# BULLETIN of the MENNINGER CLINIC

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## THE PSYCHIATRIC TRAINING OF THE MEDICAL STUDENT AND THE PSYCHIATRIST*

ROBERT H. FELIX, M.D. †

It is now almost ten years since the two conferences on psychiatric education were organized and conducted, at Cornell University, by the American Psychiatric Association and the Association of American Medical Colleges. The first of these, held in June of 1951, was devoted to the role of psychiatry in medical education; the second, held in June 1952, to the training of career psychiatrists. These conferences represent milestones in the field of psychiatric education, and the premises on which they were based are as current today as they were a decade ago.

At the first conference, it was formulated in general terms that: "the aim of psychiatric teaching in the medical school is to prepare the medical student to deal intelligently and skillfully with patients as persons, and to provide him with the basic knowledge of psychological and social problems and resources in relation to health and disease."‡ The premise on which the second conference based its deliberations was: "The goal of a basic psychiatric training program is to develop, in adequately prepared physicians, knowledge and understanding of mental health and

* Read by Dr. Alan Miller, United States Public Health Service Regional Office, Denver, Colorado, in the absence of the author, to a forum in the Menninger School of Psychiatry, March 15, 1961, Topeka, Kansas.

† Director, National Institute of Mental Health, United States Public Health Service, Bethesda, Maryland.

‡ Am. Psychiat. Assn.: *Psychiatry and Medical Education*, Washington, 1952, p. vii.

disease, and the skills and attitudes to use such knowledge effectively in the care of patients and in the public interest."*

In 1952, one of the major problems in psychiatric residency training was concerned with the psychodynamic aspects of psychiatry. In the report of the Conference, this point was developed at great length. "It is now almost universally agreed that the development of a competent psychiatrist requires an understanding of personality in terms of dynamic concepts. It requires considerable time and effort in prolonged work with individual patients to develop such understanding—far more than to gain adequate proficiency in many other aspects of psychiatry. These are practical considerations of great importance for the organization of a training program. Beyond this point there has seemed to be a considerable diversity of opinion, even regarding what constitutes psychodynamics.

"The great basic importance of psychodynamics, the costs in time, trouble and organizational complications in providing for the residents' needs in this field, and the diversity of opinion combined to make psychodynamics the foremost problem in psychiatric training on which it was thought the 1952 Conference could make a constructive contribution."†

This was the area to which the Conference gave its fullest attention, and the developments in psychiatric education in the past ten years have borne witness to the fruitfulness of these deliberations. Today, as we attempt to reassess the situation and to define new needs as yet not adequately met, it is the area of training for research which captures our attention. Research was not a major concern of the 1952 Conference. However, one of the conferees, Dr. John D. Benjamin, said about the place of research in residency training:

> "We must distinguish between the inculcation of research attitudes and activity in independent research. At the same time that we are imparting knowledge of what we do know in psychiatry, we must make the resident aware of what we don't know. This inculcation is a very important part of residency training. It should be separated from consideration of whether independent research as such has a place in the program. . . .
>
> "It is important to expose residents to a few basic facts about classical research methods and evaluation, so that they may be in a position to understand and criticize valid and invalid research statements in the literature. I think it is equally important that they be thoroughly acquainted with the many methodological problems involved as one goes from the relative simplicity of one level of organization to the relative complexity of another, and that they be made aware of the possibility of other than single-variable experiments. Helpful to this end is some knowledge of the development of scientific conceptualization and experimental method in the physical sciences over the past fifty years."*

* Am. Psychiat. Assn.: *The Psychiatrist, His Training and Development*, 1953, p. 49.
† *Ibid.*, p. 15.



Today we would need to say much more and to go much further in discussing the place of research in psychiatric training. The reason is that psychiatric research itself has made such great strides in the intervening period. A brief review of these developments points up the new complexity of the field, and the many difficult training problems that now confront us. These problems are related not only to the training of the psychiatrist, but indeed to the training of the medical student himself. We are faced with the necessity of incorporating all of this new knowledge into our training programs, so that all physicians will be better prepared for the tasks they will encounter in the world of today and tomorrow.

The last few years have witnessed a rebirth of interest in the study of the many complex relationships between mind and body. There have been fundamental changes in approach and some extremely important break-throughs at the basic level. Significant correlations between neuron and thought, between physiological and behavioral change are being discovered. The ultimate general answers to the perplexing problems of these relationships may not be found for many years. Meanwhile, however, a multitude of specific questions are being answered almost daily by psychiatrists, psychologists, physiologists, biochemists, neurologists, sociologists, pharmacologists, and workers in many other fields of scientific investigation.

Evidence that certain forms of mental illness and retardation are rooted in physical disease or dysfunction has stimulated scientists all over the world to undertake a variety of approaches to the study of the many subtle and complicated metabolic processes of the body. A prime example of this trend has been the attempt, using new methodologies developed during the past 10 to 15 years, to find some biochemical phenomena contributing to schizophrenia. Recent research has suggested that some forms of mental illness may be related to altered biochemical processes. To establish that changes in body and brain chemis-

* *Ibid.*, p. 54.

try and the occurrence of mental illnesses do have a definite causal relationship is a complicated and expensive task. The intricate and delicate processes constantly going on in each of the subsystems in the brain, and in the whole central and autonomic nervous system, are gradually being discerned. But the vast unanswered question still remains: What are the ties between all these complex chemical processes and the equally complex congeries of the mental illnesses?

One method of attacking this problem has been the search for possible psychotoxic substances that may occur in the blood or urine of patients suffering from mental illness. The past few years have seen the discovery of a number of promising leads linking schizophrenia to faulty metabolism and to one or another chemical substance. In the case of some of these substances, scientists elsewhere have been unable to replicate the findings. In the case of other substances, it has been found that the biochemical differences resulted from factors other than the presence of mental illness. Some leads need more study and are still "open."

Basic biochemical research in the field of mental illnesses is a complex, rapidly developing and rapidly shifting area of investigation. New bits and pieces are constantly being added to the picture. The new psychoactive drugs and psychotomimetic substances have given us powerful additional tools for this type of research. If chemical agents can initiate or alleviate psychoses, it is possible that chemical faults or imbalances in the body may be implicated in producing them. Perhaps the greatest value of drug research in the field of emotions will ultimately lie in its ability to reveal more about the basic causes and mechanisms of mental illness.

Interesting leads have come from research in reserpine and iproniazid, to cite just two examples. Serotonin and norepinephrine occur naturally in the brain. Reserpine decreases the level of both serotonin and norepinephrine in the brain, probably by increasing their metabolism, at the same time making a person tranquil and quiet. Iproniazid, on the other hand, causes serotonin and norepinephrine to accumulate in the brain by delaying metabolism; sometimes it relieves depression and sometimes it produces psychotic excitements. But it is still unclear whether or not the effect of these two drugs on the amount of serotonin and norepinephrine in the brain is directly and unequivocally related to the changes in behavior produced by the drugs. When we find out what these and



other psychoactive drugs really do to the chemistry of the body, we will also have learned much more about the biochemistry of mental illness.

Psychotomimetic substances are also being used as tools to uncover biochemical factors affecting behavior. These substances include such diverse chemical compounds as lysergic acid diethylamide, mescaline, sernyl, and benactyzine. If we can discover why these chemical compounds cause profound changes in behavior, we will have some significant clues which may lead us to the discovery, if they exist, of substances in the body that, under certain circumstances, may play a role in mental illness.

The whole new field of psychopharmacology has advanced remarkably in a very short period of time. The vitality of research in this field is reflected in the wide variety of studies resulting in new drugs and new techniques for testing them.

During the past few years, we have also made great progress in our understanding of the structure and function of the brain and central nervous system. For example, we now have new insight into how nerve cells transmit impulses which help to explain a great deal of cerebral and neural activity, too complicated to be accounted for by previous theories. A new technique now permits more accurate measurement of electrical activity within nerve cells. Other investigators are using electrical stimulation techniques to learn more about how the brain works and to analyze the effects of drugs on behavior.

A whole new area of investigation and an extremely fascinating one deals with the necessity for a continuous flow of information from the outside world in order to maintain normal mental processes. One study has gathered evidence indicating that the visual centers of the brain show more electrical activity during sleep than during waking states. These data suggest that sleep is associated with an alteration of the pattern of cerebral activity, rather than with the absence of activity in the brain. The findings of this study are in agreement with previous theories that the coordinated brain activity required for normal waking is partially dependent upon continuous inflow of controlling (or inhibitory) nerve impulses to the sensory mechanisms of the brain.

Basic metabolic studies have brought new understanding of conditions leading to different forms of mental retardation. These advances in basic physiological research have been paralleled by equally significant

advances in the psychological and sociological approaches to mental illness, mental health, and personality development.

One of the particularly rich areas of investigation during the past two or three years has been the effect of family relationships on the production and the course of mental illness. Much important research on family-child relationships among normal children is also being conducted. Among the advances in this field has been the development of a technique for objectively measuring parental attitudes toward child rearing and family life. This instrument has already proved useful to researchers both in this country and abroad, and makes it possible to correlate findings from many widely separated laboratories dealing with problems of parental attitudes. Investigators at the National Institute of Mental Health have devised a research procedure for measuring maternal behavior. Work already completed indicates that much maternal behavior can be understood in terms of control versus permissiveness, and hostility versus love. Studies have shown significant differences between the ways in which parents in different social classes exercise their parental authority. These differences are related to underlying differences in parental values.

Modern recording techniques and careful statistical and psychometric methods are being used to study congenital personality traits. This kind of study is a significant attempt to understand the behavioral propensities with which children are born, and may provide a method of identifying the constitutional prerequisites of both disturbed and normal behavior. Studies are being conducted at the National Institute of Mental Health on the interactions between genetic and environmental factors in early behavior development, as well as the nature of learning in the early stages of human development. The child's propensity for change is the focus of still other studies in this area.

There is also a great deal of important research now going on that is concerned with the other end of the life span. We are constantly learning more about the process of aging as a part of human development, and about the characteristics which are attributable to normal and abnormal aspects of this process.

All of these developments have been paralleled during the past few years by equally rapid and far-reaching developments in care, treatment, and rehabilitation of the mentally ill. A great deal of important research is being concentrated on the therapeutic milieu, early diagnostic



and treatment services, and more effective preventive programs. Much thought and effort is being given to new ways of dealing with the problems of the mentally ill. For example, an emergency psychiatric service program has been established by the Boston State Hospital and Boston University, and an experimental suicide referral service has been set up in Los Angeles. In other places new methods of therapy for delinquents, new techniques of outpatient care for disturbed adolescents, new experiments in foster home care and rehabilitation for mental patients, and new ways of handling psychiatric admissions are being tried out.

The entire field of psychiatry is in ferment—and the barriers between clinical psychiatry and research psychiatry are melting under the impact of new knowledge and new methodologies. Today, the need for more psychiatrists who can do research, as well as for clinicians who are firmly grounded in the behavioral sciences, makes untenable any dichotomy between good psychiatric clinical training and research training. To be adequately trained for his practice today, the psychiatrist must have training in research; he must have this in addition to his clinical training, so that he can relate himself to other disciplines on an equal basis. Similarly, the research psychiatrist cannot function properly with training predominantly in the biological sciences; he must have clinical acumen and a firm grounding in the sciences of human behavior.

Some impressive beginnings are being made in the advancement of research training and training in the behavioral sciences for future psychiatrists. The School of Medicine at the University of California at Los Angeles, has, for the past four years, conducted an interdisciplinary program of research training in the basic sciences related to mental health, its goal being to train more and better investigators for research in these sciences. Eleven departments or divisions of the School are participating in the program. These include the Departments of Anatomy, Physiological Chemistry, Biophysics, Physiology, Pharmacology, Infectious Diseases, Pathology, Neurology, Neurosurgery, Psychiatry, and History of Medicine. This interdisciplinary instruction is combined with tutorial-apprentice training, and is offered to both predoctoral and postdoctoral trainees. Each participating department has added an active investigator to its staff to assist in research training activities. Each basic science department appoints two predoctoral and one postdoctoral trainee, and each clinical department appoints two postdoctoral trainees per year.

The interdisciplinary program supplements the regular graduate curricular and training program at UCLA in two ways: (1) By the introduction of a group of courses and seminars designed to provide the trainee with didactic orientation in research needs and activities in the fields of basic science related to mental health; and (2) by the inauguration of a tutorial-apprentice training situation in the laboratories of the participating departments, to enable the trainee to gain actual working experience in research techniques currently employed in study of the central nervous system, under the supervision of an accomplished investigator.

The didactic program is tripartite, instructing the trainee in the problems of disease of the mind and brain; the research frontier in the basic sciences related to mental health; and background orientation for biomedical research. Opportunity for laboratory training on a tutorial-apprentice basis is available in the research laboratories of each of the participating departments. Also included in the program is a course in special research methods in psychiatry for trainees whose work involves the use of human subjects.

A similar interdisciplinary research program is being conducted by the Albert Einstein College of Medicine, the goal being to train scientists, to enlarge their knowledge of the nervous system and provide insights into its function, and to encourage research interest in the processes that constitute behavior.

Both the program at Albert Einstein and the one at UCLA are receiving training grant support from the National Institute of Mental Health. The Institute, since 1958, has also been supporting undergraduate training in human behavior in the first two years of medical school. The purpose of the program is to incorporate, into the training of each medical student, new scientific knowledge which will enable him to become a better physician and to develop skills in handling psychiatric problems. The need for this has become increasingly apparent during the past few years.

Psychiatry alone cannot hope to cope with the great number of individuals requiring medical care for mental and emotional disorders—the general practitioner must share a large part of this caseload. Undergraduate medical school training in human behavior will also help to introduce the future psychiatrist to behavioral science at an earlier stage in his education and may, in fact, help to attract more medical students to the field of psychiatry. Thus far, more than 30 medical schools have



requested funds under this program, to enable them to initiate or to expand such training. They have added various types of behavioral scientists to their faculties—including social and cultural anthropologists, sociologists, social psychologists, clinical psychologists, physiological and experimental psychologists, and physiologists.

The establishment of courses in human behavior in medical schools is having some extremely significant by-products. First, there is the impact on the student, who is being exposed to behavioral science data interwoven with other material, and who is also being exposed to a new professional model in the classroom—the researcher. Most of the new training in human behavior embodies a research orientation, including didactic training in the research procedures of the behavioral sciences plus an opportunity for first-hand experience in laboratory experiments in psychology.

The new training in behavioral science is also having an impact on medical school faculty. Most of the courses are being established in departments of psychiatry, and the psychiatrists in these departments are themselves helped to keep abreast of developments through collaboration with the behavioral scientists. The social scientists, too, are deriving "fringe benefits" from this new association. They are functioning in psychiatric research settings, and are being exposed to factual data against which to test their theories.

Training in research is the area of greatest need and greatest immediate potential with respect to the training of the psychiatrist. There are several other important developments—or beginnings of developments—that are significant in the field of psychiatric training.

One of these is the move toward integration of psychoanalysis into the framework of a university or medical school. The National Institute of Mental Health is now supporting a planning group which is preparing for a major conference on this subject. The main reason for such a conference is that psychoanalysis and psychoanalytic theory have survived the test of time and have shown their usefulness in many fields. There is not one medical school in the country today which in one measure or another does not teach some basic analytic principles to its students. Most departments of psychology, anthropology, and sociology draw heavily although in varying measures on psychoanalytic theory or even practice for validation of many of their own concepts. Another factor

of considerable, practical importance to medical schools and training centers in psychiatry is the appeal that the availability of good psychoanalytic training has on prospective candidates for residency training. The caliber and number of residents applying to training programs which either offer or are close to training facilities in psychoanalysis is much greater than that of more isolated places.

We are in the midst of some important changes in integrating and accepting a new, well-validated and established body of knowledge into the various teaching institutions. So far there has been no uniformity or general policy nor any kind of guiding principles for this integration and harmonization. Airing, and speaking frankly about these problems and some of the possible solutions, might help in developing sound principles, even though only general ones for such growth and integration. The chance for educators, psychiatrists, and other scientists to exchange ideas and familiarize themselves with the results of a recent survey of teaching practices and methods in psychoanalytic institutes should be fruitful and rewarding. Far-reaching principles might be evolved which will bring some order into a relatively disorganized state of affairs.

Another new trend in psychiatric training—or perhaps I should say new interest, since no major step has yet been taken—is the attempt to delineate the field of child psychiatry and to investigate the ways in which the child psychiatrist may be trained to discharge his responsibilities more completely. Child psychiatry, as it is currently practiced, is rooted in the experience of several disciplines in a variety of settings over five decades. Its present modes of training and practice have evolved as much from social needs and pressures as from training design. While medical antecedents predominate in its intellectual history (notably general psychiatry and pediatrics), other disciplines, especially psychology and social work, have contributed importantly to its elaboration. Child psychiatry has been carried out in a variety of settings—child guidance clinics, social agencies, juvenile courts, children's hospitals, inpatient centers for disturbed children, schools for the retarded, state hospitals, university departments of psychiatry, to mention the most common. Some of these settings have been clearly medical installations. Others have been of interdisciplinary or mixed composition.

However, although child psychiatry is accepted as a medical subspecialty and although the social need for child psychiatrists is universally recognized, we have only begun to define or delineate what a child psychiatrist is, what he does, or how he is trained. While training in child psychiatry is considered indispensable to the training of the general psychiatrist and has been included in many residency programs, a variety of patterns has developed in different settings. The relative effectiveness of the various methods of orienting the general psychiatrist in child psychiatry has not yet been evaluated. Moreover, it is important to differentiate these orientation programs in child psychiatry for the general psychiatrist from the specialized child psychiatry training programs. While the "team approach" has been generally accepted as sound in the psychiatric diagnostic and treatment approach to children, in some settings there has been little if any clear delimitation of the psychiatric (medical) component as distinguished from the nonpsychiatric (psychologist, social worker, etc.) components of the team. The functions of the several professional disciplines and their specific unique contributions have not always been clearly understood, and the substance of child psychiatry as a *medical* subspecialty has never been formulated.



While child psychiatry has been given official status as a subspecialty, only *minimal* standards for training have been recognized (both by the American Board of Psychiatry and Neurology and the Association of Psychiatric Clinics for Children) and these without adequate elaboration of content, method, setting and goals. The task of defining the field, of spelling out training needs, of analyzing the content of training in child psychiatry, and of developing appropriate methodology and settings for such training are still matters for the future.

There are many other areas of psychiatric training that need similar analysis. The broad changes that have been taking place in the practice of psychiatry—the movement of treatment into the community, the use of ancillary professions to help overcome the shortage of psychiatric personnel, the vast increase in geriatric patients, the proliferation of community psychiatry, the growth in public demands on the psychiatrist as a special consultant on social problems—all these and other developments make it necessary to reassess the functions of the psychiatrist and to replan his training so that he can fulfill those functions thoroughly.

The basic goal of psychiatric training still remains—as the 1952 Cornell Conference formulated it—"to develop, in adequately prepared phy-

sicians, knowledge and understanding of mental health and disease, and the skills and attitudes to use such knowledge effectively in the care of patients and in the public interest." But the goal must be reinterpreted in terms of current knowledge and needs, and new ways and methods of psychiatric training must be developed.

# THE COURSE OF ILLNESS*

KARL MENNINGER, M.D.

For centuries it was the accepted belief that mental illness led regularly to mental disintegration. The expression "to lose one's mind" implied an irreversible loss. Not death in the physical sense, but a living extinction in oblivion was envisaged. This was considered a part of the "natural history" of nearly all forms of mental illness.

No such natural history of mental illness exists, in my opinion. Mental illnesses run courses, but these courses do not have, in Sydenham's sense, a characteristic form. Not all colleagues agree with me; they like to point, for example, to the characteristic recurrence in some individuals of waves of depression or excitement. But these episodes are not identical. The actual course of illness in the cyclothymic cases is extremely variable. Some patients have severe depressions once every twenty years, or once every few months and then not again for thirty years. This certainly does not describe any natural history.

The process of mental illness, as I see it, has more the qualities of life than of death and fluctuates with the ebb and flow of that life. Sometimes the process rushes on breathlessly, frighteningly; again, it seems to be arrested, to stop moving entirely in a state of chronic dissatisfaction. But rest is not the natural state of affairs in the universe. Atoms, molecules, planets and suns keep moving; so do the processes of mental illness, even when they appear motionless. And while we cannot always predict the ultimate direction and degree of movement, as we can with planets, we have learned to detect the trend of the movement of an illness process toward or away from recovery.

Recovery is an ambiguous word. It is sometimes used to describe a continuing trend toward improvement. But the word is also used to describe the end state of such a trend, the condition of a person *after* having been sick. If one thinks of disease in terms of invasion by a noxious foreign body, its departure is a first step toward that state of recovery and back to the "normal" which will exist when the visitor and

* Freud Memorial Lecture, Philadelphia Association for Psychoanalysis, May 13, 1960. Published approximately simultaneously in the *Bulletin of the Philadelphia Psychoanalytic Association.*

This will form part of a chapter in a forthcoming book by the author in which, as in this paper, he has been assisted by Dr. Martin Mayman and Dr. Paul Pruyser.

the commotion he has caused have both disappeared. The state of emergency which existed during the invasion, with the mobilization of forces against the visitor or toward his extrusion, will have passed. The dike builders and policemen go home, as it were, and the normal processes held in abeyance by the illness are once more activated. The patient begins to walk or to work, and with this he feels better and—after a while—we say that he has recovered.

If, on the contrary, one thinks of disease not as an invasion or even as a wound so much as a cumulative failure of functions, internal mismanagements and emergency compromises, we would see recovery somewhat differently. A relatively effective and comfortable pattern of adjustment has been surrendered or compromised by various emergency arrangements, some of them very expensive. This is in the interest of survival—not the surviving of a single lethal blow, but survival in the face of a disruption of relationships and self-regulation. In mental illness it is not the external dangers as such that are feared, but the internal events set in motion by certain external events. The illness is in the nature of a strategic retreat and the next "step" may be in precisely the opposite direction.

We expect the course of illness to fluctuate, therefore, sometimes appearing to regress and sometimes to proceed. Both trends are aspects of the same thing, and perhaps it would be clearer to speak of it as the "illness–recovery process," indicating our recognition that recovery is still illness and that illness is, from the start, recovery. The barriers successively erected by the organism reflect disorganization, but they stay the process of disintegration. Reintegration or reconstitution of the organism tends to occur *pari passu* with the compromises, renunciations or regressions necessary to making the best of a bad situation.

All this is rather complicated language in which to say that I do not believe that mental illness has any fixed natural history. This does not mean that certain syndromes do not have fairly familiar forms. It does mean, however, as I shall try to demonstrate, that in the unitary concept of mental illness we cannot afford the pessimistic notion that processes of disorganization doom the organism to complete entropy as if by some kind of predestination.

### Recognition of Change

Let the reader picture in his mind a severely ill patient—a man, let us say, who was once strong and healthy but who became mentally ill.



He progressively declined in efficiency, productivity and sense of well-being. He became more and more erratic and uncomfortable; he made strange remarks and seemed to be hearing voices. He was taken to a hospital where his confusion deepened. With help from the nurse he could be gotten to dress himself in the morning, but would then sit about his room vacantly or go walking with the nurse silently, like an automaton.

Let us assume that some weeks or even months have passed and that energetic treatment efforts have been pursued with little perceptible effect. Then, one day, a slight difference is observed. When the nurse, or perhaps the physician, approaches him in simple greeting or in food service or perhaps merely in passing, the patient nods. Perhaps he even smiles faintly or says "Thank you." Next it will be noticed that his face seems more relaxed and less vacuous. There is less stiffness in his posture. He looks about himself inquiringly.

In the days to follow, if the trend continues, he seems progressively brighter and more alert. He seems to notice more things and to take a slight interest in some. He smiles frequently now, and whispers words of response to greetings instead of giving silent stares. He moves about more, and less aimlessly. He listens to other patients and occasionally even speaks to them. He begins to ask questions and to express wishes to do certain things or to go certain places.

In all this we perceive a definite turning toward the acceptance (re-acceptance) of reality. This is usually a wistful, gentle approach rather than a striking out, although the latter may occur; even a blow is sometimes to be welcomed as a frantic effort to recapture or re-establish a relationship with the real world.

Along with these efforts to find us and to communicate with us and to interact with us—"us" of the world about him—the patient is seen to relinquish various of the peculiarities which were symptomatic of his illness. He begins to eat and sleep better, to converse, to be more alert to changes in the environment, and to be able to turn his attention to things without distraction or confusion. Coincidentally his emotional reactions become increasingly appropriate and hence more flexible, so that his demeanor and behavior conform more and more to general social standards.

The successive replacement of the various regulatory devices which had been erected to maintain some degree of integration with less and

less costly ones is not all there is to recovery. It is also necessary for the patient to "climb back up," as it were, to the levels of functioning and productivity which were surrendered with the development of his illness. As his interest in the people about him increases, he finds pleasure in being with them (instead of the reverse) and then in *doing* with them. He shows an increasing desire to express his energy usefully or in a way approved by his peers. In this he expresses both his commonality with the fellow human beings about him and his uniqueness. He wants to do some of the things they do and to do some of them better than they. He wants to work with them and to play with them, and in playing he wants, sometimes, to win. He finds increasing pleasure both in the giving of pleasure to others and in the receiving of deserved approval. He can even give approval, to others and to himself. Withal there is an increased *joie de vivre.* He says he feels better, that life seems more worth living. There is a prevalent mood of optimistic expectation about the future which we can perhaps call hope.

This is the sketch of a recovering patient. The outcome is not always so beautiful, but thousands of patients follow this route just about as I have described it. Others turn back before they reach the upper levels or stop short of them. In analyzing or even describing these courses of illness we are handicapped by a lack of terms. We say that a man has improved a little or that he has improved much or that he has improved very much, or that he has regressed some. But this is apt to sound very vague and inexact to some scientists.

I have never felt that psychiatry need be as vague as it seems to be for some writers. Thus I believe that the steps or stages in the illness–recovery process can be identified, qualified and timed so that we can be more precise in what we say about the recovering patient. Indeed, just this was one of my objectives in formulating the hierarchical orders of regulatory devices[1] making their appearance in psychiatric illness. I designated them as being of the First, Second, Third and Fourth Order with an eye to reflecting increasing severity of illness, or reality severance and disorganization. This is not quantification, but it could make quantification possible.

One could, for example, attempt to graph the course of psychiatric illness as we do the changes in a patient's body temperature or blood pressure readings. Zones of progressively increasing severity of illness could be constructed, so that by using the base line to mark the passing of time in whatever units one might wish, the degree of illness gauged in some kind of quantitative terms could be indicated on the ordinate. These terms might be as simple as "mild," "moderate," and "severe," set up as departures from a symptom-free base line, or rather base-*zone.* If such a graphing chart were to be constructed and the patient's course of illness approximately graphed, we could see the course of illness as a whole more clearly and we could speak of its changes with greater precision.



### Turning Points

Graphs bring out vividly those critical moments in the course of an illness at which there is a perceptible change in the speed of change of the process. Turning points force us to analyze the illness and try to identify what factors have altered the equilibrium of adjustment in internal and organism–environment relationships so as to make this sudden change in the patient visible.

It is always a temptation to ascribe a change to some event conspicuously contiguous in time or space. And it is a perennial duty of the scientist to be slow in accepting the "truth" of the obvious. We speak of "precipitating events" with a tacit recognition that this implies a readiness of the organism for the sudden appearance of an imminent, if previously invisible, adventitious phenomenon. Similarly, when a patient improves, what we describe as the effective factor is by implication only one of many which brought about the favorable shift.

The deceptive conclusion of *post hoc propter hoc* is the more baffling because it is not always wrong. The "straw that breaks the camel's back" may be a ton of lead. A cup of water may start a process of recovery not because of diminished dehydration but because the giving of a cup of water may have powerful symbolic effect (*cf.* the scene in *Ben Hur*). Events may have a paradoxical effect. The most favorable circumstances, the most assiduous treatment, the most felicitous environment and the most persistent efforts may all prove unavailing. On the other hand, the most unlikely move or event sometimes presages a recovery. All of us have seen some of our most intractable patients recover promptly when taken by their discouraged relatives to colleagues of other persuasions or even to no colleagues at all! Over the years I have seen a dozen patients who were given the very best treatment we could give them in a private hospital with private physicians, and after the relatives, resigned

to the probability that the patients would never recover, had removed them to a state hospital they more or less promptly recovered.

This phenomenon of the paradoxical environment effect was seen on a large scale in a research reported by Le Guillant.[2] In June 1940, during the German invasion of France, a psychiatric hospital (La Charite sur-Loire) was in the direct line of the German advance. Preparations were made for evacuating this institution. A special commission of psychiatrists screened all the patients, and all of those who were only moderately ill were sent back to their families. The severe and supposedly incurable cases were retained in the hospital. At the last moment, when everything was ready for the evacuation of this final group to the south of France, news came that all bridges had been destroyed. Panic ensued. Nurses, aides and patients fled.

After several days, order was re-established, but 153 "incurables" were missing. A few of them were later recaptured; but four or five years later a special commission was appointed by the French government to find out just what had happened to the others. *Thirty-seven per cent of them had re-established themselves in various communities—presumably "recovered."*

*Bonum ex nocentibus* was a favorite paradox of Ernest Southard's. He pointed to the frequency with which doctors cured (or prevented) one illness by introducing another one—for example, cowpox for smallpox, malaria versus paresis, foreign protein reaction for arthritis, electroshock and hyperinsulinism in various psychiatric conditions. This, of course, dates back to Hippocrates and his immediate successors, who were greatly impressed by this observation and held long discussions on such matters as the healing influences of hemorrhoids.[3] Other writers have reported the beneficial effects on various illnesses, especially mental illness, of many different affections. During the influenza epidemic of 1918–20 (and in many previous epidemics) psychiatric patients with mental illness were frequently observed to improve mentally during and after their attack of influenza.[4] My personal experience with some of these cases was unforgettably impressive.

> For example, a child of four was seen at a school for mental deficiency. She had been studied by a competent staff (and seen, after her remarkable change, by many visiting colleagues). Her American-born, college-bred parents had brought her to this school because, although her physical development corresponded with her age (four years), her mental development was then estimated to correspond with that of an infant of ten months. Details of her birth history and early infancy are recorded elsewhere[5] and, together with psychiatric and psychologic examination details, will be passed over here. She was observed and cared for in this institution for a year without significant change.
>
> Fourteen months after admission she was severely ill with influenza, plus bronchopneumonia and empyema. A long convalescence followed. During this convalescence from the infection she began to show marked evidences of mental awakening! Her automatic purposeless movements disappeared, she took an interest in things about her, became tidy for the first time, learned to dress and feed herself, and participated in kindergarten activities. In six months her intelligence quotient went from 27 to 40; a year later it was 52, two years later it was 68. Her mental age, in other words, developed more rapidly than her chronological age. At eight years of age (1922) she had reached a mental age of nearly six, was doing first grade work and was removed from the state school to a public school.



These paradoxical, worse-added-to-worse cures seem to be the very antithesis of the logical procedure of tempering the wind to the shorn lamb, of nursing, soothing, supporting and encouraging the afflicted. They point up the complexity of the illness process, in which we are never able to identify all of the determining factors nor to be sure in advance how effective an interposed measure, a well-reasoned intervention may be. The influence of influenza is more apt to be deleterious than helpful, but the reverse can happen; the influence of a sympathetic friend or book or an operation is apt to be good, but it may be the reverse.

**Which Miracle?**

If illness be viewed as an alteration in regulation produced by dynamic factors, recovery can also be understood as an alteration in the regulation of the same factors, brought about by some change in the constellation, *internal and external.* Indeed, one can be impressed in either one of two opposite ways. Is recovery or chronicity the norm? Is change or inertia more fundamental? On the one hand there stands the marvel of recovery, with or without benefit of medical clergy. Our forefathers considered any recovery from mental illness as a minor miracle. And perhaps it is.

But, on the other hand, is not health normal? Is it not a mystery that there should ever be an unnecessary persistence of symptoms in this fine world? Why should anyone stay ill? When the storm has passed, the

sun comes out. Why need symptoms remain when the trouble has passed?

In this dilemma our dynamic, economic point of view can perhaps be of help. It can explain to some satisfaction how and why emergency measures come into being. It can explain how and why these emergency measures are in some cases gradually abandoned in favor of more efficient and stable steady states. Can our theory also explain why they are sometimes *not* abandoned — why the illness persists despite favorable circumstances and therapeutic efforts? I think it can. For our theory presents illness and the maintenance of symptoms as a phase of life, a way of living in the presence of many opposing difficulties. It is an extremity to which the organism is pushed and must await release by overbalancing pressures in the other direction.

### Forces Working Against Recovery

What are some of the forces that work against recovery? In putting the question thus we might seem to imply that those external factors which were connected with the incipiency of the illness, the tension-arousing incidents, the stress-producing circumstances, have disappeared. Sometimes this is true; they may have disappeared entirely, and yet the illness will continue. Sometimes they have not disappeared but remain to harass the individual's efforts in readjustment. But the natural—we like to say normal—way of doing this is to develop the strength to overcome such difficulties or to elude them in some less expensive way than by illness. I shall come back to the matter of these external burdens presently. But first let us consider the internal forces that oppose recovery.

It sounds ominous indeed to speak of such traitorous, seditious operations behind the lines, as it were. But this is of the essence in psychoanalytic theory. Alien wishes to remain ill, to handicap and cripple one's self, to exult in suffering and to avoid recovery are detectable to some measure in every illness. Freud coined a special word for the opposition erected by every patient against the work of his physician; he called it "resistance." Something within the patient resists change for the better. This resistance is supplemented and supported by many and diverse secondary gains, which may overrule the importance of suffering. Perhaps resistance represents the psychological equivalent of inertia. The many ways in which it is manifested constitute much of the content of any systematic knowledge of psychotherapy.



Emergency devices instituted to insure survival of the organism may become incorporated into the character structure. Others may be treasured for obscure reasons, after the original need for them has disappeared, until they make their own necessity, as it were (*cf.* alcoholism). Secondary narcissism, always a protective ointment on the wounds of frustration and loss and injured pride, may become a coat of insulation which impedes the recovery process by interfering with the establishment of effective therapeutic relationships.

To interpret these resistances as self-destructive tendencies is an attempt to describe them and explain them. So understood, they become vulnerable to therapeutic attack. A child who jerks his hand away from a mother who is trying to remove a splinter need not be abandoned to the consequences of the continued presence of the splinter. Misinterpretations of reality based upon childhood or even subsequent experience frequently persist throughout a lifetime unless some kind of re-education occurs. Such misinterpretations deflect the course of a patient's life as might a ship's compass near which a magnet has been placed. Persistent difficulties with authority, with responsibility, with society in the broad and narrow sense and, indeed, with all kinds of life roles may arise upon the basis of such long-hidden bias and misdirection.

One must understand and expertly deal with resistance and self-destructiveness. To deal with it by increasing the patient's use of his intelligence and enabling him to abandon some of his resistance is the mode of psychotherapy. To deal with it by making changes in the patient and his environment on the basis of our knowledge, but without expecting this to become the patient's knowledge, is the mode of other treatments. Misdirected, inappropriately expressed aggressions, the continuous rage aroused by circumstances long past, the guilt feelings associated with such hatreds and hostilities — all these can be managed through various therapeutic approaches.

To revert again to theory, the reader may find it interesting to consider the role of the internal destructive tendencies in motivating the form of the illness. This I attempted to elaborate at some length in "the choice of the lesser evil" in *Man Against Himself*.[6] There I said: "We should divide diseases into at least three groups: those in which the environment unexpectedly attacks the individual and in which his self-destructive tendencies do not in any way participate, those in which there is some degree of participation in or exploitation by the self-de-

structive tendencies of an occasion perhaps largely or primarily furnished by the environment, and finally, those diseases in which the environment is merely a passive contributor." In the latter two groups "it is immediately apparent upon inspection of the various forms . . . that they can be arranged in a progressive series from suicide, as the most complete and irreversible form, through organic disease and hysterical disease to those attenuated forms of self-destruction which are so widespread and innocuous as to be fairly described as 'normal,' *e.g.*, smoking."

I then presented two diagrams which attempted to show that as the destructive tendencies gained a more dominant control over the illness, the form of the illness changed. If the aggressions were well controlled, the individuals would be considered mentally and physically healthy; if some degree of compromise were necessary, minor illnesses or neurotic illnesses might be expected. When the destructive tendencies dominate the situation still more completely, somatic structural lesions develop, the end of which would be death; or mental disintegration might ensue, the end of which would be disintegrative collapse, or perhaps suicide. Just as the function of an organ is sometimes sacrificed in order to spare the life of that organ, so an organ is sometimes sacrificed to spare the life of the total organism.

### External Forces Working Against Recovery

The emphasis of the preceding pages on the *internal* forces which work against recovery was not meant to distract the reader's attention from those factors favoring the prolongation of illnesses which come from without—

> "The slings and arrows of outrageous fortune . . .
> The heart-ache, and the thousand natural shocks
> That flesh is heir to . . . ."[7]

The great majority of external difficulties can be coped with and are coped with, most of the time, by most individuals. But heavy blows are unevenly distributed—in time and in space. Tragic accidents, irreparable losses, unbearable disappointments, suffering and provocations of anger beyond human endurance — such things come unexpectedly. Lesser blows and wounds and irritations keep coming along in patterns of unpredictable clustering and compounding. "Troubles never come singly." "It never rains but it pours." "But from him that hath not, shall be taken away even that which he hath." To some there will come overwhelming bonanzas and pseudo success which can be equally devastating.



Ignorance often works against recovery, of course, just as does the lack of means to get help. One of these negative factors which must be mentioned is the lack of someone who cares. This is apt to sound more sentimental than scientific, but technical language sounds awkward and pretentious. Man is a social creature and isolation can be fatal. When the sense of being important *to someone* disappears, the destructive forces make a great leap forward, or self-destructive trends and external aggression wax.

Still other facts and factors might be mentioned whose persistent influence in opposition to recovery must be considered and appraised. Age and infirmity are inevitable. Hardening of the arteries is progressive. Equally resistant to the measures taken by the physician is that comparable hardening of the mental processes which is reflected in a psychological inflexibility.

Many patients' lives have become so entangled with social complications and economic difficulties and legal complexities that an improvement in one direction only augments or emphasizes the difficulties in another. This flypaper helplessness breeds a hopelessness which in itself becomes another factor retarding recovery.

### Facts and Forces Working Toward Recovery

These, then, are *some* of the many factors which oppose the recovery which *one part* of the personality wants so much. Many other facts and forces are exerting pressure against them, pushing the process in the opposite direction, *i.e.*, toward health. And again we recognize that some of these forces appear to come from without, while some appear to arise—or at least to operate—within the organism.

Among the internal pressures toward recovery, pain is pre-eminent. Pain may be the immediate result of wounds or it may be incidental to the organism's reactions to the wounds. A bee's sting hurts and the swelling it excites also hurts. A third type of pain is connected with the readjustments made necessary by the illness—the losses, the renunciations, the expense of retaliation and so forth.

The first waves of pain after an injury—humiliation, rage, fear, jealousy, sorrow or whatever—may lead to retreat, perhaps counterattack, perhaps effort at altering the situation by manipulation. In any case, the pain will not disappear immediately and new pains will be added as readjustment is attempted. First Order devices will diminish, but not

quell the pain, and soon the secondary and tertiary pains of remorse, guilt feelings, self-distrust and discouragement will ensue.

It is the persistence of this suffering which is elementary in the pursuit of a better solution. One external hope held out for every sufferer is the physician and all he stands for. But long before he consults a physician every sufferer has done something on his own, as it were, to find a more comfortable position. Various regulatory devices are called upon to cope with the mounting internal tension. Alcoholic inebriation, resolute denial and various kinds of distraction efforts may be tried. These rarely vanquish all the pain, which remains as a nagging incentive toward finding a better solution.

The most poignant pain in many individuals is that derived from the loss of satisfactions and opportunities incident to the illness, the failures in productivity and achievement. A sense of unworthiness and uselessness augments this. But the capacity to perceive pain of any kind and to endure it seems to vary a great deal in different patients.[8] And it is only too obvious that many patients suffer less than they should from the realization of their self-stultification, the failure to develop their potentialities, the inhibition of their abilities to love, to give and to create. In this area some of us often wish that the pain were sharper or more insistent or more general. The public reads eagerly of new drugs to bring about a temporary serenity; some of us would be more interested in drugs that would elaborate aspirations or spur a desire for learning or increase dissatisfaction with wastefulness and self-preoccupation.

My brother and I have often declared our position in this matter. We cannot be so enthusiastic about chemical methods to produce a state of *sans souci*; what the world needs and what more human beings need for their own mental health and that of their universe, is not to care less, but to care more. For this we have no chemicals, no drugs "to keep the soul alert with noble discontent." And yet, at bottom, this is the direction of recovery. This is the best expression of the will to live, the life instinct which is so persistently opposed by the self-destructive instinct.

To live, we say, is to love, and vice versa. To love, we might further say, is to care, and, again, vice versa. If a patient is not frozen in his primary narcissism or drowned in his secondary narcissism—because of previous failures in his attempts to establish and maintain love objects—he will continue to try to establish relationships with persons and things about him.



This is not to imply that life is a pure culture of love or that love consists in an endless mutual hand-holding. But predominantly positive relationships are ultimately productive, as well as satisfying. The production of a baby is both an example and a symbol of this, but there are other kinds of reproduction in the world. All of them require goal-seeking effort and striving.

There seems to be a great variation, also, in the capacity people have for doing and enjoying work, not only to harness aggressive energies but to further the productiveness just referred to. Play likewise seems to be very easy for some, very difficult for others. These variations are important, since much of our treatment program depends upon their exploitation and development. The variability may depend upon some unknown constitutional factor, but most of it depends upon the experiences and opportunities of the childhood and adolescent periods.

Similarly, the individual's appreciation of time, space and other realities, his reactions to authority, power and responsibility, and his philosophical, social and religious concepts can be viewed as the product of what in the broad sense of the word can be called his education. If this education has been a good one, and there is surely no need to explain here what I mean by good, the lessons learned in these areas will all help in times of emergency, bearing strongly toward re-establishment. It is easier to see how a defect in one of these areas has the opposite effect — a hypersensitiveness to authority, a refusal to take responsibility, a feverish lust for power, a poisonous prejudice against some social groups or a vacuum in religious convictions.

So much, then, for some of the *internal* factors which work *for* recovery. The external factors are better known; they are the visible elements in the process, and we are apt to call them curative, implying that it is they who "do the trick." It is interesting to compare the two meanings of the word "cure," corresponding in a way to the double meaning of the word "recovery." To cure means to heal, but the word gives us the benefit of the doubt and can also mean merely to *try* to heal, *i.e.*, to treat. Much curing is done which does not cure.

Once treatment is mentioned psychiatrists, being somewhat self-conscious, are apt to think of their own work. But we should first think of the many external forces working toward recovery quite independent of the doctor. There are nearly always friends, wise counselors, good books; there are even faithful dogs. Perhaps more people are retained

within the confines of our world by the adoration of their cats and dogs than we have any notion of.

And of this we are very sure, that many a man is saved by his wife, and vice versa. This does not imply that she is herself free from difficulties and suffering. Psychiatrists are so accustomed to hearing about the harm done by certain friends and relatives of the patient that the supportive effect supplied by those same individuals, and by others, is sometimes overlooked. Pure chance makes it almost inevitable that he will meet with some particularly helpful as well as particularly unhelpful associates and experiences.

Besides people there are things—good things, strong things, beautiful things, inspiring things. There is music, and there are books, there is art and there are trees and flowers. There is beauty in the world as well as contrasting patches of its opposite. For some people none of these things exist. For others only some of them exist. For still others, who,

> ". . . in the love of nature, hold(s)
> Communion with her visible forms, she speaks
> A various language. . . ." (Thanatopsis)

### Recapitulation

The course of psychiatric illness rarely describes a simple curve such as that characteristic of many physical illnesses. It has no consistent pattern or "natural history." It is a crisis in the continuous efforts made by an individual to cope with a changing environment. When limits of mutual tolerance have been exceeded, pain is experienced by one or both. Peace is preserved and survival guaranteed, usually at the cost of various shifts and emergency maneuvers. In spite of these, increasing disorganization may occur. The individual's self-protective devices may be damaged in particularly hyper-sensitive and vulnerable areas. As a consequence, aggressive and self-destructive impulses previously held in leash or skillfully neutralized emerge in various ways to further the suffering of both the individual and the environment. Some disorganization of both occurs, and we have suggested four clinically recognizable levels at which this can be usually identified in a patient. Clinically these levels or orders of dysfunction represent four retreat positions.

But simultaneously efforts at reorganization and reintegration are stimulated, and the battle of forces is joined. If and when the restorative forces prevail, the symptoms subside, the fear and shame disappear, the emergency devices which had been called upon to assist in the crisis are relinquished.



We have examined some of the forces which determine the surge of the battle. Their influence is visible in the change or lack of change seen clinically in the patient, turning points or plateaus in the recorded graph. We try to discover and weigh some of these forces, and to discover the dominant or critical ones, accounting for corresponding changes in the course of illness. And, among those working to effect recovery is, we believe, the work of the physician.

No observer can remain outside the process he observes. Thus we no longer listen to reports of spontaneous recovery, since we know that if recovery was reported it must have been observed, and if it was observed it was not "spontaneous." And we must deal now more seriously with the role of the observer, which is always more than observation. We must consider in what way he becomes one of the forces which influence the course of illness and in what way he can mobilize or alter other forces so as to change the balance in the direction he seeks. For certainly no physician doubts that this can be done. If some overrate their powers and knowledge while others distrust both, still few can relinquish the conviction that to some degree they can and do influence the course of illness.

This conviction is, in essence, an act of faith. Its assumptions are often disproved. It is constantly being doubted. Honest research has refuted the usefulness of a thousand methods and ten thousand drugs. But from the ashes of every devastated theory and practice there arise new structures built on sounder knowledge, and each time the efficacy of medical intervention is greater, and with it the physician's faith.

Every day of his life, however, the observing physician is reminded that what he does is *not* alone what makes the difference. Indeed, sometimes he does nothing at all except to stand by in sorrowful helplessness. And yet, his patient sometimes improves.

Every physician who observes a patient treats him, and every true physician who treats a patient loves him. It may be wise or otherwise. It may be tinctured or even suffused with other emotions. But the concern of the physician for his patient is love of the highest order. It may be a more powerful factor in the direction of recovery than anything that the doctor does. But what he tries to do expresses his concern, and adds its increment to the forces striving to re-establish peace, order and pro-

ductiveness in the life course of one temporarily disabled. It is the final and frequently determining force in the course of the illness, the illness–recovery process.

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# A TREATMENT PROGRAM FOR ADOLESCENTS ON AN ADULT WARD*

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In the last few years some adolescent patients who entered Topeka State Hospital could not be admitted to the Adolescent Unit, but had to be treated on adult wards. As their number grew, new problems arose on these wards and the treatment programs had to be modified so that the needs of the adolescents, as well as of the adult patients, could be met.

I shall describe the alterations in clinical structure and treatment program on one ward which became specialized as a "mixed" treatment unit for adults and adolescents. This ward was one of six on a men's section. It was an "active treatment" unit, with an average population of 50 to 60 patients, 15 to 20 of whom were adolescents. The adult patients were in their productive years, between 20 and 50. Most of them suffered from schizophrenic reactions, but there were also some with depressive reactions, several alcoholics, and a number with severe character disorders or problems of sexual deviation.

Physically, the ward was inadequate, lacking in bathing facilities and space to store clothing and personal items. The ward was closed, but did not have seclusion units. Most patients slept in dormitories. There was a day hall with a television set, a smoking room and a small multi-purpose room. The aides' and doctors' offices were on the ward. As an active treatment unit, the ward was fairly well staffed, having a full-time nurse, three aides in the morning, two in the afternoon and one or two on the night shift. Two resident psychiatrists were the ward's physicians. A staff psychiatrist was responsible for the treatment program and for the supervision of the residents. Because services of social workers were limited, the physicians or the nurse sometimes had to perform social work functions. Occupational therapy was available on a section or hospital-wide basis to the extent of several hours per day for each patient.

In the one and one-half years that the program was in operation, 46 teen-age patients were treated. Two were only 13 years old at the time of their admission; the others were between 14 and 18 years of age. The usual causes for hospitalization were delinquency, stealing, truancy, or unmanageable rebelliousness and recklessness. Almost all of these adole-

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scents showed an inability to form close interpersonal ties and a deep-seated disturbance in their relationships to parents and in adapting themselves to authority. The clinical pictures they presented fluctuated from day to day.[1] A few patients had clear-cut schizophrenic reactions.

As the number of adolescent patients on the ward increased, the inadequacy of the clinical structure became apparent. The system of control proved thoroughly ineffective. For the adolescents the hospital staff represented only another controlling authority, and rebellion against the hospital rules and ward routine was of first order. It was easy to elope from the hospital because the locked doors could be opened with a key made from a coat hanger. And it was easy to test and prove the inefficiency of supervision since the staff was limited and engaged in many tasks.

The tolerance of the personnel, accustomed to a certain recognition of their authority by adult patients, was strained to the utmost. Denial of this authority by the teen-age patients created anxiety and tempted the staff to respond to aggression with aggression.

The conflicts created for many of the adult patients were even more severe, and the conditions in our patient community soon became a reflection of the tensions, the misunderstandings and the struggle between "generations" as they prevail in many outside communities. The teen-agers were louder and more active than the older patients and more forcefully demanding of the staff's attention. Every activity on the ward, so far as it involved groups, was dominated by them. They forced their choice of television programs, were the first in the food line, refused to do their share in cleaning or housekeeping tasks and "ran" meetings and parties. Many of our older patients began to feel frustrated and neglected. Some reacted with anger and demands for respect, others tended to withdraw and to give up their interests in ward and group activities. There were a few older patients who seemed to be attracted by the nucleus of adolescents, teamed up with them and began to "act out" in a juvenile fashion. There was, on the other hand, a small group of adult patients who proved tolerant of teen-age behavior and capable of dealing with it.

Less urgent than the problems mentioned, but nonetheless important, were the difficulties we had in providing education, adjunctive therapy and work for the teen-agers. The clinical structure did not include educational facilities. Shops for occupational therapy and for hospital industry were some distance from the ward and patients had to be able to go to them by themselves or had to be accompanied by aides. This, in turn, presented difficulties because of the shortage of personnel.



Another problem concerned the lack of time that the staff, in particular the physicians, had for individual patients. It was impossible to spend some time regularly every day with each patient, a shortcoming we became most painfully aware of in our treatment of teen-agers.

In summary, we found deficiencies in five major areas of our treatment program: (1) insufficient control of aggressive and disruptive behavior; (2) insecurity on the part of the staff and absence of a stable, consistently helpful attitude; (3) the development of a tense and troublesome atmosphere on the ward through the domination of ward life by the teen-agers; (4) lack of educational and adjunctive therapy facilities; and, (5) lack of time on the part of the staff to meet the patients' need for attention.

## Modifications in the Treatment Program

The modifications in the treatment program rested on two major changes: A shift of authority from the staff to the patients; and, the creation of small groups of patients, each consisting of adults and adolescents, which we came to call "family units."

### *Patients' Government*

The shift of authority was initiated in the "patients' government." Before teen-agers were admitted to the ward, the patients and the three physicians used to meet weekly to discuss various aspects of life on the ward, such as the selection of television programs or the inefficient way in which the patients' laundry was done. In most of these meetings, patients tended to hold the staff responsible for shortcomings and to expect the physicians to "produce" improvements.

After teen-agers were admitted in large numbers, the staff changed this pattern. The physicians became more passive. They refused to comply directly with requests or to promise to make changes. On the contrary, they insisted that the patients themselves find solutions to their problems, and gradually the patients became more active. They set up household projects, began to take care of the storage of clothing, and worked out a system for the selection of television programs. As they took over these functions, authority was shifted to them from the staff.

The ward community, as a whole, developed its own rules and assumed responsibility for their enforcement. It was a "distribution" of authority, as Maxwell Jones[2] calls it. The staff retained "veto" rights and the

authority was shifted gradually as the patients proved capable of greater self-determination and self-control. All projects the patients undertook remained dependent upon the degree of cooperation they were able to muster, especially later on when the influence of the patients' government made itself felt even in the planning of individual treatment programs and of discharges.[3] Discussions and majority decisions were emphasized, and disagreements between patients or between patients and staff were taken up in open debate.[4]

The teen-agers participated in this ward government, at times, and in certain areas they even dominated it.[5] This arrangement made rules more acceptable to them and offered a basis for "identification" with the authority. As the staff was no longer the sole representative of a controlling power, rebellion became directed toward the ward community as a whole and often against decisions the teen-agers, themselves, had helped to make.

*Family Units*

With 50 to 60 patients on the ward it was difficult to have all patients actively involved in the patients' government. Those patients who remained on the fringe were reached through additional work with smaller units in which the atmosphere and the discussions could be better adjusted to individual needs and group psychotherapy could be used. Thus, several groups of eight to twelve patients were formed attempting to "match" the members according to age, interests, and similarity of problems, *e.g.*, a group of adolescents, a group of older men, a group of regressed patients. Although this system worked fairly well, it began to show shortcomings. Inadvertently, active patients had been lumped together in one group and inactive ones in another. In discussions each group tended to blame members of the other groups for certain problems and many areas of conflict remained untouched because the grouping did not correspond to the spontaneous grouping on the ward.

Therefore, the system of having "matched" members was abandoned, and the patients were allowed to re-form their own groups spontaneously. Almost spontaneously, I should say, because the mixing of adolescent and adult patients was encouraged. The new groups represented a more natural reflection of the general grouping of the patients on the ward. In an attempt to foster cohesiveness in these groups, all patients in one group were put in the same dormitory, were assigned to the same activities, had their ground-passes together and even ate together. However, this plan did not create closeness, but rather resistance to it and, after several weeks, we decided to let the groups grow without any interference from the staff. The physicians continued to meet with these groups once a week for discussions and the other personnel were invited to join the group of their choice. It was at this point that the groups began to acquire the significance of "family units." Patients and staff began to assume roles just as in group psychotherapy. Since the patients lived together, they not only had discussions of their problems, but also a great deal of other contact and interpersonal ties, and tensions became very strong.



The patients of each group tended to stick together. They often selected the same activities, helped each other out with money and clothing, and while they argued violently amongst themselves, they defended each other with vigor against outsiders. As a part of this unification process, the older patients in each group "adopted" the youngsters, helped them with their school work, hobbies and ward tasks, and not infrequently took them to their homes when they went on a pass. The youngsters, in return, did work and errands for them and, at least at times, yielded to their influence.

In many ways the groups thus came to resemble the mixture of parents, grandparents, uncles, teachers and even neighbors which forms the environment of teen-agers in outside communities. In this sense the adult patients on the ward provided a more natural milieu for the teen-agers than could be found on a strictly adolescent unit.

In the hospital, only the Adolescent Unit had special classes. An attempt to secure teachers for the adolescents on the adult ward failed and so it was decided to try to send them to the local schools. The curriculum for each patient was planned as part of his total treatment program and was discussed in detail with the teachers. The part-time social worker and one of the physicians for the ward joined the Parent–Teacher Association and maintained as close contact with the schools as possible. Some of the older patients helped with the homework and did some tutoring.

On the whole, the adolescent patients made better grades in school than they had made before coming to the hospital, and there was little, if any, unusual behavior on their part while they were at school. The greatest difficulty came in raising the money for the special tuition that

had to be paid for every pupil. In fact, some students had to work on week ends to make their own money for school.

**Discussion**

The treatment program—with its two mainstays, patients' government and family units—provided a milieu in which much interpersonal contact developed and in which authority was expressed in the form of "social pressure." The teen-agers shared the authority represented by the group and could derive a sense of strength from participating in majority decisions, yet, at the same time, they became increasingly dependent for their personal well-being and freedom upon the approval of the group.[7] This mixture of belonging and dependence fostered identification with the authority and made rebellion against it difficult. Further, the authority represented by fellow patients was less threatening in some ways than was the authority of the staff,[8] and it was an authority mixed with personal concern and interest, especially so in the family units. The control of disruptive behavior possible in this setting was much broader than it could have been if it had been implemented solely by the staff. Effective control could not be limited to major instances of "acting out." It had to be continuous, had to protect the environment as well as the patient, had to go into details and make itself felt just as soon as the patient's own controls failed. For example, it allowed verbal outbursts, but discouraged physical aggression. And it also meant that a young patient was tucked in at night if he, himself, refused to care about the way he slept.

As this type of "control" had become a responsibility and concern of all the patients on the ward and in many ways of the teen-agers themselves, it lost its character as an enforcement from the outside. Any rebellion against controlling measures became a rebellion against the patients' own decisions, more even, against the responsibility they had demanded and been given. There was no authority any more to rebel against except their own, and if the adolescents tried to rebel, they could only do so by jeopardizing the freedom they had helped establish, and by straining the relationships with the older patients which had proved mutually gratifying.

Kurt Eissler,[9] in speaking of the psychotherapy of adolescents, describes a process which would seem similar to the one our adolescent patients went through. He divides the psychotherapy of delinquent adolescents into two phases. In the "first phase" the patient is "compelled to undergo the process he defies during the oedipal phase, namely, identification with an authoritative person, by being forced into a strong emotional dependency on the therapist and by being exposed to frustrations." Once this has been accomplished the patient enters into the "second phase" in which "the warded off impulses return in the form of neurotic symptoms . . . amenable to the classical treatment technique." In analogy, a teen-ager in our treatment program reached the "second phase" when he had become emotionally dependent on the ward community and had, to a sufficient degree, identified himself with its authority. In the "second phase" his treatment could be continued in the same way as it was provided for the adult patients, *e.g.*, psychotherapy, adjunctive therapy, further milieu treatment and group work, but his special problem as a "delinquent adolescent" had ceased to exist.



The program described here was initiated and carried out by staff members who had no special training or experience in the treatment of adolescents. The various measures were developed step by step, often through trial and error and were frequently born out of a sense of urgency or desperation. Many mistakes were made because of overenthusiasm or apprehension and many attempts to change the structure of the ward failed because of a lack of recognition of the impact of these changes upon the section or the hospital.

The roles of the various staff members were unclear at first and the pressure to change accustomed patterns created anxiety.[10] Nurses and aides suffered from the loss of the security provided by the older, more authoritarian and hierarchical structure. The nurse's role as a mother became strongly emphasized. The teen-agers demanded much of her but she had to divide her attention between adolescents and adults and had to be flexible in her attitudes. Her training as a nurse did not prepare her for this flexibility. On the contrary, it seemed to have strengthened her dependence upon regulations and patterns. The nursing department in the hospital remained organized hierarchically and along a philosophy of orderliness, cleanliness and quietness. Our nurse frequently found herself in a conflict of loyalties between her department on the one hand and the program on the other.

The aides faced a similar, if not more severe, conflict. The defiance of their authority by the teen-agers, combined with the increasing democracy of the ward community, created considerable anxiety among them. Some of this anxiety found expression in a trend to become more author-

itarian or even punitive. It was thought at first that "education" in courses and discussions would be the answer. This was a good approach, but what appeared even more important was for the doctors to give more time to the staff. Just as the patients had to gradually find their way toward more self-determination, so the staff gradually had to work through their anxieties about their changing roles before they could accept personal ties with the patients in place of respect for their authority.

Of the 46 teen-agers treated in the program, twenty-five showed lasting improvement, ten remained unimproved, and six were in the program such a short time that their progress could not be fully assessed. Five teen-age patients improved, but, nonetheless, eloped from the hospital. Each one in this group ran away at a time of personal crisis: for instance, when the physicians were changed or when the nurse left. But each one made a satisfactory adjustment outside and later sought to clear his record with the doctors and the hospital.

The program offered its greatest potential in the treatment of adolescents suffering from personality disorders, a lesser but still some potential for those who showed basic ego-weakness and tended toward a schizophrenic form of personality disorganization. The adult patients were neither always helped through the program nor always helpful in it. None of them suffered in any serious way from the program and, on the whole, it activated their interest in interpersonal relations and their individual treatment programs.

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# PSYCHIATRIC HOSPITAL TREATMENT OF ADOLESCENTS

## Verbal and Nonverbal Resistance to Treatment

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Psychiatrists are more and more coming to view the hospital milieu as a locus of all kinds of communications. This interest stems in part from the current surge of research and speculation in communication and "information theory."[1–3] In *The Mental Hospital,* Stanton and Schwartz[4] described ways in which disturbed communication plays a role in events among staff personnel and patients. They believe that one of the most important functions of the ward psychiatrist is "intuition," by which is implied the ability to understand the countless metaphorical communications transmitted within the milieu, and to translate them into words and acts appropriate to the needs of all concerned. Similarly, the problem of metaphorical communication between disturbed children and adolescents and the members of an adult treatment team is described by Redl and Wineman.[5,6]

The purpose of this paper is to attempt a preliminary formulation of some basic messages observed being transmitted between the treatment staff and the patients in an intensive residential treatment service for adolescent patients.† One reason for this attempt is to try to abstract what, in mathematical language, could be termed a minimum family of messages consistent with meeting the psychological needs of the patients. This leads immediately to such questions as: What needs seem consistently to be expressed and re-expressed by the patients? How are these needs "coded" in metaphorical language and in (expressive) behavior? What are the needs inherent in the metaphors and how do members of the treatment team recognize ("decode") them? Finally, how can the treatment team transmit to the patients that the messages have been received and "decoded," and how can needs thereby expressed be met?

This approach differs in no important way from efforts to understand what transpires in individual psychotherapy. However, in the team treatment of disturbed adolescents, one meets certain problems, to be

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† The Adolescent Unit of the Kansas Treatment Center for Children Division of Topeka State Hospital cares for approximately sixty patients from twelve to seventeen years of both sexes and with a wide spectrum of psychiatric illness. Two-thirds of the patients live on a closed, maximum security cottage; the remainder live on a "semi-open" cottage with less intensive supervision.

described, which seem especially associated with the psychological difficulties presented by patients of this age group. Despite these, our goals remain those which are well recognized to be an integral part of any dynamically- and therapeutically-oriented hospital milieu. These are: (1) to understand as much as possible of each patient's genetic–dynamic history, (2) to apply this to efforts to understand each patient's needs both to resist and to utilize treatment, and to assist the patient to recognize and deal effectively with each, and (3) to "do no harm." This last condition is of special importance in the milieu treatment of adolescent patients who suffer from severe, disorganizing (psychotic) illness, in which those parts of the ego yet functioning effectively must be preserved and supported while new ways of living are being taught.

### Some Difficulties in Treating Adolescent Patients

One of the significant features of adolescent hospital patients, taken individually or as a group, is the peculiar dilemmas they pose for the adults who treat them. Thus, it is often said, "Adolescents are extremely difficult to work with." "Adolescents are exceptionally demanding." ". . . they are so changeable, unpredictable, destructive." What frustrates adults who deal even with "normal," nonhospitalized adolescents are their emotional lability and unpredictability, the protean nature of their defenses, their bipolar swings of mood and thinking, their proneness to act out, their querulousness, fluctuant hostility, preoccupation with their bodies and their sexual feelings.

The literature devoted to the psychotherapy of adolescent patients reveals a variety of treatment modes and modifications of technique which reflects the peculiar therapeutic problems encountered. For example, one reads that the therapist must (reluctantly) modify "classical" psychoanalytic technique; he must be ever prepared to be especially "flexible"; he must know how to deal with an intense and variable transference; at times, one reads that psychotherapy and psychoanalysis of adolescents are "impossible."[7–9] Again, it is the "relationship" that really counts. Thus, as exasperated as are the parents of disturbed adolescents, psychotherapists have proposed ways of treating them that have varied from abject authoritarianism to unrealistic overpermissiveness. It is not without basis, therefore, that Anna Freud[10,11] considers that all adolescents, hospitalized or not, suffer from a sort of "normal psychosis," the basis of which she has spelled out in her writings.



The period of adolescence, in mechanized western culture, proves to be unsettling for most people;[12] after it has passed, the mechanisms of repression and denial operate to efface the adult's memory of it. When some degree of stable identity has been achieved, the adult is wont to forget that period in his life when, caught in the distracting psychophysical turmoils of his adolescence, and groping with considerable mental pain for some sense of self, he saw himself stalled between his needs to regress to dependent childhood and, simultaneously, to progress to mature adulthood. Thus, one hears, "I simply can't understand adolescents!" or, "I'd resign if they ever assigned me to the adolescent ward."

On the other hand, many who work with adolescent patients often indicate a need to return to a kind of adult adolescence themselves. An ominous feature of this, especially for any consistent milieu program, lies in what Johnson[13] and Johnson and Szurek[14] first saw as the parents' need to stimulate their children to act out antisocially, to obtain thereby vicarious gratification for their own forbidden antisocialness through, in part, identification with the alloplasticity of their children. Adolescent patients are prone to evoke strongly ambivalent attitudes from the adult team members, and unless these are consistently understood and dealt with, the therapeutic effort will founder.

### The "Adolescent Position"

A basic problem facing any inpatient treatment team is the team's continuing need to "engage" the patient, to "get him into treatment," and to maintain the engagement. This means that, as soon as possible following the patient's admission to the hospital, enough of his initial resistances to hospitalization must be overcome so that he begins to sense that the hospital structure can somehow help him. By the term, "structure," we mean the manifold of team attitudes and physical features of the hospital which together can be molded to recognize and to meet the patient's individual needs. Thus, among other things, structure comprehends such elements as the attitudes of team members toward the patient's person and behavior, medications and other somatic therapeutic modalities, and the devices through which controls are applied, including privileges, restrictions, and seclusion rooms. In other words, structure is roughly equivalent with "consistent and dynamic milieu," and each of the numerous tangible and intangible elements of the milieu represent modalities whereby treatment is addressed to the patient.

Those who deal with adolescent patients soon recognize that the latter

come to the hospital with certain predictable resistances that add special coloring to the initial problems of motivating them to "engage" with the treatment structure of the ward. These resistances can only be fully understood if the predicament of *most* adolescents in our culture is taken into account, namely, that of finding one's self mired between dependent childhood and mature adulthood. This predicament in turn shapes both the content of the metaphors in which the adolescent patient conveys his needs to the treatment team, and the lability and intensity with which he conveys them. If we add to this the wide spectrum of labile defenses the adolescent oscillates among in his seemingly tireless efforts to resolve his predicament, we are confronted with a difficult challenge indeed.

What we call the "adolescent position" comprises a group of attitudes and behaviors we may describe as follows:

First, in most cases, the patient is unable to understand or to admit the real "why" of hospitalization; that he could be mentally ill is denied with conviction; the word, "sick," is abhorrent to adolescents, who respond to it with hostility.

Second, the treatment team is composed of *adults*, and the adolescent seems convinced that adults cannot understand him.

Third, adolescents ill enough to be hospitalized have suffered serious prior traumas at the hands of adults, most often parents. A consistent feature of adolescent personality is the readiness with which the child infuses his early transference to treatment figures with a need to perceive them directly as parent figures.

Fourth, based directly upon this mode of perceiving adults, the adolescent strongly anticipates the recurrence of any or all of three major traumas: the adult will retaliate punitively and "hurt" him; or, the adult will reject or abandon him; or, the adult will prove by his actions that he is not a perfect, blameless, omniscient, and omnipotent figure, qualities in which, despite protests to the contrary, the adolescent wants desperately to believe.*

Fifth, to preclude the recurrence of these traumas, the adolescent must

* The persistence of the wish to find the adult (parent) figures perfect and all-powerful, albeit ambivalently held, accounts for the well-known and often heroic efforts made by adolescents to "devalue" these figures. This phenomenon is, in turn, a function of their needs both to remain dependent upon and simultaneously to break free from adult controls. The problem of the child's ego ideal is especially important in the case of adolescents with antisocial character problems and those who show "delinquency," discussed in part by Johnson and Szurek.[14]



attempt to neutralize efforts of the adult team members to engage him in a therapeutic process. He views the hospital structure as an adversary with which he is locked in combat, and which he must defeat; his efforts to vanquish treatment structure, like his defenses in general, assume many forms.

### The Adolescent's Efforts to Defeat Structure

The essence of the adolescent patient's problem can be reduced to the question of how best to "deal with" adults. Among the devices used are the following:

1. *Identification with the Aggressor.* Some adolescents usually attempt sporadically or consistently to cope with the structure by becoming "little adults." Thus, we observe the "assistant doctor," "assistant nurse," "mother hen," and "big brother" phenomena, wherein the child adequately guides, advises, or succors less apparently integrated peers, and emerges with a pseudo-adult façade. The meaning of such behavior is often clear enough; the child says, "I will maintain control by controlling others." Again, the child states, "You see how grown up I can be, and that ought to convince you that I do not need to be treated (to be changed)."

> One 13-year-old girl persistently acted as a "big sister" for her peers on the ward, counseling, advising, guiding them. When this defense was frequently interpreted to her, she reverted from a placid, pseudo-mature-appearing girl to one indulging in frequent temper outbursts, moderate assaultiveness to peers, and haughty insolence toward team members, leading to numerous short-lived episodes of seclusion. Concomitantly, she discussed some of her problems about boys with her ward physician, as well as her problems regarding whether she was really able to attract male peers and to be looked upon as a "woman" by them.

2. *Leveling* is one of the more frequently used devices to defeat structure. By this means, the child tries to make a sibling or a peer of the various adult team members; often, this assumes the form of being "buddy-buddy" or a "pal." The message here is, "If I can prove that you are no better than I am, I can be assured that you have nothing to offer me, and I need not 'engage.'" For example:

> At several weekly ward meetings with his patients, a new ward physician was met with numerous requests to indulge in telling off-color jokes with the patients, who offered to "trade" him a joke for a joke.
>
> A familiar variety of leveling comprises efforts by the patients to degrade (devaluate) the physician, nurse, or aide. Thus, one hears, "Oh,

he can't help us—he's as crazy as we are." One severely negativistic, psychotic 14-year-old girl persistently and openly stated to the ward physician, "Oh, get out of here . . . you're crazy . . . you're stupid." This was met by persistent interpretations that she seemed desperately frightened that the adults who were offering her help in reality wanted to injure her; after some weeks, the verbal tirades decreased in frequency, and she became more comfortable and mildly friendly toward adults.

Several boys asked their ward physician, half seriously and half playfully, whether *he* had "problems" just as they were supposed to have. Implicit in this query resided not only a need to level the physician, but also a need to fathom whether the physician was enough like them to permit a degree of identification with him. Both needs were simultaneously interpreted to them, evidently to their satisfaction at the moment.

3. *Flirtatiousness and Seductiveness.* A more complex message is contained in the various kinds of flirtatious and seductive behavior adolescent patients often exhibit toward the adult team members. More often, it is the adolescent girls, who by usually transparent but occasionally rather subtle, pseudo-sophisticated maneuvers, try to vamp the male adults. Such behavior represents counterphobic sallies at dealing with sexual impulses that are frightening and bewildering to the child. Again, however, one often apprehends the message, "If you can be seduced by me, you are not perfect," or "I can frighten you," or "You will thereby prove that you want to use or manipulate me," hence, "I cannot trust you and you cannot help me." Girls generalize, "He's just like all men" (meaning, like my father, a seducer); boys generalize, "She's just like all women . . . easy makes . . . can't resist" (castration wishes and fears).

One attractive, 15-year-old girl, with surface "hysterical" features, initiated her relationship with a new ward physician via seductive glances and posturings at various times. She was given gentle but persistent interpretations, amounting to, "I wonder why you have a need to make something sexual out of your contacts with me?" As she began to assimilate this, she began to talk more about her needs to "control" things, and to display a behind-the-scenes-operator approach to her peers and various ward situations. This was, in turn, dealt with by interpretations and restrictions from privileges. In this case, a "sexual layer" covered more deeply situated power strivings; her erotic maneuverings served both to cover and to allow expression for an aggressive manipulativeness.

4. *Oversubmissiveness.* The occasional adolescent patient who shows what appears to be ready compliance and eagerness to use the structure has almost always discovered that one can beat the adults at their own game by such maneuvers. If such maneuverings are not dealt with



promptly, the child remains unchanged. Abetting such a state of affairs is the reluctance of various team members to disrupt such a welcome placidity, especially in view of the difficulties they often must face in dealing with the majority of more disruptive patients.

In such cases, it becomes of paramount importance to help the child to understand the meaning of his compliance, and the ways in which he uses it to scotomatize underlying problems as well as to lull team members. A danger, often discovered as one "moves in" on the child's compliance, is the child's first line of resistance, expressed by the message, "So, you want me to be bad, eh?" The obvious conclusion is that, "Anyone who wants me to be bad cannot help me." We have noted this defense frequently in children with an obsessive–compulsive character pattern.*

One such child, a 12-year-old "model child," entered because of disturbing thoughts that various members of her family "would be better off dead." On the ward, she was the epitome of the sweet, compliant little girl, beneath whose façade lurked mounting, inhibited, disruptive hostility. With persistent interpretations, in part directed at her compliance, she began to evolve into an overtly more manipulative girl with a near-genius for involving her peers in disruptive behavior without being discovered herself. This was, in turn, interpreted, and outlets for her aggression provided. As a result, her disturbing obsession with death abated considerably.

Subsequent therapeutic work on a more intensive level allowed her to become comfortable in expressing her anger at her parents for having "made me a goody-goody girl," and her further anger that they "gave me a wrong steer," since despite her efforts to comply with their wishes, she had wound up in the hospital. Later work revealed death wishes directed at her mother for having failed to protect the child against her oedipal wishes toward her father and for having used her as a "little adult," a substitute for the mother, in the latter's relationship with the father.

5. *Persistent Avoidance.* Some adolescent patients will make consistent efforts to absent themselves, in various ways, from contact with the structure. Such efforts vary from daydreaming and fantasy to self-seclusion and refusal to participate in any of the regular ward or off-ward

* Buried within these messages lie several of the adolescent patient's major fears, such as, "You really want to rob me of my self-determination, and to make a conformist out of me." Again, "None of my ideas are any good, and you really want me to think just as you do." In our experience, handling these basic messages is best accomplished in individual psychotherapy, and can usually be undertaken only after a significant relationship has developed between patient and therapist, generally only after many months of therapeutic work.

activities. In our experience, persistent avoidance serves a regressive need; the message implied is often, "By absenting myself, I will provoke you to retaliate and to counterattack; this will prove that you hate me (or, will hurt, damage, or kill me), hence cannot help me." Again, avoidance may imply that the child fears his own aggressive or destructive impulses; its manifestations are legion, and include such phenomena as convulsive seizures, negativism, and chronic sleepiness; the less common dissociative, fuguelike, and "oneiroid" states in part also express similar needs.

A special form of avoidance is persistent refusal to eat; unlike the common food fads and "dieting" which adolescents show, persistent refusal to eat seems more common among recently admitted patients and is to be taken as a sign of severe illness. Thus, the majority of patients who showed such behavior were either borderline or frankly schizophrenic children, some of whom were currently suffering from acute, circumscribed psychotic episodes which would later clear.

> A not infrequent phenomenon is either the patient's own requests for seclusion, or behavior aimed to provoke it, whether conscious or not. Aside from the patient's need to provoke seclusion to prove that the adults will "retaliate," is the child's need to escape from the structure and to avoid "showing himself," meaning his traditional defenses, to others. In some cases, such escape permits freer indulgence in fantasy of major degree, or in frank hallucinations, which the child senses would disturb peers. One of the most untherapeutic uses of seclusion is to allow the patient to accomplish such avoidance; on closer examination, most cases of daily, long-term seclusion are usually found to be doing just that. *

6. *Scapegoatism.* Many adolescent patients are prone to denigrate or vilify some of their more seriously ill peers; or, a patient may manipulate a more disorganized peer into acting out, or into engaging in unacceptable behavior, thus affording vicarious gratification to the instigator. One of the messages this kind of behavior transmits is, "If I can divert your attention and energies to other patients (or, to the *really* sick ones), you will not notice how sick *I* am." Persistent interpretations directed at this particular motive are often of great value in convincing the patient that one indeed understands the problem and has not been deceived.

* Often the need to provoke "retaliation" (aggression; counteraggression) subserves the need to be loved. Thus, "If you punish me, you must love me." It also subserves needs to be injured, violated, attacked, which are, of course, sadomasochistic.



> A not infrequent variety of scapegoatism, applied to one's self, is noted in abjectly silly, bizarre, or untoward actions of various kinds. Thus, one 14-year-old boy, diagnosed as psychoneurotic, gesticulated, walked, often spoke in a childish, silly way. Several interpretations amounting to, "I guess you really *are* trying to convince me you are crazy," brought these inappropriate actions to a halt.

7. *Outright Rebelliousness.* Adolescents who deal with their inner problems by acting out (alloplastic defenses) initiate numerous episodes of disorder on the ward. Tantrums, pugnacious negativism, assaultive and destructive outbursts, self-mutilations, wild, frenzied furores and other techniques may be used chronically or in rapid sequence. One of the most consistent messages such behavior conveys is, "If my extreme outbursts can disorganize you, you cannot apply structure consistently; I will have distracted, hence defeated you."

Of course, interpretations directed at this message cannot be given during such episodes nor, for that matter, can any others which are verbal in nature. On the other hand, they may be given at opportune moments between outbursts, along with whatever other interpretations are appropriate for the particular child. During the outburst, gentle but firm physical control, medications, isolation of the patient from as many external stimuli as feasible, even restraints to limbs offer the best "interpretation" that the adult team members do understand the child's needs.

8. *Transference Diffusion.* A favorite technique by which adolescent patients attempt to "dilute" the therapeutic structure is by a process one might call transference diffusion (a more familiar term for this is *transference splitting*). Adult patients often use this technique to draw two or more members of the treatment team into a more "intimately therapeutic" relationship with the patient. In such cases, the patient will try to confide, in the ward physician, material more legitimately dealt with in his regularly scheduled psychotherapy hours; or, material legitimately shared with the ward physician may be brought to the ward nurse, an aide, or another physician. Such maneuvers are often transparent, but may frequently be so subtle as to obscure their essentially manipulative character.

Of course, transference diffusion finds a ready outlet in the confidences patients share with their wardmates, especially among adolescents, who proceed to take material to their peers rather than share it with any adult. Like any other effort to defeat structure, transference diffusion is overdetermined; confidences so shared meet the child's needs for group

belonging or for close peer relationships, but they also serve notice that the child is unable to share material with those best equipped to understand it and to assist the child to evaluate and deal with it. It is amazing how important data regarding a patient's thinking, feelings, or overt behavior will percolate through a ward population and yet be withheld from the ward physician or the other members of the treatment team.

An important variety of transference diffusion comprises the child's efforts to move the physician to grant visiting privileges with parents, close relatives, or former peers as quickly as possible following admission. Certainly the child feels abandoned or deserted by these, given over to a strange institution and to strange custodians, frightened by the unfamiliarity of his situation. However, an often neglected aspect of the child's need quickly to visit with relatives and former peers is precisely his efforts to keep transference spread thinly enough to preclude "engaging" with the hospital structure. Hence, we routinely interdict such visiting privileges for at least two weeks after admission, and make efforts to insure that they begin concomitant with or following the inception of casework with the parents. The child's perception that the hospital and his parents comprise a team dedicated to helping him, and in basic agreement with each other, constitutes one of the most vital factors in the inception of his treatment; if the child can make this observation soon after admission, the time required for residential treatment is often considerably shortened.

An aspect of transference diffusion that often brooks ominously for the integrity of the adult treatment team is the often subtle ways in which the patient will try to play off different adult team members against each other. Aides or nurses may evoke and find themselves dealing with material that should be shared with the ward physician, or the latter may find himself suppressing data the aides and nurses should have. The child is often exquisitely sensitive to interprofessional frictions, and to the internecine problems inherent in a team composed of members of different levels of psychiatric competency; he will often manipulate the situation in order to prevent a consistent body of data from reaching at least one responsible focus. The message here is, "If I can spread myself thinly among you, none of you can gather enough data by which to plan and execute a consistent approach to me."

Finally, a prime focus for transference diffusion among adolescents is found in the often intense if fleeting boy–girl relationships that develop



among patients living on different wards of a mixed unit. In these often profoundly moving and disturbing relationships, important confidences are shared and needs for experiences explored which may never come into possession of adult personnel. The ways in which one has to deal with these relationships require the utmost in delicacy and tact, lest the participants either feel that the adults are rending them apart, or else sense that the adults are unable to put a stop to the relationships out of fear that they will alienate the children.

9. *Somatization.* Neurasthenic complaints and hypochondriacal self-preoccupation are common enough among nonhospitalized adolescents. One is not surprised, therefore, that some hospitalized adolescents regularly seek out members of the treatment team with a variety of physical complaints. Aside from the deeper symbolic significance of the symptoms, one discovers that the child will bring such complaints in an effort to deflect attention from his or her psychological problems, as if to say, "If I can succeed in attracting and holding your attention to my body, you will pay less or no attention to the sick ways by which I try to cope with things."

10. *Peer Age Caricaturing.* A not uncommon effort to vanquish treatment structure is observed in a complex of behavior we have chosen to call peer age caricaturing; another way of phrasing this would be to say that the adolescent "out-typifies himself." Such behavior involves acute or chronic efforts to exaggerate overtly the kinds of behavior traditionally associated by adults with members of the adolescent age group. Thus, the child may try to emulate the histrionic behavior of the various teen-age television or movie idols; he or she may affect to appear inordinately if happily helter-skelter, emotionally labile, playfully seductive; he may moon over stories in "True Confessions"-type magazines. In his efforts to appear overly typical, he says, "You see how typically teen-age I am; my behavior is really appropriate if a bit exaggerated for my age, and I am not sick, hence you do not need to treat me."

11. *Elopement.* In one sense, actual elopement from the hospital constitutes the child's most drastic method of neutralizing the treatment structure; running away from home is a common symptom in many of our patients' prior histories, and often served as one of the reasons for referral for hospitalization. In fact, running away tended to occur when the supervising adults showed the child that they were either unable to grasp or meet the child's needs; the elopement itself often followed in the wake of

progressively intolerable aggressive needs which, for one reason or another, the child could not express openly toward appropriate or displaced objects. Oftentimes, the child eloped to solve the problem of whether the hospital or the parents "really love me the most," which means, which would exert the greater effort to hold onto him and to help him despite himself. Again, elopement often served to prove to the child that he or she could "make a go of it alone," hence was really not dependent upon the team (parent substitutes).

As a matter of fact, elopement from the hospital, as from the child's parental or other home, occurred in a setting in which one or more of the patient's basic messages were either not apprehended or not acted upon by members of the treatment team. In many instances, the physical fact of elopement provided a means by which burgeoning aggressive and erotic impulses could gain access to motility; having thus dissipated them, the child would return to the hospital, voluntarily or not, either contrite and guilt-ridden or boastful and haughty over the success of the extramural adventure.

### Behavior of Adolescents as Understood Through Their Basic Metaphors

Our central thesis is that, despite the variety of verbal and expressive-motor vehicles by which the child transmits his basic metaphorical messages to the adult team members, the variety of such messages is exceedingly small. Without attempting a detailed, dynamic analysis of the origins or the multifold symbolic meanings each basic message comprises, we may list and briefly discuss each as follows:

1. *"I Am Bad."* It is safe to say that we have never observed a hospitalized adolescent who sooner or later and in various ways did not communicate his feelings that he was "bad." The "badness" is a function of the hostile stringencies of a punitive albeit inconsistent superego, and implies guilt; it further implies a perception of one's potential or actual transgressions, and implies a "depressive position" in which the "bad object" is incorporated into the ego ("double introjection" of Rado[15]). Thus, depression among these patients is in part a function of this self-view. As a corollary, much of the adolescent's alloplasticity represents an effort to prove to the punitively perceived adults (and to the superego) that he is indeed as "bad" as they believe he is, and he must "show" them.

To the adolescent, "I am bad" has many different meanings. Thus, it may mean



"I feel bad" (depressed; hopeless; "no good"), or
"I have hurt others" (or, my parents), or
"I am responsible for my parents' divorce," (or for my mother's, father's, siblings' death), or
"I can hurt (kill, injure) you (adults)," or
"I can destroy you" (property).

As noted, an especially important aspect of the "I am bad" message concerns the child's fancied or actual perceptions of the adult team members' wishes that he act out. The team members' wishes become potent stimuli and reinforce the child's chronic belief that acting out of control is really what the adults (parents) have always desired of him anyway.

Thus, the meaning of much of the observed breakdown of the child's inner controls becomes clear enough. In doing what he senses the adult wants him to do, he identifies himself with the adult's "bad self."*

2. *"I Am About To Lose Control."* When the adolescent perceives an imminent breakdown of his devices to hold aggressive or erotic drives in check, he becomes anxious; if the treatment team fails to perceive, hence to act on his plight, various kinds of panic will often ensue. Difficulties in inhibiting fresh instinctual charges of unneutralized aggression and eroticism constitute one of the major problems of hospitalized adolescents, and the failure of the treatment structure to respond to the child's metaphor which transmits a threatening loss of control abets the progress of the breakdown.

> Thus, a 14-year-old girl signaled loss of control at least 24 hours prior to an outburst by complaining that "nobody can do me any good." Another preceded panicky rage attacks on furniture and peers by showing increasingly erotically seductive behavior toward male team members. A third girl signaled by open masturbation. A 13-year-old boy signaled that he was about to attack and severely beat a peer by playfully slapping adult team members on the back repeatedly during the week prior to his assault on the peer.

3. *"I Am Afraid You Will Abandon Me."* The fear of abandonment is perhaps basic to all the other fears expressed by the child, and is usually syncretized with other fears and messages that amount to the same thing.

* Regarding this identification, the acting out (1) implies that the child has incorporated the "bad self" of the adult, as already noted, (2) may express the child's need to destroy the incorporated "bad self" by displacing aggression onto substitute objects, and (3) may express the need, therefore, to destroy part of the child's own self, either via displacement or through evoked punitive retribution from others. The original incorporation involved a parent figure at a stage before the child could make any kind of good–bad judgment, and when the parent figure was perceived as a perfect, omniscient, or omnipotent object.

Thus, the child may express in metaphor (or, in the case of psychotic children especially, *directly*) to the adult team members such messages as, "I am afraid you will hurt me" (or will retaliate, or will seduce me into sexual acts with you).

In such instances, fear of injury (castration), seduction, retaliation, or one's own potential destructiveness symbolize fear of abandonment, and masquerade more basic fears that the adult will allow the child to starve and perish. The struggles of adolescents for a stable self-identity represent, in part and to a degree dependent on the depth of their psychopathology, struggles against the loss of boundaries, hence some authors conceptualize adolescence as a struggle against disintegration. Thus, for example, the fear of abandonment or death may express itself in a fear that the adult will not "understand" the child.

Although our formulation may seem reductionistic, we prefer, for the purposes of this discussion, to state it as follows:

Fear of abandonment = (Fear of "lack of understanding" by the adult
(Fear of retaliation by the adult
(Fear of lack of control by the adult
(Fear that the adult will condone "being bad"
(Fear of one's own instinctual demands
(Fear of one's dependency, which places the child in the vulnerable position of helplessness if abandoned.

**Discussion**

Our efforts to understand the metaphorical messages of hospitalized adolescents have led us to perceive their struggles as the inevitable "conflict of generations" that evolves between them and the adult figures who represent and articulate treatment structure. On the one hand, the child tries to defeat structure, while on the other hand, he is terrified lest he succeed. So many behavioral incidents on an adolescent ward can then be understood if we remember that the behavior itself often results either from the child's perception of his imminent success in defeating structure, or that he has already defeated it.

As we see it, then, effective treatment comprises, first, an adequate recognition of the child's efforts to defeat structure, and second, appropriate ways to convey to the child that recognition has occurred. So that, just as the child expresses his needs in metaphor, the adult team feeds recognition of the needs back to him in metaphor. Operationally defined, the feedback from the adults comprises those myriad efforts by which structure is built and maintained. Thus, an injection of ataraxic medication, restriction from a recreational activity, a verbal interpretation, or a period of enforced seclusion, constitute the feedback metaphor the child needs to perceive. By intricate communicative processes not fully understood, this structural, metaphoric feedback helps the child to inhibit and to neutralize unsublimated aggressive and erotic impulses, hence to free energy by which growth can occur.



The essence of treatment structure is, of course, consistency, and the degree to which the adult team members can agree how to use structural metaphor in each individual case will determine the degree to which they help the child to inhibit and to neutralize impulses that constitute one of the foundations of the child's difficulties and of his need to be hospitalized. As yet, we have no comprehensive theory of how this comes about; actually, such a theory would represent a theory underlying milieu therapy in general, and we shall not essay to construct one here.

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# Albert Deutsch

1905–1961

Albert Deutsch, Honorary Fellow of the American Psychiatric Association, foremost journalist champion of the mentally ill, distinguished historian and scholar, courageous protagonist of reform, friend and critic of psychiatry, died in his sleep of a heart attack at the age of 55 on Sunday, June 18 at Horsham, England where he had been attending a meeting of the World Federation of Mental Health.

THE ALBERT DEUTSCH MEMORIAL FOUNDATION has been established by friends of Albert Deutsch. Julius Schreiber, M.D., is the President. Vice-Presidents are: Robert H. Felix, M.D. (Washington, D.C.); William C. Menninger, M.D. (Topeka); Norman Reider, M.D. (San Francisco); Seymour Kety, M.D. (Baltimore); Marion Kenworthy, M.D. (New York City); and Mr. Charles Schottland (Boston). Attorney David Bress of Washington, D.C. is Secretary–Treasurer. In addition to these, members of the Board of Trustees are: Judge David L. Bazelon, Mr. Arthur Rosenthal, Mr. Charles Schlaifer, Viola Bernard, M.D., G. S. Stevenson, M.D., Mr. I. F. Stone, David Shakow, Ph.D., Karl Menninger, M.D., and Pearl Simburg, psychiatric social worker of Berkeley, California whom Albert was to have married upon his return from England.

The Foundation, among other things, plans an annual journalists' award and the publication of a memorial volume of Albert's writings. It welcomes gifts in his memory and wishes also to obtain anecdotal material, letters, and other manuscripts that would be helpful in preparing his biography. It would also like to hear from volunteers in communities across the nation who would like to assist in building the Foundation. Gifts (payable to the Albert Deutsch Memorial Foundation) and other communications should be addressed to the Foundation at Room 1130, Dupont Circle Building, Washington 6, D.C.



## READING NOTES

I had an interesting talk with Sloan Visiting Professor Konrad Lorenz. He paid an outstanding tribute to an American scientist he thinks we do not sufficiently appreciate, H. S. Jennings. I told him immediately about the book we all know, namely, *The Biological Basis of Human Nature*. But he said it was not this book but an earlier one which was Jennings' greatest, written in 1906: *Behavior of the Lower Organisms*. "This book," he said, "and the teaching of this man were greatly appreciated by Karl Buehler. For the first time organisms were seen as wholes without anything mystical. In this way Jennings became the savior of behavioral science because he found the way out of the mechanistic morass."

Lorenz also talked to me at length about experiments of moving eggs of migratory birds before they had hatched. He credited a colleague, Franz Sauer, for demonstrating, *e.g.*, that certain European warblers migrate in a Southwesterly direction guided only by the star constellations. It has been proved that individuals of this species will fly in this direction when the autumn constellations appear without having any leader and without ever, themselves, having seen these stars before. In experiments made in a planetarium it has been found that as the planetarium is rotated, with no change in the weather, temperature, time of year, amount of light, etc., the birds direct their flight or attempted flight accordingly. If the spring sky is shown they head for the northeast side of the planetarium. If the autumn sky is shown they head for the southwest side of the planetarium and if the skies of a different hemisphere totally unknown to them are shown they get all mixed up and flutter to various parts of the planetarium in confusion.

What this may mean in regard to racial memory or inborn engrams, I leave to the imagination of the reader.

° ° ° °

"There are eight degrees in the giving of charity, one higher than the other:

> He who gives grudgingly, reluctantly, or with regret.
> He who gives less than he should, but gives graciously.
> He who gives what he should, but only after he is asked.
> He who gives before he is asked.

He who gives without knowing to whom he gives, although the recipient knows the identity of the donor.
He who gives without making his identity known.
He who gives without knowing to whom he gives, neither does the recipient know from whom he receives.
He who helps a fellowman to support himself by a gift, or a loan, or by finding employment for him, thus helping him to become self-supporting.—Moses Maimonides (1135–1204)"

From *Rehabilitation Record* 1:5, 1960.

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One Charles W. Halleck, a lawyer of Washington, D.C., presents in *The Georgetown Law Journal* (Winter, 1960) an article on "The Insanity Defense in the District of Columbia—A Legal Lorelei." The poetical allusion in the title is never made clear. The article is devoted to a series of case decisions and subsequent events from which the author attempts to deduce that there is a situation existing now in which it is better for an innocent man to plead guilty. To put it in another way—sometimes a man had better plead guilty than plead innocent-because-of-mental-illness, because in the latter case he will be clapped into an asylum and kept there. The psychiatrists either stupidly persist in keeping mentally ill patients under treatment or else can't make up their minds what to do with them and so go off and leave them locked up indefinitely. Calling certain conditions illness is nothing but a polite way to buy off the punishment that society has carefully arranged for misbehavior.

This is a phenomenon which we have not adequately studied — the intelligent, educated and obviously conscientious man of law who is apparently incapable of grasping the meaning of psychiatry. I don't know Mr. Halleck, but he is nobody's fool, and yet any college sophomore who had had any reading in psychiatry could criticize both the language and philosophy of this article. One explanation is that the author takes the archaic and unrealistic legal language as seriously and literally as the most devout fundamentalist takes the words of the King James version of the Bible. The fact that there is no unicorn or leviathan does not faze him. There must have been one once, or it wouldn't have been in the Bible. Similarly there must be something like this or it wouldn't be in the law.

I would like to meet Mr. Halleck. I think I would like him because he is serious and he is concerned. But I am not sure that he and I would understand two sentences spoken by the other fellow. (Just to carp a little at him because he is so precise in his language—is it M'Nachten's case (p. 275) or *the* M'Nachten case and did M'Nachten ever have a case?)



* * * *

*Holiday* for November, 1960, contains an article concerning a subject I have frequently mentioned, namely the ethics of killing animals for fun. In "Anatomy of the Hunter," Gene Caesar says that he and others who go to the woods to kill something offer a variety of reasons for doing so, but "there is only one motive—enjoyment of killing." He lists a number of methods of disguising the thrill of slaughtering.

The technical school of evasion . . . "I dropped into basic prone position with a tight sling, quickly estimated elevation and windage through the Lyman Alaskan 4× scope and sent a couple of hand-loads after him at slightly more than 100 yards. The 180-grain Speer bullets, kicked along by 45 grains of Dupont #4350, would have knocked him flat if I had hit him. . . ."

The nature-lover disguise . . . "Night was coming on fast. The sun had sunk behind the spruce-carpeted hills and its rays shafted upward like a battery of gigantic searchlights. Now the broken ridge country was filled with pools of purple shadow that, from the slope above, looked vaguely like water. In a peaceful little rye meadow I finally brought down one of the elusive bruins, a big fellow with a prime glossy coat."

The "varmint-shooting" argument, the "game-gourmet" argument, etc., he also illustrates with artistic skill. But he thinks people are basically cruel and will go on enjoying being cruel or it may diminish as we get older and more civilized. He concludes that those who can't face the real facts of what they are doing had better let killing alone. This is an honest article and I respect him.

* * * *

A 1959 publication of the Cuban Ministry of Health and Hospital's Assistance (sic) is entitled *Booklet on Sanitation History,* No. 15. This particular booklet is devoted to Dr. Carlos J. Finlay and the Hall of Fame of New York. Finlay was a Cuban who discovered and announced the transmission of the yellow fever by mosquitoes in August, 1881, twenty years before Dr. Walter Reed and Dr. William Gorgas tested

and confirmed the scientific discovery and made it public knowledge. "Fortunately for the reputation of the American people as lovers of justice a change has set in. . . . Textbooks and reference works are being revised, and there is good reason to believe this (great) injustice will be erased."

In addition to all the other interesting material in this book, there is a fascinating description of the problem of the mosquito the world over.

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The January, 1961 issue of the *American Horticultural Magazine* is devoted entirely to cultivated palms, with keys and descriptions and many pictures. The palm is one of the few plants so distinctive in aspect as to be rarely confused with other plants. But it would probably stump the average person to say what these characteristics are, other than absence of bark and of wood. Two palms are considered among the most useful of all trees. Which are they?

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*Bulletin* Number One from the W. C. Paul Arboretum in Memphis is a magnificent start for any horticultural publication. It presents in a clear, dignified way the genus Magnolia. For most Southerners there is one Magnolia, the well-known *grandiflora* or "Big Laurel." For most Northerners there is one Magnolia which they call all sorts of names but which is actually *soulangeana.*

But, as this little publication shows, there are over 30 different *soulangeanas* and a dozen recognized *grandifloras*; besides that, there are *scores* of other kinds of Magnolias, some of which are more beautiful than either of these. (Several of these I would like to see us get as special memorial trees for some of our former staff members.)

You can divide all Magnolia genera into those which bloom before the leaves appear and those which bloom after the leaves appear. Or you can divide them into the evergreens, the deciduous, Magnolia and the oriental (dusty, smooth bark).

Incidentally, our Tulip Tree or Yellow Poplar belongs to the Magnolia family, genus Liriodendron.

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An interesting footnote in "Divine Justice and Human Justice" by Giorgio Del Vecchio (*The Juridical Review,* the Law Journal of the Scottish Universities, 1:155, August 1956) was as follows:



"L. Settembrini, *Ricordanze della mia vita* (Bari edition 1934) vol. II, p. 41. This passage may be translated:

"You who make the laws and judge mankind, answer me and say: Before they were fallen into crime what did you do for them? Did you educate them in their childhood, and counsel them in their youth? Did you cheer them in their misery? Did you educate them with work? Did you teach them the duties of their status? Did you explain to them the laws? You who call yourselves the lights of the world, did you illuminate those who walked in the shadow of ignorance? If you did not do this, which was your duty, are you not to blame for their crimes? Who then gives to you the right to punish them? And you who punish them according to your law and your Justice—you will be judged according to another law and another Justice."

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Professor Garrett Hardin of the University of California at Santa Barbara, biologist, writes in *Think* Magazine for October 1960 about the implications of the word "heresy" in science.

The Arabic equivalent is said to mean both *novelty* and *heresy*; in Greek the word only implies *choice.* If the idea that anything new is wrong, anything anyone thinks out for himself is wrong, anything against common sense is wrong—then Copernicus was wrong, Galileo was wrong ("heretical"). Dr. Reginald Scot's book *Discoverie of Witchcraft* was destroyed by royal edict, Sigmund Freud was denied the Nobel Prize for having written nonsense (and such indecent nonsense, too). The author climaxes his article with a letter by Thomas Huxley, the grandfather of our Professor Aldous Huxley, in which he relates to a friend the circumstances under which he was later alleged to have said he preferred being an ape to being a bishop. What he said was in answer to a rude question by the Bishop:

"If then, said I, the question is put to me would I rather have a miserable ape for a grandfather or a man highly endowed by nature and possessed of great means and influence, and yet who employs those faculties and that influence for the mere purpose of introducing ridicule into a grave scientific discussion—I unhesitatingly affirm my preference for the ape."

KARL MENNINGER, M.D.

# BRIEF BOOK REVIEWS

*Drugs and Behavior*. LEONARD UHR and JAMES G. MILLER, eds. $10.75. Pp. 695. New York, Wiley, 1960.

This book represents a good cross section of the better research and thinking on the effect of drugs on human behavior. There are 63 contributors. Research approaches to the field are carefully evaluated. This is an excellent book for someone wishing to get a good view of current thinking in the field. (D. W. Hammersley, M.D.)

*The Changing Nature of Man: Introduction to a Historical Psychology (Metabletica)*. By J. H. VAN DEN BERG. $4.50. Pp. 252. New York, Norton, 1961.

It is fascinating to see that Europe, traditionally the progenitor of typologies and ideas about the relative fixedness of character, has now also produced a psychology of change. Its author is interested in the changing nature of man, and in the changing accounts he gives of himself in terms of personality theories. This book, however, falls short of giving a *theory* of change. It notes certain changes in a series of essays on past and present relations between children and adults, on cultural and historical determinants of behavior, on man's changing attitudes toward the miraculous, and on inside-outside relations. Though its pictures are often overdrawn as a reaction to an all too flatly assumed prevalence of stability concepts in psychology, the book has edifying and liberating properties. (Paul W. Pruyser, Ph.D.)

*An Introduction to Psychoanalytic Research*. By KENNETH MARK COLBY. $3. Pp. 117. New York, Basic Books, 1960.

This book fairly represents both the promise and the limitation of its title. It is a cogent and at times provocative statement of the basic issues of psychoanalytic research, geared, however, to the level of the novice rather than the sophisticate in research problems. Subject to specific controversy is the author's one-sided presentation of electronic recording, seen only in its scientific advantages, with the concomitant complexities it raises severely understated. Again, in making a good case for the place of numbers in psychoanalytic research, there is an unintended de-emphasis on systematic *qualitative* observation according to predefined categories, which is another way of handling the observational data of psychoanalysis research-wise. Recommended as an excellent introduction. (Robert S. Wallerstein, M.D.)

*Clinical Medicine and the Psychotic Patient*. By OTTO F. EHRENTHEIL and WALTER E. MARCHAND. $10.75. Pp. 383. Springfield, Ill., Charles C Thomas, 1960.

The usual volume on medical and surgical conditions in special situations offers little more than inadequate synopses of textbook material. This book is different. It consists of a series of papers detailing the experience and methods of the Medical and Surgical Service of the large neuropsychiatric Veterans Administration Hospital at Bedford, Massachusetts. Among subjects discussed are the diminished symptomatology of psychotic patients, the changed prevalence of illnesses in a psychotic population, the effect of intercurrent illness on pre-existing psychosis, and illnesses peculiar to or of special





frequency among psychotic patients. The special requirements of psychotic patients in history taking, examination, and therapy are well presented. Any internist or surgeon working in a mental hospital will find much of value in this book. Psychiatrists should find it of particular interest. (Samuel Zelman, M.D.)

*The Psychoanalytic Study of the Child*, Vol. 15. RUTH S. EISSLER and others, eds. $8.50. Pp. 490. New York, International Universities, 1960.

Those who follow this annual collection of rich clinical and outstanding theoretical papers have learned to have high expectation from each new volume. Volume 15 is no disappointment. It contains a wide and varied selection of excellent papers. Like the previous volumes, it adds to our understanding of normal child development and of the genetic aspects, psychopathology and treatment of emotionally disturbed children and adults. This book is recommended as a needed addition to every psychiatric library, and is recommended reading for all who are concerned with the psychic processes of children and adults. (Robert E. Switzer, M.D.)

*Recent Developments in Psychoanalytic Child Therapy*. JOSEPH WEINREB, ed. $5. Pp. 188. New York, International Universities, 1961.

The eleven papers in this volume were presented in observing the thirty-fifth anniversary of the Worcester Youth Guidance Center. The outstanding paper is by Anna Freud, who reviews and summarizes, in the light of her own experiences, some of the basic literature on adolescence. The other papers clustered under The Child Guidance Clinic as a Center of Prophylaxis and Enlargement, Diagnosis and Selection, and Selected Treatment Situations present the broad application of psychoanalytic ego-psychology to areas related to child guidance clinic functions: prophylaxis; public education; pediatrics; medical education; teacher education; clinic diagnostic, intake and selection policy; nursery school as a diagnostic help; prediction in longitudinal study; treatment of preschool children via parents; children with organic illness; borderline states. The papers and discussions are interesting and stimulating. (Robert E. Switzer, M.D.)

*Graphology*. By HENRY A. RAND. $1.90. Pp. 208. Cambridge, Mass., Sci-Art, 1961.

This small book is better able than the run of popular graphological works to show what goes on in handwriting analysis. Based on the findings and ways of approach of several graphological schools, especially Klages's, it uses for its interpretations a popular psychology made somewhat more sophisticated though in need of changes and supplementation by the clinical psychologist. Only a minimum of a rationale is given, even that one-sided since the theory of the graphic movements as expressive gestures leaves out the visual and practical components in the motivation of handwriting. Besides, some detail findings are highly questionable. (Heinz M. Graumann, Ph.D.)

*Psychoanalytic Concepts of Depression*. By MYER MENDELSON. $6.50. Pp. 170. Springfield, Ill., Charles C Thomas, 1960.

Despite some minor blemishes of mistaken understanding and some necessarily overcursory treatment of significant contributions, this book is a worth-

while and useful bringing together of the major psychoanalytic concepts on depression into a logical and coherent development. The juxtaposition of the views of major contributors brings into sharp relief the amount of scientific difference that still precludes full consensus about such basic aspects of the theory of depression, as the place in it of aggression, and of orality; of the nature of the introjective mechanism in depression; of the regulation of self-esteem; and of the basic character structure of the depressive. (Robert S. Wallerstein, M.D.)

*Spiritual Therapy: Clinical Studies in the Clinical Pastoral Care of the Sick.* By RICHARD K. YOUNG and ALBERT L. MEIBURG. $3.50. Pp. 184. New York, Harper, 1960.

Notwithstanding an unfortunate title (*pastoral care,* not *spiritual therapy,* is the appropriate term) and a patronizing introduction, this book presents its subject with a sound sense of relevance to the patient. There are chapters on the pastoral care of the heart patient, the peptic ulcer patient, the asthma patient and eight other typical problems. Each chapter begins with an excellent summary of the relevant medical facts by Young and Meiburg but checked for accuracy by medical specialists. Only after seeing the soma in its own terms do the authors turn to the problems in pastoral care posed by the various syndromes. There is ample use of clinical pastoral material and, in almost every instance, the lessons drawn from inpatient pastoral care are extended to suggestions about the program of the church and more general pastoral work in the community. (Thomas W. Klink, B.D.)

*The Art of Marriage Counseling: A Modern Approach.* By W. L. HERBERT and F. V. JARVIS. $2.75. Pp. 125. New York, Emerson, 1960.

The approach which the authors outline in this book is neither modern nor is it counseling. Moreover, the authors make sweeping statements throughout the book without giving proper credit to sources quoted. There is not a single footnote in the book. Finally, they reject the dynamics of personality. Typically British, the style of writing is excellent. (James B. Blunk, B.D.)

*The Chemical Basis of Clinical Psychiatry.* By ABRAM HOFFER and HUMPHRY OSMOND. $8.50. Pp. 277. Springfield, Ill., Charles C Thomas, 1960.

A simply written monograph whose greatest value appears to me to be in its extensive bibliography of the work that has been done in the chemical correlates of psychiatric symptomatology. The authors show an impressive knowledge of the current researches into psychobiology and are courageous enough to attempt to explain anxiety as a hormonal imbalance, depression as an epinephrine insufficiency, etc. Osmond and Hoffer are sincere and have done pioneer research with "psychedelic" (psychotomimetic) compounds. My primary criticism of this monograph (which I thoroughly enjoyed reading) is that they do not differentiate fact from fancy. The adrenochrome concept, Heath's taraxein concept, and others are presented as factual, whereas these concepts have not been confirmed by others; rather, they appear to have been disproved. Some clever and inviting hypotheses are offered, which were they validated would be important additions to our body of knowledge. (Paul E. Feldman, M.D.)



*Making the Ministry Relevant.* HANS HOFMANN, ed. $3.50. Pp. 169. New York, Scribner's, 1960.

Professor Hofmann, director of the Harvard University Divinity School's Research Project on Religion and Mental Health, predicates that the ministry of the churches has become irrelevant to the situation of modern man. In reply to a query as to changes needed to regain its relevance, he quotes Paul Tillich, Reinhold Niebuhr, Samuel Miller, Seward Hiltner, Kenneth Appel, and Reuel Howe. Tillich, reflecting profound acquaintance with depth psychology, proposes that such items of faith as the Kingdom of God, the Atonement, the Incarnation, are adequate instruments for expressing and believing the modern human situation. Niebuhr notes the contribution of psychiatry with a familiar iconoclastic touch. Hiltner, analyzing a fragment of pastoral counseling process, offers his understanding of the differential nature of pastoral care for the needs of individuals. (T. W. Klink, B.D.)

*Evaluation of Drug Therapy.* FRANCIS M. FORSTER, ed. $4. Pp. 191. Madison, Wisc., University of Wisconsin, 1961.

This little book is the outcome of a symposium at the University of Wisconsin in May, 1960. Its purpose was to determine the basic principles underlying the methods employed for evaluating drug therapy in neurologic and sensory diseases. The first half of the book deals in a broad way with research principles applicable to almost any field of clinical investigation. The latter part of the book deals somewhat more specifically with diseases of the nervous system and of the eye. This book can be recommended as background reading to any physician who is interested in or plans to become involved in clinical investigation. (Russell M. Wilder, M.D.)

*The Psychology of Character Development.* By ROBERT F. PECK and others. $6.50. Pp. 267. New York, Wiley, 1960.

A report of research focused on the microscopic structure of individual character. Thirty-four children who had been studied in the "Prairie City" project were further studied in an attempt to arrive at a systematic theory of character development. Three general kinds of data were gathered. The first group included I.Q.'s, inherent inventories, and personality questionnaires; the second, sociometric scores on character and personality traits; the third, interview protocol, projective techniques, and essays. From the mass of material, six personality characteristics were found particularly relevant to moral functioning: moral stability, ego strength, superego strength, spontaneity, friendliness, and hostility-guilt complex. The conclusions drawn by the authors are provocative and stimulating. (Edward D. Greenwood, M.D.)

*The Morning Notes of Adelbert Ames, Jr.* HADLEY CANTRIL, ed. $6. Pp. 245. New Brunswick, New Jersey, Rutgers University, 1960.

*The Morning Notes of Adelbert Ames, Jr.,* is a collection put together posthumously from Ames's notebooks by Hadley Cantril, his protégé and co-worker in the study of perceptual phenomena. Cantril explains that Ames made a regular practice of setting himself some question before going to sleep, and then jotting down the next morning the thoughts which germinated from the question. It is not unexpected that such reflections, when they come from a

man about whom Whitehead could say, "There's an authentic genius!" sparkle with stimulating ideas and occasional epigrammatic brilliance. (Martin Mayman, Ph.D.)

*Casework Papers 1959.* NATIONAL CONFERENCE ON SOCIAL WELFARE. $2.50. Pp. 143. New York, Family Service Association of America, 1959.

*Casework Papers 1960.* NATIONAL CONFERENCE ON SOCIAL WELFARE. $2.50. Pp. 154. New York, Family Service Association of America, 1960.

These two issues of Casework Papers from the National Conference on Social Welfare reveal striking similarities and differences. No one theme is discernible in the 1959 issue, which moves from papers dealing with the broad area of the nature and administration of the public social services to specific techniques of the helping process. The 1960 group of papers deals primarily with dynamics, research, and other issues concerned with that group of clients whose acting-out behavior presents challenging problems to the lay public as well as the professions. The wide range of social problems with which casework deals is reflected in both issues. Both demonstrate a dynamic and pioneering profession as it strives on all fronts to clarify and build up a body of knowledge, attitudes, and skills for social work as a whole. (Winifred Wheeler, M.S.W.)

*Premarital Counseling: A Manual for Ministers.* By J. KENNETH MORRIS. $5.25. Pp. 240. Englewood Cliffs, New Jersey, Prentice-Hall, 1960.

The author, a clergyman with experience in premarital counseling, presents no easy solution to the pastor's problems but emphasizes deeper understanding of the complexities of building a Christian family life. Effective counseling he bases on the premise that Christian character must be rooted in the physiological, psychological, and sociological as much as in the religious condition of the home. (Virgil Janssen, B.D.)

*Toward Understanding Human Personalities.* ROBERT W. LEEPER and PETER MADISON, eds. $5.50. Pp. 439. New York, Appleton-Century-Crofts, 1959.

While relying more on psychoanalytic theory than they seem aware, the authors at the same time give concept-formation (inferred from problem-solving behavior which they admit to be governed by unconsciously-held ideas) a prominent position as they seek to base personality development in a learning theory context. With a modified Gestalt-field theory approach, the book lays emphasis on perception and motivation as they blend to serve as "steering processes," whether conscious or unconscious, in behavior. The "*re-integrative*" characteristic of perceptual and motivational processes is presented as accounting for the clustering of these processes together into concepts or personality habits. The book is a simplified, eclectic, heuristic approach to personality. (Elizabeth H. Faulk, Ph.D.)

*Child Guidance Centres.* By D. BUCKLE and S. LEBOVICI. $4. Pp. 133. Geneva, World Health Organization, 1960.

This monograph is a résumé of a seminar in Lausanne, Switzerland, directed toward the strengthening of national services in child mental health. More specifically, the seminar dealt with child guidance centers (clinics), their structure and function and their place in social and medical services. Thus the monograph is a rather elementary handbook, very well done and notably valuable where attempts are being made to establish new facilities. (Robert E. Switzer, M.D.)



*Emotional Problems of the Student.* GRAHAM B. BLAINE, JR., and others, eds. $4.95. Pp. 254. New York, Appleton-Century-Crofts, 1961.

Fourteen present or former members of the Harvard University Health Service, most of them psychiatrists, present their experiences and views. Neuroses, psychoses, basic character disorders, and other major disturbances are discussed with illuminating examples. Half the complaints, however, involve difficulty with studying. At Harvard 10 per cent of students consult staff psychiatrists, on their own volition or by request of the authorities, and three-fourths of these are enabled to make adjustments. Chapters are devoted to the special problems of graduate students in the arts, science, and business, and of medical students. The point of view throughout the book is that of dynamic psychiatry. (Nelson Antrim Crawford, M.A.)

*Chronic Schizophrenia.* LAWRENCE APPLEBY and others, eds. $6. Pp. 368. Glencoe, Ill., Free Press, 1960.

This book is the published account of a three-day Institute on Chronic Schizophrenia at Osawatomie State Hospital in the fall of 1958. Fifteen specialists in the theory and treatment of schizophrenia were invited to participate. The organizing concept of the institute was related to the question of what could be done for the large number of patients with chronic schizophrenia in state hospitals, with a minimum of personnel. Approximately a third of the book is devoted to the development of theoretical constructs, primarily by Doctors Will, van der Waals, Sher, Des Lauriers, Bateson and Weinberg. Dr. Karl Menninger presented a unitary concept of mental illness and suggested discarding traditional psychiatric nomenclature. The remainder of the book is devoted to "specific approaches," utilizing intrusive total push programs and increasing the responsibility of patients. Reaffirmed is the necessity for the full utilization of nurse and aide in therapy oriented group action. (Herbert Klemmer, M.D.)

*The Crisis in Psychiatry and Religion.* By O. HOBART MOWRER. $1.95. Pp. 272. Princeton, New Jersey, D. Van Nostrand, 1961.

A monoideic drama with Freud and Calvin as the villians, conscience as the assaulted maiden, and a professor from the University of Illinois heading the rescue party. Nearly half of the book consists of quotations while the other half is an exercise in axe grinding and the demolishing of straw men. Not very good as the first issue of a new series of "Insight Books." (Paul W. Pruyser, Ph.D.)

*Working with Groups: Group Process and Individual Growth.* By WALTER M. LIFTON. $6. Pp. 238. New York, Wiley, 1961.

Every group faces a twofold difficulty, the tendency to complete conformity and the inclination to follow a forceful leader. Endeavoring to avoid these pitfalls, Doctor Lifton shows in detail how an assembled group in any field can be led toward individual development and at the same time a group democratic climate. The reproduced reports of group sessions are particularly valuable. (Nelson Antrim Crawford, M.A.)

*The Human Problems of the Minister.* By DANIEL D. WALKER. $3.95. Pp. 203. New York, Harper, 1960.

This well-written and stimulating book is addressed primarily to the professional minister, who feels a compulsion to exemplify the life he preaches. It should, however, interest anyone concerned with the study of professional role identification and the resultant personality conflicts. The volume is particularly directed to the minister's denial of his own personal problems and conflicts of interest, and to the suppression of the accompanying affect. The solutions tend to be more practical than psychological; nonetheless, they provide an adequate foundation for consequent consideration. (Noble Butler, B.D.).

*Thought Reform and the Psychology of Totalism.* By ROBERT JAY LIFTON. $6.95. Pp. 510. New York, Norton, 1961.

After two years of psychiatric field research in Hong Kong with Western and Chinese civilians, Doctor Lifton has written a richly documented book on brainwashing. It contains many detailed case studies, reports of confessions, and interesting reconstructions of the methodology of ideological change in persons. Anyone who is interested in effecting a change in persons—psychiatrists, educators, reformers, rehabilitators—should benefit from reading this book, not the least because of the interweaving of three basic themes: ethics, techniques and efficiency. (Paul W. Pruyser, Ph.D.)

*People of Cove and Woodlot Communities from the Viewpoint of Social Psychiatry.* Vol. II of The Stirling County Study of Psychiatric Disorder and Sociocultural Environment. By HARLES C. HUGHES and others. $10. Pp. 574. New York, Basic Books, 1960.

Vol. I in this series was theoretical and methodological. Vol. III will report the epidemiological findings. Vol. II lays the substantive groundwork. It contains descriptive and statistical assessments of many sociological variables in the communities comprising bilingual Stirling County in Canada. Its major aim is to compare "integrated" with "disintegrated" groups of people. The latter are characterized, by and large, by poverty, cultural mixing, decline in religious behavior, broken homes, poor communications, affective deprivation, *anomie*, work-shyness and self-defeating attitudes. (Paul W. Pruyser, Ph.D.)

*El Grupo Psicologico.* LEON GRINBERG and others, eds. Pp. 322. Buenos Aires, Editorial Nova, 1960.

This is the second volume of a series being published in Argentina by a group of psychoanalysts. Their work with the small psychological group in clinical practice was described in detail in the first volume which was reviewed in January 1959. Without it, much of the excellence of this present book is lost. On the other hand, with increased experience, the authors have greatly broadened the treatment of the subject. The dynamics and technical aspects of group therapy, and its application to treatment, education and research, is all presented with a wealth of clinical material. With such sections as those on chronic schizophrenia, mothers, cardiovascular disease, medical education and psychiatric training, among others, one can look forward to reading the third book promised by the authors on the same subject of the psychological group. (Kenneth Munden, M.D.)