly reducing this relationship to a pure quantitative problem of libido-distribution.

What can be said about primary narcissism and object-love? It seems an acceptable assumption that primary narcissism is rightly called objectless in the sense that the neonate is not aware of an outer world and has no objects, such as the adult has. The infant is presumably not yet aware of an inner world in the proper sense, either. It must, however, be assumed that the newborn infant already receives sensations from the outer world which in due time will mean something to him, *i.e.*, become objects in the psychological sense. In the beginning, the child reacts with displeasure to most external stimuli, with the exception of those concerning the nutritional situation. This seems important, for it proves that even at this stage the child does not reject the outer world as long as it provides gratification and pleasure. This makes us doubt Freud's assertion[8c] that "hate, as a relation to objects, is older than love." As far as a judgment can be based on later stages, accessible to investigation, it must be concluded that in the beginning the child is absolutely incapable of distinguishing the two series of sensations, those from its own body and those from the external world. According to Piaget,[25] there are many arguments in favor of the assumption that the child experiences his subjective sensations and affects as absolute realities, with a complete lack of distinction as to internal or external origin.

About the delimitation between internal and external world, Mach[25] thought that from an undifferentiated reality the sensations are classified step by step by the activity of the child, so that two mutually corresponding systems develop. From his investigations with somewhat older children, Piaget[25] concludes that the child has a correct perception of the conscious data, but even if these observational data are identical to ours, their localization is different. The child's thoughts are system-

atically objective; he considers his feelings as common to all and is, therefore, only very little conscious of his own ego. The consciousness of an internal world is not the result of a direct intuition, but rather of an intellectual construction. In the beginning the child probably displays his whole content of consciousness at one level without distinguishing perception, ideas, thoughts, or emotions. Everything is one absolute reality. In this initial stage of total realism the child probably feels identical with the images he perceives; he *is* the world.

Ferenczi's[28] article "Stages in the Development of the Sense of Reality" might well have cast some doubt on the hypothesis that the *origin* of the belief in the omnipotence of thought is to be found in self-love. In his opinion, in the beginning of mental life the child appears to himself as being omnipotent because of the impression he necessarily gets from his existence. "All children live in the happy delusion of omnipotence which at some time or other . . . they really partook of." Self-love is not basic to this experience of omnipotence; the connection is just the other way round. For appearing to oneself as being omnipotent is certainly a lovable experience of self-sufficiency. Ferenczi does not elaborate on it, but one can hardly doubt that he was well aware of possible narcissistic resistances against the development of the sense of reality.

Piaget,[25] too, reasons convincingly that it is due to the undeveloped sense of reality, the undeveloped state of the intellect, that the child has experiences of participation, magic causality, and omnipotence of thought. These experiences seem primarily not to be determined by libidinal factors. To hold on to the belief in omnipotence of thoughts when this no longer is forced upon the individual by an insufficiently developed sense of reality is, of course, a narcissistic manifestation. This belief, as Freud[12] pointed out, also is found in neurotics and primitive men. It seems to be a defense against despairing helplessness in the face of threatening, overwhelming forces.

Husserl[20a] remarks that we can very well imagine a consciousness having the same sensations as we, ourselves, but that is not able to interpret these sensations in the way we do. In spite of having the same sensations, such a consciousness has no intuition of things, or of events connected with these things; it does not observe houses, trees, the flight of a bird, or the barking of a dog. Neither is it aware of a self as a somatic and psychic entity. The sensations of such a conscious-

ness do not count as signs of the properties of objects; they are simply experienced, but not "objectifyingly interpreted." This is approximately the state of the newborn, on a far smaller scale, and largely limited to the sensations aroused by the nutritional situation with the maternal breast as its vague focus. There is one restriction, however. Even though these sensations have no significance as signs of the things of an external world, they have a great affective importance for the child—the bliss of satisfaction or the pain of frustration. In other words, these experiences—fusions of sensory- and affect-awareness, as Brierley[30a] calls them—form practically the child's whole conscious life during these initial stages. There is without doubt a very early libidinal cathexis of the sensations the child receives from the nutritional situation in general and from the maternal breast in particular. We do not know the extent of the complex of sensations representing the mother in the self-world continuum at the time object-formation begins which makes the mother, or part of her (*e.g.*, the breast), into an object in the outer world. However, we have to agree with Freud[13] that the libido concentrated "in effigy" on the mother in the undifferentiated or differentiating stage remains concentrated on her when she becomes an object in the external world.

The conception, so often defended—first the objectifying interpretation, leading to an external object, then cathexis of this object, giving rise to the formation of an object-libidinal dependence which has little or nothing to do with the biological dependence of the child—meets with serious objections. Although it goes without saying that during the first years of life important qualitative changes occur in the object-relationship with the mother as a result of the development of the sense of reality, I still hold with Alice Bálint[31] that "the object-relationships are as old as their biological foundation."

Primary narcissism also appears to be compatible with a beginning primitive object-love in the initial phases of life. The antagonism between narcissism and object-love, therefore, does not seem to be the predominating original "fact" assumed by many authors. That this antagonism is accepted by so many authors seems to be mainly due to two factors. The first is the original concept of narcissism, which posited an antithesis between self-love and object-love. The second is Abraham's hypothesis, shared by Freud,[7c] that the main characteristic of schizophrenia is the lack of libidinal cathexis of objects, a lack due to a withdrawal of the libido from these objects, the reflexive turning back of this libido on to the ego being the explanation of the megalomania in this disease.

Experience obtained in the course of psychotherapy of schizophrenic patients did not confirm Abraham's hypothesis. In Fenichel's opinion[32] expressions such as "the schizophrenic patient has regressed to narcissism" or "has lost his objects" or "has parted with reality," or "the schizophrenic's ego has broken down" all mean one and the same thing. It seems clear that if this is true, there is more involved than a libidinal regression:

1. "The schizophrenic has regressed to narcissism." The schizophrenic regresses from an adult narcissistic organization to the narcissism characteristic of earlier and earliest phases of ego-development.
2. "The schizophrenic has lost his objects." Here the restriction has to be made that a schizophrenic loses only his adult objects; that is to say, he replaces adult object-relationships with very early ones. The transference phenomena prove that there always remains an object-relationship even when it is a very primitive one.
3. "The schizophrenic has parted with reality." Here, too, restrictions have to be made. The first is that we know of chronic paranoid patients who notwithstanding their delusions and hallucinations are able to carry on a successful professional life. This proves that the parting with reality may be only a partial one. The second restriction is that the schizophrenic patient parts with reality only as it appears to the normal adult. It seems more correct to say that he replaces "adult reality" with reality as it appears to the infant. Freud was critical of Jung, who could not accept Freud's hypothesis that the detachment of the libido from the object and its withdrawal into the self could cause the loss of reality in psychosis. Nowadays we can appreciate the doubts of Jung, and I believe that ego-regression is the central problem.
4. The expression "the schizophrenic's ego has broken down," meaning his ego has regressed, implies a resurgence of primitive object-relationships and a primitive way of psychic functioning.

Clinical observations prove that in spite of long-standing ego-regressions, the ego-functions which enable the patient to deal adequately with reality remain available. The often unexpected and sudden integration of the ego testifies to this. For this reason, I am in favor of Federn's conception[33] that the ego-regression in schizophrenic psychosis amounts to a decathexis of ego-functions pertaining to the sense of reality, and the reintegration, to a re-cathexis of these functions. Maybe it is more correct

to say that we have to do with a decathexis of an adult ego-state and a re-cathexis of earlier and earliest ego-states, which accounts for the manifest schizophrenic psychosis.

In the external world we perceive an absolute separation between the bodily self and the other person, also between the first and the physical objects of our world. From a psychological point of view this separation is far less pronounced. For instance, the sensory qualities we perceive are as well in the objects as in ourselves. Am I right when I assume that Sandler[22] has something comparable in mind in writing: "The internal imago of the mother . . . is . . . an indispensable part of the relationship; without it no object-relationship (in the psychological sense) exists"? Or Joffe and Sandler[10] in stating that a part of the self-representation which reflects the relationship to the love-object, and which constitutes the link between self and object, can be referred to as the object-complementary aspect of the self-representation? The problem of at what stage in the development the biological relationship which exists from the viewpoint of the observer starts to become of psychological importance, in the experience of the infant, seems to me to be an academic moot question.

As long as one does not confuse the very first beginning of an object-relationship with a fully developed one, the question does not seem to be of great importance. As soon as the infant has a pleasurable experience or a feeling of well-being intimately connected with a certain sensory awareness, there is, to my mind, the very first beginning of a psychological relationship. Maybe, for lack of experience with infants, I ought not to speak so boldly. I believe, however, it is now generally accepted that the love the mother expresses in the handling and taking care of her baby is communicated to him and contributes highly to his feelings of pleasure and well-being. For this reason I feel in adherence with Brierley,[30b] in whose opinion infantile sexuality is not autoerotic in the sense Freud first supposed, that is, objectless, and its aims are not limited to the attainment of organ-pleasure. Even the suckling has an object in the external world, his mother's breast and nipple, and he exhibits a variety of reactions toward this object which show that very early in his life it means something to him; *i.e.*, that it is an object in the psychological sense.

Based on these considerations we have to judge that the transition from the earliest undifferentiated stage to the first delimitation of ego and outer world cannot be attributed to the vicissitudes of libidinal cathexes.

At this stage of development there is little reason to distinguish between ego-libido and object-libido. Things become different, however, when we consider the consequences for the child of his object-formations. Most authors call the gratification the infant experiences during the undifferentiated stage, autoerotic. From the point of view of the adult, much of this gratification is due to the loving care the infant receives from the mother or mother-substitute. It seems probable that during this period the child is unable to distinguish between sensual pleasures stemming from his body-functions, stimulated without help from the outer world, and satisfactions which are brought about primarily by influences from the outer world. In this condition the objectifying interpretation which makes the mother an external object—even if only a part-object—causes a profound change. The child becomes aware that the satisfactions he has so far experienced are greatly dependent on the outer world instead of being the result of his omnipotence.

The carrying out of the objectifying interpretation makes it necessary for the child to accept the painful understanding that something which at first seemed to be omnipotence, in reality was utter dependence. How painful this transition is will much depend on the behavior of the mother. From this point onward, two psychic attitudes become possible. The child can try to obtain libidinal gratification without recourse to the outer world. This attitude obviously leads to a greater reliance on autoerotism. Or the child can acquiesce in his dependence on the outer world for libidinal gratification. Since the biological dependence unavoidably leads to object-libidinal dependence, it seems probable that an hypertrophy of the autoerotic attitude is an unnatural development which already reflects traumatic disappointment in the object.

Normal development of the narcissistic libido is blocked, and the child becomes overly narcissistic in the original, narrower meaning of that term. The appearance of an autonomous attitude, inclining to self-sufficiency, and an object-dependent attitude are normally parallel and independent occurrences in the life of the child. But the autonomous attitude with roots in the experience of omnipotence may be deflected from normal channels of development if the child is thrown back upon himself by disappointments in his object-dependence. It is on this point that enmity between narcissism and object-love first becomes apparent, based on the ego's recoil from objects and its subsequent striving to keep libidinal gratification in its own hands. The opposition between autonomous and ob-

ject-dependent attitudes confers a definite sense to the opposition of ego-libido and object-libido: libido, the gratification of which the ego in its striving for autonomy highhandedly considers to be its own business, as against libido, the gratification of which implicates a remaining dependency on the object.

Autoerotic gratification of the primitive ego is progressively replaced by the satisfactions the increasingly mature ego provides itself actively in its relations with the external world. The main accent lies on the activity and autonomy of the ego.

Husserl's[20] term "objectifying interpretation" does not, of course, refer to an instantaneous occurrence, but to a process that demands time and progresses in steps. Piaget[26,27] devoted two heavy volumes to this aspect of ego-development. The gradual development of the sense of reality, again and again threatens the narcissistic equilibrium acquired by the child. The child repeatedly faces the painful conclusion that he mistook dependence on external objects for omnipotence. It may be open to dispute whether this is the first frustration imposed on the child by the development of the sense of reality, but there are certainly a great many to follow. The process of ego-development from this point to puberty, which unveils the world as known by adults (so well described by Piaget), entails many repetitions of this frustration. At each new step the child has to give up something of the labile narcissistic equilibrium reached so far; he must modify his self-love, while the reward in the form of greater satisfaction, or greater security, is usually not ready at hand. Hence the narcissistic resistance against the development of the sense of reality, which presumably is never absent and is often reinforced by neurotic complications.

To be reduced to a state of such consciousness as Husserl imagined, a consciousness having the same sensations as we, ourselves, but unable to interpret the sensations in the way we do—as in the so-called agnosias due to lesions of the brain—is without doubt a terrifying and anxiety-provoking experience. This point of view seems to support Sandler's contention[20] that the act of perception is a very positive one, protecting the ego from being traumatically overwhelmed by a mass of unorganized sensations arising from the various sense organs, a perception, therefore, being an act of integration which is accompanied by a definite *feeling of safety*, the latter being genetically a derivative of the earliest experiences of need-satisfaction (p. 352). There seems to be nothing against calling an act of sensory-integration successful when in it "excitation (from any source, id or outer world) is smoothly and effectively dealt with by the ego," provided it still delivers a correct or valid perception. Inclusion of id-excitations in an act of sensory-integration may well endanger this happy outcome, as we know from transference manifestations in our daily work and from the work of Piaget. Many psychoanalytic authors write about the perception of the outside world as if this is a purely passive process, not much more than an imprint of the external world upon our mind. They are certainly wrong, but nevertheless most sensible. For, in so doing they avoid the baffling problem of the relation between the subjectivity of knowing and the objectivity of the content of knowing. But even in avoiding this, it is good to be aware that the problem exists.

This touches on some questions I have concerning some formulations in the Sandler-Rosenblatt[23] paper "The Representational World." According to the authors, using the concepts of the representational world makes it possible to avoid certain theoretical difficulties and to define such mechanisms as identification and interaction in a relatively simple way. Identification "becomes . . . a modification of the self-representation on the basis of another . . . representation as a model." The authors stress that the representational world is never an active agent; this must also be true of the various representations which compose it.

My problem is that a modification of the self-representation, as it seems to me, does not guarantee in any way a real change in the behavior of the person concerned. From this it seems to follow that identification is more than a modification of the self-representation.

Unless there is something wrong with my understanding of the term "representation" as used in this paper, both object- and self-representations are often far off the mark. In many of our patients, if not in all, the self-representation is remarkably inauthentic, the same being true of their object-representations. One candidate presented himself as the victim of "the meanest parents in the world." He failed to produce any evidence substantiating this representation of his parents, but instead brought overwhelming evidence convincing me, and somewhat later himself, that in reality he was the victim of an unresolved oedipal complex of extreme intensity. Another candidate, apparently in good faith, presented himself as a truly conservative manager of his financial affairs. He was forever budgeting; but it did not take long to find out that in reality he behaved as if guided by the self-representation of being already a "well-established

doctor" with means at his disposal a successful practitioner commonly has. In spite of all his budgeting, he regularly overspent to such a degree that it sometimes happened that he did not have money left to buy even the most necessary food for his family.

We are all familiar with the fact that the self-representation can be very fictitious; the world would be a better place if this were not so. Realizing the ego-ideal, or ideal self, that is to say, changing the actual self so that it conforms with the ideal self, is not the same as changing the shape of the self-representation. Sandler[21] writes: "The formation of the ideal self has been described as if in fact the individual is easily capable of changing the shape of his self-representation to conform to his ideal, but we know from clinical experience that this is often far from being the case" (p. 156). I am inclined to infer from my clinical experience that to change the shape of a self-representation is not that difficult at all. The trouble with many neurotic characters is that they often do not have the slightest insight into what kind of self comes to the fore in their behavior in a given situation. The shape of a self-representation, as I see it, therefore can be more or less objective. The same seems to be true of object-representations and of the representational world as a whole. In the course of normal psychic development, the representational world becomes more and more objective—comes closer to being an objective representation of the real world. The idea, or notion, of an ideal self, as it seems to me, is also a kind of representation. It seems doubtful to me that with the concept of a representational world, as it stands now, Sandler really succeeds in avoiding the theoretical difficulties he has in mind, without getting involved in other ones. I would not mention these points if they were not pertinent to our topic.

Fictions which serve as a basis for self-regard are so common throughout the continuum from normal to pathological organizations, that they often seem to be regular occurrences in psychic development. The individual in certain periods of his development constructs an ego-ideal which may easily become a life fiction if it comes to replace the functional ego as the basis for one's self-regard. The little child, dejected by his smallness, especially when he is by far the youngest in his family, dreams of an impressive adulthood and tends to behave as if he were already an adult. The boy at the beginning of adolescence is just as much in need of his adolescent ego-ideal and his hope that some day he will measure up to it. As long as the ideal retains the character of a goal to strive for, it serves a useful purpose. It becomes a danger only when it assumes too much compensatory character. The need to build compensatory self-images fosters the formation of an ego-ideal larger than life and impels one to put the fictitiously idealized self in the place of the unsatisfactory real self. When development follows a favorable course, with the ego unfolding itself in the image of its ideal, then in a sense the ideal is transmuted into real ego-structures; the ideal becomes ego, not fictitiously, but in reality. The ideal provides the growing, form-seeking ego with a suitable mold. This is possible only when the ideal realistically and satisfactorily embodies not only the strivings, but also the real potential of the individual, and is not too far out of line with other factors which determine what he can expect from life.

The relations between ego and ego-ideal, actual self and ideal self, are, of course, important for the differentiation between normal and neurotic secondary narcissism. Normal development aims in the direction of a more competent ego, in accordance with childish, not wholly unrealistic, ego-ideals. In the neurotic personality the ego-ideal often has become an end in itself. He admires the person he is in his ego-ideal, and ignores the unpleasant reality. However sound and satisfactory the ego may be at a certain period of life, the ever-changing life situation makes continual change in the ego imperative. Consider for the moment those changes in the life situation which are inseparably connected with life itself: growing older, the gradual curtailment of the future, and in the female the conspicuously clear impact of the menopause. The ego alterations adopted to meet these changes always occur by way of the ego-ideal. Thought, in a wide sense, anticipates future reality and foresees the demands which sooner or later will have to be met by the ego. The ego-ideal formation, which gives direction to life, *i.e.*, to the ego, can perhaps be described in this way: a realizable ideal can be arrived at only when one's present and future reality are adequately grasped. The extent to which one has realized his striving for objectivity is decisive here. Healthy self-regard facilitates this process, whereas the self-regard of the neurotic impedes it by demanding the misrepresentation of both inner and outer reality. The only defense against this danger is the striving for objectivity, the awareness that one is always inclined to look through glasses too colored by his biases.

The undeveloped sense of reality and the emotional dependency on the parents place the child in a primitive subjective reality which

has little in common with the objective reality of the adult, and for this reason may well be called a "faulty" reality. This primitive reality makes his feelings of well-being and self-regard dependent on the fulfillment of wishes which have no place in objective reality and easily give rise to character-attitudes which only later trouble him by burdening him with expectations which often imply a refusal of a more objective appraisal of reality and which he must laboriously revise. In short, the child's un- or underdeveloped sense of reality predisposes toward the coming into being of an ego-organization which tries to maintain self-regard in an unrealistic way, as well as regards the reality of the self, that of the external world, as the psychic reality of other persons to whom he has to relate. It would, of course, be more correct to use the plural and to speak of the child's "primitive realities." One aspect of ego-development certainly is, that it amounts to a succession of ego-states, each with its own age-appropriate reality and ways of maintaining self-regard. Whether these are later revised depends first of all on the more mature forms of autonomy achieved by that ego which enables it to sustain its self-regard in terms of the satisfactions which flow from the ego's successful dealings with the outer world.

The less an adult has to misrepresent reality in his strivings to maintain a positive self-regard, the healthier his narcissistic organization is.

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PSYCHOLOGICAL PROBLEMS IN LOW-INCOME FAMILIES: A RESEARCH PROJECT

I. RESEARCH IN PROGRESS

JAMES B. TAYLOR, Ph.D.

In 1959 a large urban renewal program was initiated in Topeka, Kansas which involved the displacement of over 600 low-income families from their homes in a deteriorating section of the city. At about the same time, another group of low-income families was displaced by construction of a four-lane highway running through the city center. For many of these families, such forced removal was a major crisis, accompanied by reactions of loss, grief, uncertainty, and fear. To mitigate such effects, federal regulations made it possible to give counseling and home-finding services to those people displaced by the urban renewal program. In contrast, no such services were available for families removed by the highway construction. Thus a natural experiment was set up: two comparable groups of low-income families were being forced to move; one group being given help and one group not. To find out the effectiveness of such help, before and after interviews were conducted with families displaced by urban renewal, with families displaced by the highway, and with a third group of low-income families who were not displaced at all.

As an outgrowth of this earlier study a research project was conceived which would offer evaluation and rehabilitation services to a group of low-income families not included in the urban renewal area. The purposes of this new project were threefold: (1) to assess the importance of psychological problems in lowering the vocational adequacy of low-income people, (2) to experiment with intervention methods which might raise the vocational adequacy of low-income people, and (3) to evaluate how well these intervention methods work in producing a more adequate adjustment.

In planning the project no attempt was made to specify the methods of intervention in advance. Included might be counseling, brief psychotherapy, role playing, referral to appropriate agencies, involvement in civil rights movements, educational help. From the beginning, however, an integrative approach was attempted; the focus was to be on the total social and personal adjustment of the low-income family, rather than upon the restricted economic or vocational aspects of their predicament.

Financial support for the project was provided by Grant RD-1243-P, "Emotional Correlates of Vocational Rehabilitation," from the Vocational Rehabilitation Administration, Department of Health, Education and Welfare, Washington, D. C. Although designed as a five-year project, the initial grant commitment was for a three-year period (1963–1966). Supervision of the study was arranged under the auspices of The Menninger Foundation's Research Department. Dr. William Key, professor of sociology at Washburn University, was selected as principal investigator, and Dr. James Taylor, a social and clinical psychologist, was appointed director of the research.

The choice of other staff was determined by the purposes and design of the research. Since the emphasis had been placed upon the psychological and psychiatric aspects of poverty, it was clear that purely statistical fact-gathering would not uncover the intimate data desired. What was required were clinicians, experienced in establishing rapport and eliciting significant information without awakening anxiety or hostility; and also able to evaluate situations, interpret untutored conversation, preserve ethical standards in relation to confidential material, judge the advisability of intervention in some situations and advise how and where help could be obtained. Needed were people who could apply clinical insights and skills to problems outside the office setting.

Research then was to be done largely by a clinically experienced staff working with a sociologist and a social psychologist. At present the clinical staff includes two psychiatrists, Fernando de Elejalde, M.D. and Ronald Filippi, M.D.; two clinical psychologists, Donald Leventhal, Ph.D. and Phyllis Levy, Ph.D.; and three social workers, Virginia Feeley, M.S.W., Beth Sheffel, M.S.W. and Jennie Wykert, M.S.W. Edward Greenwood, M.D. serves as clinical consultant, and Richard Benson, M.S.W. as social work consultant. Mrs. Margaret Canfield is research associate and William Harzog is research assistant.

Used to working in an office, comfortably ensconced behind a desk and an appointment book, these professionals were asked to go out as teams into impoverished neighborhoods; often into houses where large families were packed into a few rooms, where porches sagged onto litter-covered yards, where cockroaches swarmed and outhouses were common, and where squalor and apathy were the norm. But on the

same block they might find other kinds of families too; families who, while struggling to get by, find pride and satisfaction in their lives. The teams went unannounced and without appointments. Typically, they would knock on a door, introduce themselves, and say, "We're doing a study of work and the problems people have with it. Could you give us some time to talk with you?" To their initial surprise, they usually were greeted with cooperation and friendliness; outright refusals were rare.

The Task of the Neighborhood Clinician

When a pilot study had shown that this way of establishing contact was feasible, the formal research was begun. Two hundred households in a low-income neighborhood of East Topeka were selected as an experimental population. Using 1960 census block data, blocks were chosen to meet the following criteria:

1. Racial distribution: approximately 45% non-white, 55% white (the latter figure includes a sizable Mexican-American group).
2. Average dollar value of property: \$7000 or below (the median for Topeka being \$11,600).

Although block statistics were not available for family income, census data showed a median family income of \$4266 and \$4610 for the two tracts included in the sampling area. These figures overestimate the income of our population, since the teams are interviewing people who live on the most deteriorated blocks of the area. Within these blocks, 200 households were selected at random for an initial interview. To date, initial interviews have been held with 93 low-income families.

In the initial unstructured interview, the team assesses the work experiences and problems of the respondent and his family. Rather quickly conversation branches off into other areas of life also: child care, relations between spouses, housing, racial prejudice. This expansion of interview content comes naturally. Work and its vicissitudes is a very central topic with low-income people and involves all areas of their life. The interview itself is clinical in nature, with the questions unspecified in advance. Clinical interviews make use of the staff's training, allow more flexibility, and are likely to produce more significant information. But although the interview is unstructured, interviewers are familiar with the topics to be covered and the specific questions which they will have to answer upon their return to the office.

Notes are not taken during the interview. Since each member of the interview team reports the contact independently, discrepancies and mistakes can be caught later. A further correction for memory error is contained in the procedures themselves: the team members dictate their reports while the experience is fresh, usually within fifteen minutes of the interview's termination. In dictating their notes, the team members are encouraged to include as much detail as possible, both about the interview process and about their own feelings and thoughts.

Following the dictation, each team member is seen individually by a research assistant and given a structured questionnaire. This "debriefing" session includes a few open-ended questions, the research assistant asking the question, recording the answer, and probing as needed. Other parts of the debriefing are more structured. Rating scales are extensively used; for instance, the clinician fills out 44 different scales to describe each interviewee. After these procedures are completed the two team members are free to discuss the case with each other, although not with other interviewers.

From this initial debriefing session comes much of the basic data to answer our first research question: *i.e.*, What role do psychological problems play in lowering the vocational adequacy of low-income people? From these 200 contacts will come a cross-sectional picture of a low-income neighborhood; a picture with includes not only families in trouble, but families who have made an effective adaptation.

In the later conference with the clinical director, the teams decide whether intervention with the family is needed. If intervention seems appropriate, the case is assigned by a table of random numbers to either a control or an intervention group. The control cases will not be seen further by the teams, but will be interviewed again in a follow-up evaluation. The experimental cases receive whatever help the ingenuity and resources of the team can provide. In these latter cases, the clinicians attempt to move from a fact-finding interview to a helping relationship—in a word, to an "intervention contract."

To date, active intervention has been inaugurated with 18 families. The following vignettes give some idea of the kinds of cases seen and problems encountered.

> A physically disabled, middle-aged Negro man whose apathy and depression have kept him from receiving adequate medical care or seeking rehabilitation.

A Mexican girl, speaking little English, who is kept isolated and bound by her linguistic lacks and her husband's pathological jealousy.

A suspicious and aloof Negro woman from a middle-class background, riddled with guilt and self-contempt because of her two illegitimate children and the "shame" of being on welfare.

A disorganized white woman, married to a petty thief, who is unable either to deal with her husband's manipulative behavior or the task of raising her children.

A large interlocking Negro family, comprising four households, most members being on welfare. The family's many problems include illegitimacy, prostitution, rape, attempted murder, and mental retardation. Family interaction is marked by great hostility, and by a drifting, apathetic mode of behavior.

A white, middle-aged laboring man from an Ozark background, whose strength is no longer adequate to his job. He is reacting to his feared loss of masculinity by sexual advances to his stepdaughter, and by increased alcoholism.

Intervention techniques have included counseling with families, attempts to introduce some coordination when several agencies are working with the same family, providing transportation to referral sources, introducing a trained nursery-school teacher into the home to demonstrate child-rearing methods, and serving as liaison for housing, employment and educational opportunities. Intervention is terminated when the team judges that no further progress is likely.

Six months after the team has terminated an experimental case, the family will be reinterviewed by another team, while a control family, seen initially at about the same time as the experimental one, will be reinterviewed also.

In brief, then, the experimental design calls for initial diagnostic and screening interviews with 200 families, randomly selected from a low-income area. Those families which are judged to be in need of intervention are randomly assigned to a control or experimental group, and intervention is attempted with the experimental cases. Follow-up interviews will be given to both groups, six months after intervention has been terminated. Information about the family patterns, social patterns, stresses, personality, and adaptations is collected during the initial interview, and is supplemented in the experimental cases by interviews over a considerable time span. Follow-up interviews allow an evaluation of control and experimental cases after intervention has been terminated.

Social Factors

The discussion above has focused on the problems encountered in analyzing the clinical materials, and has dealt largely with the analysis of family interviews. From the inception of the project these issues were seen as only one portion of the research task. If we are to understand the relationships between individual personality, the family, and the social system, it is necessary to investigate social processes as well. We need to find out what part social agencies play in the lives of multi-problem families; we need to clarify the historical happenings and trends that have produced the working-class neighborhood and its attitudes. We need to decide whether it is realistic to speak of a single "culture of poverty" in this setting, or whether it is more appropriate to speak of discrete "microcultures"—the microculture of the respectable poor, or the microculture of the Negro matriarchy. Such needs can only be met by sociological and historical studies and by methods of analysis that focus on the social system and its processes.

So far the sociological and historical analyses have been exploratory. Historical materials are being collected from library sources and from "old-timers" in the neighborhood. Research assistants have interviewed teachers in the neighborhood schools, observed classrooms and Parent Teacher Association meetings, and talked to parents. It is anticipated that this exploratory work will continue with other groups: the traditional and the sectarian churches, the welfare agencies, and the informal neighborhood leaders. These exploratory studies are being augmented by survey research data, and by attempts to ascertain the sociometric patterns of the family groups in the low-income community. This aspect of the research is as yet too recent for detailed reporting, but it will probably play an important role in our final understanding of the social-psychological world of low-income people.

Clinical Judgments as Research Data

As the preceding pages have made clear, the basic material for the project comes not from direct observation of behavior or from standardized questionnaires, but rather from interviews. The clinicians observe a wide sample of behavior in their interviews. From these observations they must derive a coherent picture of the family and its milieu. It is necessary that the interviews give enough information to support valid

conclusions, and that clinical judgments be adequately reliable and, insofar as possible, stated in precise and quantitative terms.

Early in the project a pilot study was conducted and thirty families interviewed. This pilot study served as a training period, allowing the clinicians to become familiar with the research task and the kinds of data available in home interviewing. Since interview teams (rather than single clinicians) make the contact, every case will be seen by two workers. This procedure allows a check on the reliability of clinical judgments. And since the clinical teams may return for many interviews, it is possible to see whether their judgments change as they become more familiar with the case.

More troublesome is the need to specify clinical judgments in precise and quantitative terms. So much information is gathered, and so many judgments made, that assessment procedures must be as pointed and brief as possible. The judgments themselves must be cast in terms that allow for comparison between cases. To meet these needs, a variety of rating scales have been devised: with these a family and its problems can be described briefly and comprehensively during the forty minute "debriefing" session. Table 1 lists the variables that are covered during this session.

TABLE 1

VARIABLES ASSESSED DURING DEBRIEFING SESSION

1. Family Pattern
   a. Identifying information for each member—age, sex, race, relationship, education, marital status, employment.
   b. Identifiable problems in the family relationships—difficulties with spouse, children, neighbors, social agencies, business concerns.
   c. Identifiable family stresses—financial, racial, economic.
2. Employment Pattern
   a. Work history—job title, present employment, stability of employment, work adequacy.
   b. Work attitudes—expressed feelings toward present employment, employment goals, employment preferences.
3. Personality of main informant—coping adequacy, evidence of psychopathology, patterns of affect expression, patterns of cognitive functioning.
4. Physical difficulties of main informant.
5. Informant's overt reaction to interview, interviewer's reactions to interview.
6. Summary of family problems.
7. Assessment of intervention potentialities and problems.

Clinical reports also provide the research data for the exploration of new intervention methods. Here the researcher must rely upon clinical notes, discussions, and conferences; the complexities of the clinical method preclude more formal data collection. These notes and reports may be made precise and quantitative, using such techniques as content and sequence analysis. But much of the insight into intervention methods must come from the clinicians. Our intervention attempts are frankly exploratory; the variables are neither clear-cut nor predictable. In studying intervention methods the researcher must necessarily act like a descriptive naturalist—finding out what was done, and why, and recording the team's exploration with as much detail and care as possible.

Six months after a case is terminated the family is interviewed again to evaluate what changes have resulted from intervention. A control case is also reinterviewed, both cases having been seen first at approximately the same time. As a partial control for bias, the families are reinterviewed by a team with which they have had no contact, and to whom the case is unfamiliar. The evaluation interview, like the initial interview, will focus upon the emotional, vocational, and social problems of the family. Analyzed will be changes in the specific problems that led to intervention, and the more general psychological and social adjustment of the family.

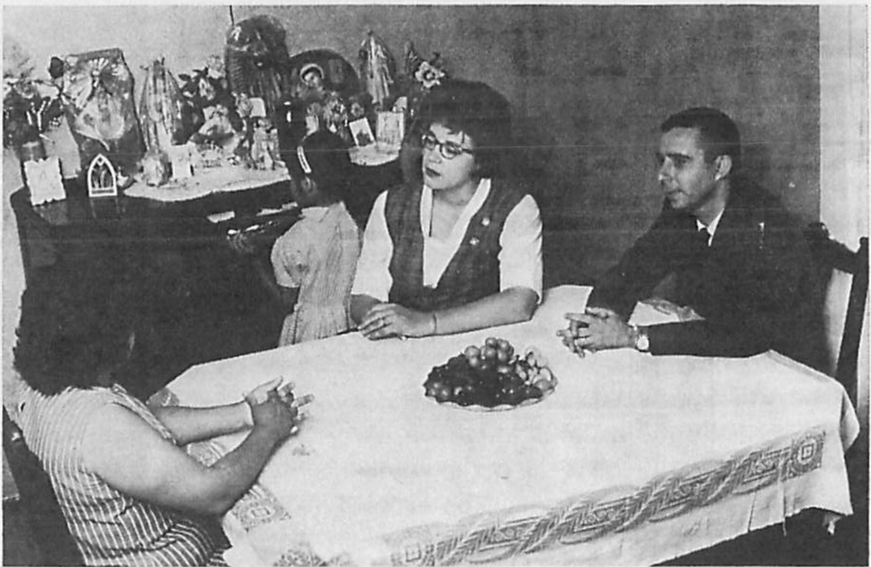
Initial Impressions

When the teams began their interviewing, they were surprised to find less psychopathology than they had anticipated. Sociological studies have so stressed the negative aspects of poverty that it is easy to forget that the majority of the poor are able to function adequately, find satisfactions, enjoy the pleasures of marriage and adapt with dignity to the vicissitudes of the human condition.

The teams have come to differentiate between two groups of low-income people. In Victorian times it was customary to speak of the "respectable poor" and their "disreputable" cousins. Present-day researchers have suggested more neutral terms: the "stable working class" and the "disorganized working class." It is in the disorganized working class that most of our intervention cases are found.

Desertion, divorce, and illegitimacy are common among disorganized working-class people. Typically the nuclear household consists only of a mother and several children. If the mother works, the children are cared for by a grandmother or relatives; or the mother may subsist on a welfare grant. Often the woman forms transient common-law relation-

A Clinical team introduces itself.



The team proceeds to more personal discussion.

The team begins acquaintance by sharing recipes.

A scene in the neighborhood.

ships with men, who come, stay for a while, help support the family, and depart. These transient relations may occasionally be dignified by a marriage ceremony, but with indifferent results. There is something self-sustaining about this type of family pattern: in some of our cases it has continued through several generations. Although perhaps more typical of the Negro and Indian, it is found also among the White and Mexican groups.

Such households breed a series of problems both for the mother and her children. The woman is apt to feel trapped. Apathy is common. Beneath this, but close to the surface, lie frustration and rage. These feelings tend to be vented on her children. She may in punishing them give way to bursts of anger, coupled with guilt. The children, raised without affection or firm expectations, are likely to suffer moderate or severe ego damage. Especially the male children are likely to catch the brunt of the woman's anger, since it is the irresponsible and aggressive male who has victimized her. Aggression may be coupled with an active discouragement of exploratory or assertive behavior on the part of the child. The male raised in such a household is likely to grow into an unstable and inadequate adult. In his youth he is likely to get into trouble with the juvenile court, and in school, and to leave home early. This pattern reinforces the woman's attitude toward men—"a good man is hard to find." The girl children accept the maternal attitudes, angers, and expectations. They find marriage difficult and self-respect hard to achieve. Often they drift into promiscuity, pregnancy, and find themselves trapped in the same plight as their mother. Thus, the family dilemma is carried on through several generations.

There are, of course, degrees of family disorganization. We have seen women on welfare grants with no husband and several illegitimate children, whose morale is high and whose life offers them some hope. A stable family may, with death, divorce, or desertion, slip into difficulty. But in its rough outlines this syndrome does characterize a good proportion of the disorganized families we have seen.

Once the family becomes disorganized, its problems become self-perpetuating. Few laboring men are anxious to take on the burden of several extra children. The men who are drawn to such liaisons are usually inadequate or transient, and are poor marriage risks. Even if marriage is possible, the woman's attitudes are likely to preclude it. In fact, not being married may give a woman some control in a common-law relationship: she can get rid of a brutal lover and still be supported by welfare.

This option is less available if she is married to the man and dependent on him for support. The opportunity to work and send her children to nursery school may also be unavailable. In the first place, her own apathy, fear, and lack of self-esteem hinders her in seeking employment. Secondly, her wages are apt to be low, often below a dollar an hour. Nor are employers eager to hire women with unstable or nonexistent work records, and whose children may make unexpected demands on working time. Without skills, without work, without hope, the woman in this situation is indeed trapped, and often has little chance of escape.

With such situations, the clinical teams may offer some new alternatives. They may offer help in getting training or finding jobs. They may bring together people and community resources; they may explore with the family alternative possibilities of child rearing; and they may by their presence and interest reduce the despair and apathy of the family.

It is still unclear how much help the clinicians can give in cutting through these vicious circles and moving the families to a higher level of adequacy. Some initial results have been encouraging, but the proof of the technique must await the final evaluation.

Intervention in the home turns out to have both assets and liabilities. Since clients are not referred, but are instead sought out, the clinicians come with a different mandate to the families. Other research has shown that low-income people tend to view psychiatrists with suspicion, tend to be concerned mainly with somatic complaints, and do not talk easily about psychological matters. These problems are partially avoided when the clinicians come as strangers. The interviews take on a more social flavor; as if one family was visiting another. In these interviews, the teams often are impressed with the amount of psychological understanding which low-income people can express. Because the clinicians come more as neighbors than as professionals, the families appear to talk more freely and in a more psychological way. Difficulties and potentialities seem more easily diagnosed in the home than in the clinic.

On the other hand, the clinicians' lack of a clear professional role may lead to certain problems in home contacts. The teams have little control over the circumstances of the interview. In their home, people are free to rely on what we have come to call "environmental defenses": they may disrupt the interview by leaving the TV on loud, avoid confrontation by bringing in friends and relatives, or simply "not be home" when a visit from the team is expected. Again, the family may at first suspect the clini-

cians of being welfare inspectors, or policemen and react accordingly. Although such resistances and suspicions can be overcome, they sometimes make the initial interviews difficult and unrewarding.

Faced with these problems, the teams have taken on a more neighborly role during the early contacts. They will often discuss neutral subjects, such as cooking or fishing, and share their experiences as one person to another. This "self-sharing" serves two purposes: it gives the team an identity as two people rather than as two strangers, and it shows the low-income person that they do not respond to him with contempt or patronage. As the relationship between the teams and the client develops, this friendly role can shift into a more professional one. The teams will focus on the family problems and try to be of help. This shift in activity produces a shift in expectations, so that the family comes to view the teams as helpers rather than visitors.

It is our impression that this method of intervention is more demanding than is office practice. In the neighborhood, the clinician takes responsibility for initiating and maintaining contact. This means the neighborhood clinician is more vulnerable than when he is seated behind a desk. Certain families, with which we have ultimately had some success, reacted in their first ten contacts with what one social worker described as a "blah" attitude—it seemed obvious that they did not want to see the clinicians, that they had not the least desire to talk about their life or problems, and that they only wished to be left alone. It is not easy to come back again and again under these conditions. Yet this apathy and negativism often turns out to have a defensive and testing function; it may mask a lonely despair and a cry for help.

Once intervention is inaugurated, other problems arise. Appointments may be regarded casually, and time itself seems not important. Many of the disorganized poor have difficulty in trusting anyone, and are especially sensitive to anything they perceive as a breach of trust. To these people speech may be less important than action and verbalization of motives may be difficult. In such cases the teams become more action-oriented; they may demonstrate how to handle an obstreperous child, or may accompany a person through the stressful procedures of applying for a job.

In home intervention the usual professional divisions between psychiatrists, psychologists, and social workers tend to break down. When the family is intact, sex roles become more important: the female professional tends to deal more with the mother and children and the male more with the men.

As the teams have gained experience, they have broadened their interests. From an early concentration on emotional problems, they have become more concerned with the possibilities of milieu treatment in the community. The traditional agencies for dealing with the poor keep them from starving, but offer little more. The services are seldom oriented toward family rehabilitation, or toward coordinated planning. First-hand experience with the poor has made these lacks glaringly obvious, and has suggested a variety of ways in which agency practices could support rehabilitation attempts. From these suggestions has come a close though informal linkage with the recently inaugurated "poverty program" in Topeka.

In summary, our initial experiences have led us to believe that the project will have implications for psychiatric practice and for social action. The teams are exploring new methods of intervention, some of which can be adapted by nonclinically trained workers as well. At the same time, as familiarity with the world of the poor increases, the teams are able to offer suggestions for new forms of social help. Thus the research activities may be expected to contribute to a spectrum of problems, casting light not only on the dynamics of class-linked psychopathology, but on the potentialities of social-psychiatric treatment as well.

II. DIFFICULTIES IN NEIGHBORHOOD WORK

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Certain difficulties seem likely to arise whenever any professional person attempts to work with a lower-class family. The strains may be similar for a teacher in a slum school, a physician in a city hospital, or a case worker with a welfare load. If these strains remain unexamined and unresolved they are likely to lead to inappropriate action. The teacher may flee the slum school, the physician may become embittered and contemptuous, the welfare agency may "build in" procedures that look to the outsider like a defensive withdrawal.

A close look at such sources of strain indicates that the techniques of the neighborhood clinician, and the insights he develops, may prove useful to many professional groups who are subject to similar strains. And insofar as the project, described in the preceding pages, provides a viable model for work in community mental health, we can expect our own experiences to be recapitulated by others.

In the beginning, before experience accumulated, the clinicians in this project were concerned about appearing as "do-gooders," as "snoopers," as "meddlers." They were much concerned with questions of ethics, confidentiality, and the use of information from other agencies without the people's knowledge. They were sure that two middle-class people appearing at the door would be overwhelming, that they would be seen as "ganging up" on the family. Although these concerns have some occasional basis in reality, they more largely reflected the team's anxiety in a new and strange environment. As the clinicians became more comfortable and could more realistically assess the degree of their assumed omnipotence, it became apparent that deprivation and adversity do not make defenseless people, and that the team's presence at the door was far from shattering.

When they realized that they were not placing people's lives in the balance by their interview, that they were actually welcomed and entertained by some, the clinicians were reassured and began to look more closely at themselves for the source of their concern. In varying degrees, they had been afraid of physical violence, of having doors slammed in their faces, and of being personally rejected. These stereotypes and fears stood in the way of utilizing clinical skills. One team in an early contact

was greeted by a frightened, suspicious woman, half hiding behind a doorframe, who wanted nothing to do with them. Affronted and rebuffed, their fears verified, the team left. Many interviews later a similar incident occurred; but by that time the clinicians were able to deal appropriately with the client's fears instead of being handicapped by their own.

What had occurred in the interim? Two processes seem paramount: (1) the teams had incorporated in their role certain techniques and certain ways of thinking which made contact possible; and (2) they had developed ways of mitigating the personal strains which had beset them.

Sources of Strain

One source of strain was akin to "culture shock." The term "culture shock" refers to the dissonance and anxiety aroused when a person from one culture comes into sudden contact with another. In his sudden confrontation he is apt to find that his beliefs, his values, and his assumptions are not universal; that whole groups of people can despise what he values and value what he despises; and that the eternal verities are not so eternal after all.

The clinicians began with certain stereotypes; the notion of "poverty" conjuring up images of "blackboard jungles," of delinquent gangs complete with switch blades and black leather jackets, of apathy and anger. The "scientific" literature at first reinforced such stereotypes. Spinley's comment,* for instance, was not atypical:

> "The slum child shows a marked absence of a strict and efficient conscience, an unwillingness and inability to deal with disturbing and unpleasant situations, and a flight from these. He is unable to postpone satisfactions . . . he has marked aggressiveness which is permitted violent expression, and his attitude towards authority is one of hostility and rebellion."

Although our experience indicates now that such conclusions are the grossest kind of caricature, they are common in the sociological literature.

More subtle problems appeared as the teams began their interviewing. Clusters of reactions arose around the issues of privacy, guilt, and envy. As one of us suggested in a staff paper:

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*SPINLEY, B. M.: *The Deprived and the Privileged.* London, Rutledge & Kegan Paul, 1953.

"Because of our own feelings about privacy as something that everyone is entitled to and as something that is associated with dignity, it is not surprising that knocking on people's doors and attempting to gain entrance into their homes, uninvited, should often make us feel uneasy . . . We may feel, for example, that the lower-class cannot refuse us when we come to their doors. This puts us, as interviewers, in a position of superiority which may at the very least make us feel guilty. Similarly, there may be the feeling that if someone came knocking on our doors, we would turn them away. It may be that we would feel more comfortable if the lower-class had the pride and status to do the same. Moreover, once one feels guilty and uncomfortable because of the lower-classes' lack of pride and dignity, it is a short step to feeling some social responsibility for their plight. And, again, this is likely to produce within us the feelings of discomfort and self-dislike.

"We may experience feelings of guilt because of the realization that we are much better off than they and, in addition, are secretly glad that we are better off. Being faced with the living conditions of the poor and their lack of dignity may also stir up in us fears that 'it could happen to me.' On the other hand we cannot disregard a second feeling that may be aroused, *i.e.*, the latent wish to be like them. We may envy them their freedom from responsibility, their leisure, and the fact that they are allowed free expression of their drives. We may secretly wish that we ourselves did not have to clean the house or go to work. Since in order to function as members of the middle-class we must reject these wishes, we may in the same way tend to reject the lower-class."

Of greater importance were problems arising from shifts in professional practices and techniques. Clinicians, accustomed to being sought out by patients, tended to feel that by knocking on doors uninvited they were intruding. They were troubled because they came with no pre-established identity or reason for intrusion. Used to having their role established by their titles and their institutional affiliation, they now found they had "to sell themselves." The fear of beng rebuffed was strong, all the more so because their usual work setting protected them from this experience.

They also felt helpless when confronted with major situational problems—poverty, unemployment, poor physical health. In their usual work they dealt with intrapsychic problems, and at first they lacked knowledge of the resources available for situational problems. When resources were available, they often came from unfamiliar agencies or agencies with low status in the psychiatric world. Initially, the clinicians tended to regard many public agencies (welfare, the police) as "lesser breeds within the law." Often the clinicians were unfamiliar with the functions of such agencies, and did not know how to make referrals to them. Having to go to other agencies threatened their own wishes for omnipotence and competence. It was sometimes most frustrating to the clinicians to realize that they might not have much to offer and that other groups could do more.

Another source of helplessness lay in the clinicians' unfamiliarity with the lower-class subculture. There was always the nagging fear that they were making errors in judgment. For example, to them, a janitorial job carried with it connotations of low status, low pay and menial work. Yet they found that, for many Negroes, being a janitor in a modern office building was a job of considerable status. At first the teams tended either to cling to their old standards and to evaluate accordingly—"anyone who has three illegitimate children must have masochistic needs"—or else, going to the opposite extreme, they tended to deny that their clinical knowledge had any application at all.

The experimental design also imposed certain strains. The researcher's insistence on a control group—a group needing yet not receiving intervention—meant that the teams would often see a pressing need, yet be enjoined from doing anything about it. The limitations on case discussion between teams also led to frustration. Finally, the team's feeling that they had to produce dramatic results ("because otherwise the government will have spent this money for nothing") led sometimes to an inappropriate pressure for decisive action.

Another source of strain lay in the interview procedures. It took time for the teams to develop an effective rhythm, and for the clinicians to work with each other in a complementary fashion.

Strains were also imposed by the changed power relationships implicit in the new role. In the office interview, the clinician is in control: interviews are held in a familiar office, patients come as supplicants seeking help, the therapist sets appointment times and fees. Not so in the home interview; there the family can tell the therapist to leave, can refuse to discuss certain issues, and has at first no expectation of a long-term relationship. All of this forced the clinicians into being more "social" in their behavior. They had to explain who they were, to take the lead in eliciting information, and to establish bridges of communication. The discomforts arising from this active-intrusive role sometimes led the teams to feel exceedingly grateful when they encountered

friendliness and cooperation. Although their gratitude might help to establish a warm and useful relationship, it also sometimes caused the teams to offer more help than was appropriate, simply in repayment for the relief of their discomfort.

This "social" flavor itself often led to a role dilemma. The clinicians had to strike a balance between their psychiatric and their social roles. At times they attempted to fall back on earlier ways of handling home visits: thus the psychiatrist might ward off his anxieties by acting like a general practitioner and spending much time discussing medication or health problems. In other cases the clinicians did quite the reverse, leaving their professional knowledge at the door and treating the contact simply as a social visit. The teams also encountered difficulty in maintaining the optimum emotional distance between the interviewee and themselves, a distance which allowed both empathy and detachment. The immediacy of the home environment, and the social feeling of the visit, often led them into too great a sympathy, and caused them to miss significant cues.

The clinicians were of course familiar with similar pitfalls from their previous training, but in this new setting their customary skills were not easily applied. As a result, they often found themselves going through difficulties that recapitulated their earlier experiences in training for clinical practice. An experienced psychiatrist does not enjoy making again the mistakes he had made as a neophyte physician in the first year of residency training.

As the teams met with success in making contact, their initial stereotypes were examined and discarded. Familiarity with the neighborhood produced desensitization, so that the clinicians became more comfortable with disorder and squalor. We hypothesized that many of the unfortunate stereotypes about low-income people arise because the professional person so often has an authoritative and punitive role: he comes to the family to talk about school failures, or to check on whether they are destitute enough for welfare. He is likely to demand punctuality and obedience, and to force the family to expose deficiencies rather than strengths. From the first we tried to avoid such punitive confrontations. Success in making contacts lessened the fear of rebuff.

An earlier note written to give advice to new members of the staff reflects this shift in orientation:

> "First, it seems appropriate to tell those just beginning not to worry

> about information, but to concentrate on getting people interested enough in us and the project to let us come in and talk with them. Then we must listen and get to know them as individuals, as something other than 'poor people,' 'part of the sample' or whatever other generalization we use. It is not easy to see through the dirt, the clutter, and the smell, of some of the families, to understand what the person is like. The smell of alcohol on the breath of someone, a man hanging around the home of a divorced woman, a supposedly divorced woman who appears pregnant—we must not judge by generalizations. We must have them tell us how it is. And the only way we can learn and know is to listen, with no preconceived notions—or at least as divorced from them as we possibly can be. This takes practice and it takes a kind of personal security which in part derives from meeting the individuals and gradually seeing them as such. We do not feel so willing or able to judge when we learn the man with alcohol on his breath at two o'clock in the afternoon is constantly battling the effects of two heart attacks which completely disrupted an active, productive life. Or when we discover the idle man is not so healthy, and that every attempt to get a job which ends in refusal is only further verification of his poor health and his lowly self. We must hear and understand the loneliness of people as they search for some place for themselves, some way of being someone to another, of amounting to something."

There is a recapitulation here of earlier clinical training, where the neophyte clinician discovers that he must develop an effective relationship with a patient, and that "diagnosis" involves much more than the application of a stereotyped label to a checklist for symptoms. But, although in broad outline the same issues arise, new techniques are necessary to the work. One of the staff said:

> "I have felt, from the beginning of the pilot study, that our usual clinical technique of asking questions, of listening and reflecting, is not the most productive technique in our present situation. We must come through to the people we see as real people, and not as clinicians. This involves sharing common experiences, comparing notes, talking about our children and families, perhaps discovering that we have similar acquaintances, or have visited similar places. I have found that moving in too quickly can scare people away before they really want to say no. They need a period of time to appraise us and to know who we are. This may mean talking about the flowers in the porch box, the pup playing in the yard, the child peering from behind mamma's skirt, or anything which can naturally allow for an interim for evaluation."

When a team member chats with a woman about recipes or her kitchen work, nonculinary messages can be conveyed as well. The

conversation may touch upon infant feeding problems and how to handle them, upon techniques of meal planning and household organization, etc. When the social worker compares notes with a mother about toilet training, it is often possible to communicate professional knowledge and techniques. A feeling of friendly interest is conveyed in such discussions. The teams have come to feel that, with a low-income population, intervention on such a concrete level may prove more helpful than abstract discussions.

In other aspects of the work there was a fusion of the social role. It is seldom appropriate for a clinician in office practice to bring "guest experts" into the psychiatric interview, but it is quite common for one social group to introduce friends to another social group. Thus the clinician-in-the-neighborhood may find it easy to introduce a nursery-school worker into the family, or to arrange contacts with the vocational rehabilitation counselor.

The emergence of this new and more comfortable role brought with it a reduction of strain. The teams knew what they could do. They began to extend their contacts with other helping agencies—the police, welfare, the schools. Although difficulties remained—the occasional rebuff at the door, the missed appointment, differences with teammates, lingering uncertainty about the meaning of "psychopathological behavior" in a low-income setting—the teams were increasingly able to function with good morale.

III. CLINICAL VALUES OF THE TECHNIQUE

RONALD FILIPPI, M.D.

In the research on psychological problems in low-income families described in the preceding papers, the interviewing teams consist of a man and a woman from the disciplines of psychiatry, clinical psychology and psychiatric social work. As a member of one of these teams, and as a psychiatrist, I have been impressed with the diagnostic value of the method used of interviewing families in their homes.

Research in prevention has for some time emphasized the possibility of early diagnosis based on extensive psychiatric and psychological information. In our initial interviews, for which the term "screening" seems most appropriate, we try to get an extensive and panoramic view of the situation. As we continue with some of the families, and accumulate additional information from other sources, the process becomes more and more "diagnostic" in the largest sense. We are not so much concerned with labeling as with understanding, and we find that our understanding grows sounder and surer, more relevant and valid, when studying people in their homes. This seems to hold true not only for picking up the highlights of a situation in our screening interviews, but also for arriving at comprehensive, diagnostic appraisals after detailed study. So marked is the difference, that the office interview can be compared with observation in vitro and the study of human behavior in its natural habitat with observation in vivo.

Consider one example of diagnosis in vivo. Imagine the team on a sunny October day entering a living room darkened by blankets over the window. The window panes are partially broken; the blankets held in place by a stack of bricks. Two shabby pieces of furniture stand out clearly amidst the litter and debris that covers the floor. On the wall hangs a picture of the late President Kennedy, and next to the front door is a plate proclaiming "Prayer Will Always Help." In the air, floating almost like clouds above the grimy mess, hang a dozen neatly washed and ironed girl's dresses, white and pristine. In this room a couple argues bitterly and hopelessly with each other, like two characters in Sartre's "No Exit" hell, while their naked little boy rocks himself in front of the blaring television set.

Compare the richness of these environmental cues with the sparse cues that we get by observing the patient's grooming in the office. While

we are not always exposed to such a bewildering complexity of impressions, it is true that much more diagnostic material is available in the home environment.

At times the new situation makes one feel that one is starting to learn psychiatry all over again. In clinical office practice we are apt to be misled by the vividness and immediacy of the patient's talk, and are frequently guilty of forgetting that he exists in a physical and social environment. Our predilection for verbal communication, reinforced by the general inhibition of activity in the office, leads us to forget that "man invented language to conceal his thoughts." Especially when dealing with people who have a different way of life from our own, it becomes very difficult to understand the adaptive function of seemingly pathological behavior. But when we are able to see the person functioning in his setting, much that was hidden becomes clear. We are in a better position to understand the full range of adaptive and defensive behavior that is exhibited. Suspiciousness of neighbors, provocativeness toward people in authority, unusual use of time and space, idiosyncratic responses to temperature, irrelevant and almost incoherent talk, loss of emotional control—all these become clearly visible in their dual aspect: as weaknesses and disruptions of certain functions, but also as highly effective modes of maintaining balance with a minimum of discomfort to the individual. Thus we are less apt to make partial judgments. We instead often find, as Karl Menninger* has written, that "integration at the top level is what it is, sometimes despite and sometimes because of whatever we find in the subsystems."

Observation in the homes has enabled us to see also a whole new gamut of behavioral patterns, "environmental defenses," which usually play a much less conspicuous part in clinical practice in the office. In these the person uses parts of his environment to ward off anxiety-arousing situations. This is not acting-out behavior: it is not a simple motoric discharge of impulse. Rather it may be seen as an adaptive transaction, whereby the person uses the home environment in the service of the ego.

For instance, the demanding, unrestrained behavior of a small child may supply the "reality input" necessary to his mother. In more extreme cases we find people setting up crisis situations that seem to provide periodic rallying points for ego functions. We find them making adaptive efforts when they face being cut off from basic commodities such as water, light and heat. At times it appears to us as if the family had maneuvered themselves into troubles, because the trouble itself served a defensive function. Insofar as such environmental defenses form a major part of an individual's total defensive structure, he may appear far stronger when he is seen in his familiar environment, where such defenses are available to him, than when he is seen in the office.

*Menninger, Karl: *The Vital Balance.* New York, Viking, 1963, p. 94.

In their own environment people give us messages by action. They communicate, through their behavior, needs and feelings that probably could never be communicated to us otherwise. For instance, one day when we came for an interview with a very moral-sounding woman who had begun to talk with us about her relations to men, we found her in bed with a man. If we find the furniture rearranged each time we visit, as in a perpetual game of musical chairs, we may infer that feelings of dissatisfaction with the self and the world are expressed. Again, actual behavior may communicate how *we* are viewed, and how we are heard. Often our discussion of work problems is followed by some work-related activity, which in turn leads to further discussion. For instance, on the fifth visit to a man who had previously been found drunk and loafing on the porch, we learned that he had started to pick bottles out of trash cans to make money. Such behavior allows us to explore whether we were seen as admonishing authorities, or as role models, or as people to placate and avoid. At another level, this behavior tells us that the person regards himself as relatively worthless: he is only capable of the most lowly and marginal work.

The illustrations given thus far perhaps convey the impression that the teams usually encounter situations where problems exist that require treatment or at least change. It is true that one particular problem may stand out with urgency and clarity; in this way resembling the "chief complaint" of a clinical case. In spite of such similarities it is well to remember that we are not sought out for help, but rather come asking for help. We are not presented with a "chief complaint," and our role is not that of the psychotherapist. Since our study derives its mandate from societal concern with the problems of the poor, one can argue that in this respect it more nearly resembles the public health role. While some basic features—active intervention and the "no cost service"—are the same, our efforts are directed at the relation of man to the world. We are catalysts

for change. In this way we are unlike the public health worker. From the moment of our appearance, a reverberating and reciprocal process begins; the family strives to maintain equilibrium by casting us into certain roles, while we attempt to utilize the temporary imbalance to effect change. We have the freedom to let the situation work on us and to respond in the most appropriate manner we know, rather than attempting to impose any standardized procedures.

We begin by asking for people's help with our study, sketching our interest as a broad concern for work, family, education and recreation. Thus our first interview is fairly structured and most people find it comfortable. After this, however, our initial role of "researchers" becomes unclear and ambiguous. We continue to present ourselves as educated, knowledgeable, and human, while avoiding the standard images of the doctor, the welfare worker, the minister, or the county health nurse. We let the family decide with us how often we will see them; we will ask but not insist on certain appointments; and we do not require that any particular material be discussed. It is during this phase that we try to show ourselves as real persons in order to bridge the gap between their social world and ours. Or we may do it when we are struck by a person's lack of emotion over a disturbing event. Thus, when some of the experiences they tell us arouse indignation or confusion or frustration, we may share our feelings with them.

After a bond is established we begin to evolve a new and more specific role for ourselves, a role that is defined for a jointly determined purpose. For instance, we may set up a number of appointments to meet with a couple to discuss their marital relationship, or we may set up meetings with the mother and her three grown-up daughters to "straighten out the family." We may introduce a nursery-school teacher or a rehabilitation counselor or a volunteer to help with reading or arithmetic. Generally we can offer opportunities to learn new skills, or to discover resources, or to acquire better modes of adjustment.

We find that our family focus provides many insights into small group structure and function. There are very large family systems in which the nuclear family of parents and children seem scarcely to be differentiated from the extended family. We find other well-differentiated nuclear families who contain so many children of different ages that the household appears more like a congregation than a family. Some families subscribe formally to male dominance but are actually matriarchies run by the wife

or the mother-in-law. We see many variations in group structure: fatherless families, motherless families. By viewing the explicit and implicit role systems in the family we are able to perceive aspects of agreement and disagreement among family members, to discern the origins of interfamily conflict, and to detect the mechanisms developed to keep the interpersonal relations in balance. We can observe the ways in which a choice of role leads to drive satisfaction and impulse control, provides defenses against anxiety, and gives a stable self-concept. We can also see how hidden needs of the parents induce certain kinds of behavior in their children.

The Two-Person Team

We find that the use of team therapists working with the family has the effect of one small group (the two therapists) interacting with another small group.

We began to visit families as a male-female clinical team for a variety of reasons, not the least of which were our own needs for mutual support and protection. We expected that this structure would provide a useful opening gambit if only a man or only a woman was found at home, thus minimizing the stress of the encounter for both the interviewers and the interviewees. But it had other advantages as well. The fact that the two team members each come from a different profession deepens their observation and allows them to compare their data and the judgments built on them. Quite basically, there is an advantage to having a man's and a woman's point of view.

There are disadvantages, too, such as administrative problems in scheduling of team interviewing time. Another set of problems originates in the relations between team members. Initially, both partners feel self-conscious or concerned over too much or too little aggressivity by the partner, over being left out or cast in a secondary role, or over not being liked as well as one's partner. These feelings can be overcome as the team partners begin to communicate more easily and more often. Supervisory consultation too helps when points of impasse are reached. As a result of their collaborative efforts, the representatives of various disciplines tend to pick up techniques from each other.

Since both team members present themselves together to the family, the family members may prefer one to the other. We have usually found it helpful to go along with such preferences. In some cases, a pairing-off

process occurs, sometimes running counter to our conventional professional roles. For instance, in one interview the social worker talked only with the woman of the house, who turned out to be extremely disturbed and delusional, while at the same time the psychiatrist was having an amiable chat with her husband in the woodshed about power tools.

We have also found, as our work proceeded, that the teams grew more comfortably aware of interdependence between team members. Concrete and unsettling experiences forced home to us how much at a loss a team member can be by himself, when he has become used to the team interview.

Finally, we have been struck by the opportunities for sophisticated techniques of intervention and diagnosis that are implicit in the two-person clinical team. In the first place the team format seems to facilitate the development of transference feelings. Each of the team members can act as observer when transference behavior occurs. For instance, when the interviewee reacts in an overdetermined way to one clinician, treating her as an authority or a mother figure, the process can be clearly observed by the other one.

The presence of a second team member also has a protective function. It serves to prevent the possible development of a homosexual or heterosexual panic in the person being interviewed. Other unacceptable feelings—rage, love, overwhelming hostility—are diffused and chaperoned. All this results in more spontaneity, and less inhibition of expression of feelings and thoughts. The dual therapist structure also makes possible new kinds of relationships in which one therapist may take a confronting role, while the other is supportive and encouraging. For instance, when a woman complained bitterly about her husband's inadequacy as a father, one team member asked whether she had ever encouraged him to take more interest in the children. She reacted to this as if she had been blamed for a misdemeanor, and launched into a long account of her husband's virtues. Very quickly the other team member verbalized the latent feelings, asking his partner whether the comment was meant critically. It is easier to confront a person with an interpretation of his resistance when the other team member remains, so to speak, on the other side.

Related to this are other possibilities. We are increasingly using exchanges between team members in front of people as model interactions for clarifying meaning and feelings. This technique seems particularly effective when the family members are silent. We then discuss between

ourselves out loud what each other's thoughts or even disagreements are about the situation. For instance, one team member stated that working for a very low wage was not worth the effort, while the other pointed out that work *per se*, with its regular hours, its schedules and its responsibilities, was beneficial in itself. Just as the people themselves appear more spontaneous when both team members are present and "chaperoning" each other, so too do we as clinicians experience a sense of freedom. We develop more spontaneity and are less reluctant to use ourselves in the relationship.

Gardner Murphy* describes under the "principle of emergence" the kind of things which I think we are finding:

> "The principle of emergence means that new conceptual tools are required at each level of integration—or that the data inherently and in their own right, require new methods of conceptualization . . . as realities become more complex [we must] look not for new substances but only for new *modes or organization*."

It is with this in mind, and *not* with the intention of rejecting or throwing overboard what we have learned as clinicians, that I want to suggest that in this new role we are increasingly hearing and seeing people as if we had never diagnosed patients in our offices and hospitals before. We are trying to avoid being hemmed in by our everyday jargon, imprisoned by time-honored constructs. It is as if we have to lay aside our clinical spectacles and use again innocent eyes and ears. This I think is possible when we expose ourselves not naively, but clinically and humanly, to the realities of life. Accompanying this is the sense of excitement and adventure that Gardner Murphy* has conveyed:

> "One wants more and more of the world itself, not because it is there . . . not because it is ideal but because it is real; not because it contains unlimited hidden meanings—though, indeed, it does contain them—but because in its own right it is exciting, moving, satisfying, yet always prompting to new modes of contact, always giving birth to new hungers."

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*Murphy, Gardner: *Human Potentialities.* New York, Basic Books, 1958.

READING NOTES

Time grinds slowly in my Reading Notes department. On December 29, 1957, I took a clipping from the *Manhattan Mercury* about books and libraries. All right, seven years old, it is, but probably still true—"The United States has the lowest proportion of book-readers of any major English-speaking country. According to the Gallup poll on the subject, only 17 percent of all Americans interviewed were reading any book . . . and 61 percent of all Americans had not read any book during the previous year except the Bible. Englishmen read more than three times as many books as we do. Australians and Canadians read twice as many.

"Half of our adults live within a mile of some public library—but only one-fifth of them visit it. To obtain the same ratio of libraries to our population as Sweden has, the U.S. would have to increase its libraries from 7,500 to 77,000. And to reach the same ratio of bookstores to our population as Denmark has, we would have to increase them from 1,500 to 23,000 bookshops."

* * * *

Fashion is fickle in music as elsewhere. For example, the following appeared in the reissue of *Harper's Weekly*, New York, Saturday, April 20, 1861:

"Wagner's opera, *Tannhauser*, has been produced in Paris, and failed entirely. Money was spent in profusion, every advantage of scenery and costume was afforded, the choruses and the orchestra were perfectly drilled, preliminary puffs, and the national sympathy of the great number of Germans resident in Paris, were not wanting; there was the most ample and careful preparation, as if one of the Meyerbeer's great works were to be produced; the Emperor was present on the first and second nights—but the third night has not come. The musical burst in the very crisis of the opera, whereby is expressed a profound and vital spiritual change in the hero's mind, instead of thrilling Paris, made it laugh. That, of course, was the end. 'Wagner composes for the future,' says pleasant Paris: 'a la bonne heure, we won't let ears stand in their way.' And so they pass it on to the future, scrupulously declining to hear.

"Our Philharmonic has played the Tannhauser overture several times, and we are all more or less familiar with it. There are passages of great beauty and power, and the final triumphal march is certainly very grand. Even laughing Paris does not deny him genius. But there is undoubtedly

a grandiose effort throughout which is not satisfactory. You find yourself saying to the instruments, as Hamlet said to the players: 'Leave your damnable faces and begin.' There is an elaborate anticipation and preparation; but when you ask when, in pity's name, is it coming, you learn to your dismay that the 'it' has come and passed.

"Still a Parisian judgment is only conclusive for Paris, after all. Meyerbeer is the imperative musical fashion in Paris, although he is a German. But, in general, Germany insists upon its own music so strongly that Paris rebels. Paris does not believe there can be a good German singer. 'Mon Dieu! they don't know how to open their mouths!'

"So, if Wagner has failed in Paris, there may be many reasons for the failure besides the music."

* * * *

Health Industry is a new medical journal dedicated to the economic, financial and managerial aspects of the medical "business." Volume 1, number 1, appeared in November 1963. Robert L. Smith, son of our friend and colleague, Lauren Smith of Philadelphia, is President; his father is Chairman of the Professional Editorial Review Board. Frank Braceland is on the Medical Advisory Board. We were invited to join this fine company but we thought it wise as employees of a nonprofit corporation to deny ourselves this honor. But we commend the young journal and its young officers, hoping that by rendering unto Caesar what is Caesar's they will help to purge the medical profession of corrupting economic trends and temptations.

* * * *

The coin business is surely coming up in life or is it only that some of us are getting better educated about what has been here all the time? Recently I obtained from a large oriental collection that was being broken up one of the coins in circulation at the time of Christ, known as a Herodian Lepton. It is copper or bronze. There is an anchor engraved upon it, surrounded by a cornucopia. My antiquarian dealer informs me that this is probably the coin referred to as "the mite" in the famous New Testament passage where the gift of the widow was praised as greater than the gold tithes of the wealthy.

* * * *

Daedalus is the journal of the American Academy of Arts and Sciences and its quarterly issues are always thought-provoking. The Fall 1963 issue was devoted to a study of "The Professions" which, as the introduc-

tion declares, are everywhere triumphant in American life. Clark Kerr has predicted that the "knowledge industry" will come to occupy the same key role in the American economy which the railroad industry did a hundred years ago. Thorstein Veblen's old dream of a professionally run society thus comes closer to realization.

In every profession it seems that there is a balance of a kind between the universal and the particular with always some measure of both. To put it another way, there is the theoretical and the practical aspect of law or of psychology or of sociology.

In this issue competent specialists successively discuss the legal profession, the medical profession, the clergy, the teachers, the military profession, city planners, politicians and, of course, psychiatry. The latter field is presented by Norman E. Zinberg of Beth Israel Hospital and Harvard Medical School. He submits that psychiatry faces a dilemma relating to its isolation from and yet theoretical dependence upon the rest of medical science, and the medical profession.

He illustrates this by an example which finds its counterpart in many contemporary problems in our Foundation. He speaks of the psychiatrist being invited to participate in the work of the college and how pleasant this is or was for both parties—*at first*. The colleges liked the help they got and the psychiatrists liked the work they got. But pretty soon the psychiatrists discovered that professors, administrators and deans were abdicating responsibility in favor of psychiatric recommendations, students were using psychiatry for a way out, and the psychiatrists were so overwhelmed with assignments they couldn't do a proper job. The psychiatrist began to wonder whether he was a consultant to the students, to the faculty members or to the college. What is a consultation for anyway and whom is it with and about what? When one of us is asked to be a consultant to the governor or to the chief of police or some factory manager, do we go with the idea of examining some patient or with the idea that the principles of case study can some way or other apply to organizations? This is surely an unwarranted assumption. But on the other hand is psychiatry expected to be of no general usefulness or, let us say, no usefulness outside the doctor's office and the hospital?

The problems of other professions are treated in other articles and the whole number is well integrated at a high level of writing and thinking.

* * * *

A new idea or theory, offered in *Scientific American* for November 1963, was that aspirin is the most widely consumed drug in the world. It is not only dramatically effective in reducing pain, but also actually reduces fever. Now fever is one of the defensive responses in the body evoked by disease, and yet this counteraction to the total healing process seems to further the healing process. This leads author Collier, Director of Pharmacological Research at Park Davis & Company in England, to suggest that in some way it moderates the defenses of the body. Its traditional beneficial effect on arthritis, Collier explains by a complicated theory and a fine chart—which I don't understand.

In the same issue, E. J. Sachar, a colleague at the Boston Psychopathic Hospital and Harvard Medical School, wrote one of the best summaries of the contrasting positions of behavioral science and criminal law which I have seen anywhere.

* * * *

Early in May, 1831, two distinguished young Frenchmen arrived in the United States commissioned by their Minister of the Interior to make a study of American prison systems. The report of Gustave de Beaumont and Alexis de Tocqueville *On the Penitentiary System in the United States and its Application in France* has recently (1964) been reprinted in English by the Southern Illinois University Press. Since it turned out that one of these authors had phenomenal sociological vision, time spent in reading this report does not go unrewarded. But its message can be stated in a sentence: The penitentiary seems to be a necessary evil, but there is no evidence of effectiveness and small prospect of improvement.

K.A.M.

Delinquency and Child Guidance: Selected Papers. Menninger Clinic Monograph No. 15. By AUGUST AICHHORN. OTTO FLEISCHMANN, PAUL KRAMER and HELEN ROSS, eds. $5. Pp. 244. New York, International Universities, 1964.

One year before his death in 1949 August Aichhorn addressed an Austrian professional audience in order to help it see *delinquency in a new light,* the light he had so masterfully provided for generations of workers in this field. As he describes the historic struggle which led from cruel punishment to modern notions of treatment, he quotes there a medieval chronicle which describes the horrible play of a group of five and six year old children. One little boy was to be the butcher; another was to play the pig; a little girl was to be one of the cooks and to catch the pig's blood. While the "pig's" throat was slashed, a judge caught the butcher and brought him to the court house where he was to face the council. A wise man solved the predicament of that council by suggesting that the boy be offered his choice of a beautiful red apple or a big gold piece. He would be declared guilty and executed if he took the gold, but he chose the apple and went free.

Aichhorn has taught us to look at the gory acting-out games of children and adolescents in a new way. We are now searching for that apple, that unconscious conflict which explains the game; and he has helped us to develop the methods which bring us into contact with the delinquent child and permit us to help him reach for the apple which leads him back into the community. His enormous ability to identify with the child without ever losing identity with the community and its values, his skill in "deceiving the deceiver," comes alive once more in this little volume which covers selected essays published in German between 1923 and 1948, thus covering twenty-five years of creative work in which he rounded out and complemented his opus magnum, *Wayward Youth.*

I wish that Otto Fleischmann, the main editor and prime mover of this publication, could have lived to see the fruits of his labor and of his dedication to the work of Aichhorn. He and I often spoke about our common teacher and we wondered how one could make him alive once more in this new and different culture, and through the medium of a foreign language, as well as through the printed word, without the direct impact of the charismatic quality of his magnetic personality. But, as I reread these

chapters on education, on guidance and treatment, I feel that Fleischmann, Paul Kramer and Helen Ross have come remarkably near that goal. One feels grateful to them and to The Menninger Foundation as well as the publishers to have made Aichhorn's later thoughts available to the American scene and to thus strengthen in us once more the search for that beautiful red apple that society needs to discover in order to successfully treat delinquency rather than to merely rely on an uninformed concept of law and on revenge.

Aichhorn sets a goal for us as he suggests that: "When the task is accomplished, then the total chaos that waywardness presents to us today will be disentangled. Juvenile welfare authorities and welfare educators will then not be confronted by an endless confusion of damaged juveniles and in desperation yield to the temptation to join with society and the law in condemning them. As a logical result of scientific research, we will be equipped with knowledge of symptomology, etiology and therapy of waywardness. The rehabilitation of the wayward will no longer be limited to the accidental success of gifted educators, but will be the predictable result of systematic scientific work."

Rudolf Ekstein, Ph.D.
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BRIEF BOOK REVIEWS

"Life-Meanings" of Future Teachers. By LUCY K. ACKERKNECHT. $4. Pp. 160. New York, Philosophical Library, 1964.

The findings of this report (an attempt to study values through statistical examination of thematic responses from essays on "the meaning of life" of 420 teachers' college students) suggest that the great majority of the students are certain about their own life meaning, finding it in "self-actualization," in cooperation and interaction with others, especially "those close to us." Religion, concern for country or for humanity, competitiveness, egocentrism, and "pessimism" were of little concern. An effort to sort responses into active, passive, other- and self-oriented, religious and certainty modes was suggestive but inconclusive, restricted by limitations of attempting to correlate frequency of thematic responses with gross demographic data of the students. (Roy Menninger, M.D.)

Psychological Studies of Famous Americans: The Civil War Era. NORMAN KIELL, ed. $6. Pp. 302. New York, Twayne, 1964.

This volume is a provocative and stimulating example of both the virtues and the irritations of the inter- or cross-disciplinary approach to a subject. The

writers of these essays include psychiatrists such as Philip Weisman, who writes on John Wilkes Booth; psychologists such as William James writing on Walt Whitman; and historians convinced of the value of psychology to their field, such as C. Van Woodward writing on John Brown. Inevitably, the historian reared in the politics, war, and money nexus is apt to be light on individual and group motivations, while the psychiatrist and psychologist are apt to insist that history "is dealing with human behavior in the past." Semantics and definitions become the crux of the matter. If the complexity and multi-causal nature of history are to be kept in focus, then "behavior" must include not just Caesar's ambitions when he crossed the Rubicon (and their possible psychosexual causation), but also the institutional growth and decay of the Roman Republic, the economic decay of the small farmers, the bankruptcy of creative ideas and religion, and much, much more. (Lewis F. Wheelock, Ph.D.)

Transference: Its Structure and Function in Psychoanalytic Therapy, Ed. 2. By BENJAMIN WOLSTEIN. $7.75. Pp. 272. New York, Grune & Stratton, 1964.

The second edition of Wolstein's examination of transference is in his words "being reprinted with major additions and minor corrections." This is considered a mixed blessing by the reviewer for the author leaves unchanged the dated criticisms of Freud's earlier thinking. Undoubtedly this book will be of most interest to the student of the "interpersonal school." However, it is recommended to anyone wishing to have his understanding of psychoanalytic concepts stimulated. (Harvey L. Schloesser, M.D.)

The Annual Survey of Psychoanalysis, Vol. 8. JOHN FROSCH and NATHANIEL ROSS, eds. $12. Pp. 371. New York, International Universities, 1964.

It is a pity that this indispensable source book for any person concerned with psychoanalysis should keep falling further and further behind the current literature. Volume 1 reviewed the psychoanalytic literature for 1950 and was published in 1952, a two-year lag. Volume 4 reviewed the literature for 1953 and was published in 1957, a four-year lag. The current volume, Volume 8, reviews the literature of 1957, an eight-year lag. In Volume 8, 281 bibliographic entries are divided into nine major topics and a number of subtopics. The present volume maintains the high standards of synopses set by the first seven. One hopes that future volumes will appear at an accelerated rate. (Philip S. Holzman, Ph.D.)

No Language but a Cry. By BERT KRUGER SMITH. $5. Pp. 170. Boston, Beacon Press, 1964.

This small volume is essentially for parents and other nonprofessional people interested in the broad field of treatment for emotionally-disturbed children. It is written in a clear and straightforward fashion, giving brief descriptions of some of the symptoms of mentally-ill children, and outlining some of the approaches used in helping them. The author also gives an accurate appraisal of the vast shortcomings in the treatment resources currently available, and points the way to some of the measures needed to correct this tragic situation. (Keith Bryant, M.D.)

Group Therapy in Childhood Psychosis. By REX W. SPEERS and CORNELIUS LANSING. $6. Pp. 186. Chapel Hill, University of North Carolina, 1965.

This monograph reports a four-year study, still in process, which takes place at the Child Psychiatry Unit of the University of North Carolina School of Medicine, on the "feasibility and effectiveness of group therapy in the treatment of young psychotic children and of the collateral group therapy of their parents." The theoretical frame of reference is based on Margaret Mahler's extensive writings on infantile psychosis. The virtue of this particular study is its clear, succinct summary style, the flexibility of its approach, and the pragmatically dictated shifts in the therapeutic procedures as time went on. Few startling, new insights are reported, and there may be too generalized an optimism about results. There is no doubt as to the need for the treatment of these unfortunate children by a group of dedicated therapists from a variety of disciplines using an assortment of experimental approaches such as group therapy for the children, group therapy for their parents, individual therapy sessions when indicated and occupational therapy. (Arthur Mandelbaum, M.S.W.)

Transference and Trial Adaptation. By JOOST A. M. MEERLOO and MARIE COLEMAN NELSON. $6.50. Pp. 155. Springfield, Ill., Charles C Thomas, 1965.

The title of this book employs a technical word relating to an aspect of psychoanalytic treatment, and marries it to another technical concept, *trial adaptation*, employed by some schools of psychology. The jacket states that the authors have "*not confined* themselves (italics are the reviewers) to the specialized jargon of the psychoanalysts and the psychotherapists." Discussion of the phenomenon of displacement as seen in many aspects of life other than the psychoanalytic and psychotherapeutic treatment situation to which the word *transference*, by definition, was originally restricted, makes interesting although confusing reading. The authors explain their use of the terms in the title in this sentence: "After all, what we are saying here in many sophisticated words is that deep friendship, even when only one-sided, is the best cure for impaired human relationships." (K.A.M.)

Why People Act That Way. By LUCY FREEMAN. $5.95. Pp. 246. New York, Crowell, 1965.

Miss Freeman is well known for her responsible reporting in the fields of welfare, health and, especially, psychoanalysis. This book is an exposition of psychoanalysis, written for the lay public, with grace and skill. Remarkable is the wealth of illustrative material, including many interesting pictures. Anecdotes, brief reports of research in psychology and anthropology, references to literature, art, folklore, mythology, the stage, public figures and news accounts are woven into a lively pattern around the warp threads of familiar psychoanalytic theory. (Jeanetta Lyle Menninger)

Madness and Civilization: A History of Insanity in the Age of Reason. By MICHEL FOUCAULT. $5.95. Pp. 299. New York, Random House, 1965.

The French edition of this book appeared in 1961. The book is well written and well translated, and seems to make effective use of source material. Its

most conspicuous lack for the reader is the fact that there is no index. The author's thesis is provocative and alarming. "The world that thought to measure and justify madness through psychology must justify itself before madness, since in its struggles and agonies it measures itself by the excess of works like those of Nietzsche, of van Gogh, of Artaud. And nothing in itself, especially not what it can know of madness, assures the world that it is justified by such works of madness." (Lewis F. Wheelock, Ph.D.)

Neuroanatomy: A Programmed Text, Vol. 1. By Richard L. and Murray Sidman. $11.50. Pp. 656. Boston, Little, Brown, 1965.

This unique volume is basically composed of a series of very simple and helpful diagrams, a minimum of text, and a succession of questions in the form of blanks which the student must fill in. Step by step, the student is taken through some of the fundamental intricacies of the anatomy of the cerebral hemispheres, with many repetitions, in a gradual enough fashion so that neuroanatomy does not become frightening or distasteful. A great deal of thought is reflected in the structure of the text. As primary material for the medical student this volume shows promise but for advanced students it soon becomes tedious. This is a self-instruction text, although it is designed as an adjunct to the usual type of laboratory instruction. (Joseph M. Stein, M.D.)

Color and Personality. By K. Warner Schaie and Robert Heiss. $11. Pp. 295. New York, Grune & Stratton, 1965.

This manual for the administration, scoring and interpretation of a new projective technique—The Color Pyramid Test—has been developed and widely used for personality assessment and clinical purposes in Western Germany. The rationale of CPT is predicated on the assumption that responses to color stimuli—in the form of preferences for hue, saturation and brightness—reflect individual differences and consistencies with respect to control of affect, emotional flexibility and mood states. In introducing the test to American readers the authors provide instructions for CPT's administration, a scoring scheme, scoring norms for several age and sex groups, as well as extensive psychometric evidence as to reliability and validity. An interpretive rationale, which is to some extent empirically grounded, indicates how assessment of "emotional structure" and clinical inferences may be derived. Actuarial methods for the prediction of personality traits are also presented. The simplicity of its administration, specificity of application, and some of its psychometric virtues appear to recommend the test as a useful supplement to the personality assessment armamentarium of clinical psychologists. (Herbert E. Spohn, Ph.D.)

Healing the Sick Mind. By Harry Guntrip. $4.95. Pp. 224. New York, Appleton-Century, 1965.

Published for the general public, this book presents views on a variety of issues pertaining to mental health. The author believes that mental ill health results from experiences of overwhelming fear in infancy—"fear in a primary sense . . . the small and helpless child at the mercy of a bad environment." He discusses the implications of this theoretical construct for both diagnosis and treatment. He discusses the merits of psychotherapy as compared to other treatment modalities and presents his arguments against the critics of psychotherapy. (Phillip Green, M.D.)

Short-Term Psychotherapy. Lewis R. Wolberg, ed. $9.75. Pp. 348. New York, Grune & Stratton, 1965.

A timely book by nine contributors attempts to evaluate the effectiveness of short-term therapy versus long-term therapy. Although psychoanalytic principles and technique are constantly referred to, certain modifications are suggested such as more limited goals, more activity on the part of the therapist, limiting the transference, and the utilization of environmental manipulations, somatic therapies, hypnosis, and group approaches to reduce resistance and promote change. This should be an effective book to encourage the experienced therapist and analyst to experiment with short-term therapy. Lewis Wolberg's chapter on Technique and Lothar B. Kalinowsky's chapter on Somatic Treatment are outstanding. (Herbert Klemmer, M.D.)

Psychoanalysis and Current Biological Thought. Norman S. Greenfield and William C. Lewis, eds. $8. Pp. 380. Madison, University of Wisconsin, 1965.

Fifteen participants in a conference on psychoanalysis directed themselves to the biological and physiological aspects of psychoanalytic theory. As with most conferences, the contributions, published in this volume, are only loosely related to each other. All, however, indicate the extension of psychoanalytic concern from its early beginnings, as a psychology that illuminated unconscious processes, to a general psychology that embraces the congeries of man's experiences. Some of the contributions are more strictly biological, for example Weiner's, Rubinstein's and the late John Benjamin's. Others, like Klein's, are intriguing forays into unexplored psychological phenomena. (Philip S. Holzman, Ph.D.)

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