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PROCESS IN THE SUPERVISION OF PSYCHOTHERAPY*

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There are, of course, many problems that supervisors encounter in teaching psychotherapeutic work, and the excellent book by Ekstein and Wallerstein[1] details a number of them. We would probably all agree that most beginning therapists encounter difficulties in learning to appreciate transference manifestations, countertransference experiences, and the varieties of resistance. They also have difficulties in handling certain typical emergencies, in dealing with problems of interruptions, terminations, fees and so on.

I do not intend to demean the importance of these problems by turning attention to something else, but I think, after some reflection, that one core problem in supervising psychotherapy transcends all the others. I refer to the teaching of the idea that psychotherapy is a *process*—the evolution of an encounter between two people. Rather than the noun, "psychotherapy," I prefer to use the adjective, "psychotherapeutic," an adjective that modifies the noun, "process." I am using the word *process* here as it was used by Kurt Lewin[2] thirty-three years ago. In contrasting Aristotelian with Galilean dynamics, Lewin reminded us that the physical vectors in Aristotelian physics are totally determined by the nature of the object. In modern physics, on the other hand, the existence of a physical vector depends upon the mutual relations of many physical facts including the relationship of the object to its environment. Thus in Galilean physics, it was not possible to infer the general laws of a process

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task of discerning these continuities. To be aware of them is to accelerate the pace of change, which is after all the purpose of the entire therapeutic relationship. Let me illustrate this point with a fragment of a psychoanalysis.

A young unmarried woman, prone to periodic severe depressions and fearful of any deep involvement with any men who might be eligible as a husband, spoke one day of her disdain for ministers and priests. They are only people, she protested, so why do other people respect, revere and obey them? The analyst, observing the vehemence of her contempt for ministers who are guiding people, suggested that there was something quite interesting to her about being told what to do. In response to this remark she noted that she herself, in spite of her aloof appearance, was gullible, particularly with her previous therapist—himself a minister—her sister, and the analyst. Perhaps, she admitted, it was comforting to believe in someone, in something, and to be looked after.

The next day she reported a dream. She was to move into a foster home and her friends, A. and B., were to be the foster parents. In the next dream scene she was with her mother waiting for an old boyfriend who was to come for them. But he did not come and she waited and waited. Her associations did not return to the theme of the day before but centered about A. and B. They have a new baby, she recalled, are good churchgoers, thoroughly devoted to each other, as if they were newlyweds. A.'s father, however, is an unfaithful husband and A. is disappointed in him. The second scene led to the recall of several incidents of broken appointments by faithless boyfriends. The analyst's interpretative work linked the previous hour to her dream, as if the dream were a response to that hour. He said that the dream meant that if she could allow herself to be cared for, to put herself confidently into the care of another, to assume a feminine role with a man, something she wished she could do, *then* she would be disappointed because men are faithless and cannot be relied on. The treatment process proceeded to help her understand her burnt-child reaction to her passivity and clarified many more facets of this problem. No doubt the analyst's awareness of the continuity of the interviews facilitated the therapeutic process. The concept that the treatment situation in its concrete totality, a situation that transcends the moment or the day, and changes with each intervention by the therapist, yet proceeds lawfully and continuously, is difficult for the beginning psychotherapist to understand.

3. *Situation process.* The third form of process in psychotherapy concerns phase changes in the overall course of the treatment, that is, the beginning, the middle with its unfolding concern for transferences, reality encounters, genetic reconstructions, and confessions, or the end. The formal state of the relationship at any particular time sounds the fundamental tone of the theme, although, to be sure, more momentary overtones add to its complexity. The supervisor must help the learner to recognize the influence of the therapeutic state on the communication. For example: The same patient who so despised the clergy began her first therapeutic hour with a remark that she must take care not to feel obligated to anyone, or to ask anyone for favors. She vividly illustrated this point by describing how, when her car was stuck in the snow, she proudly refused the help of many passers-by, preferring the *quid-pro-quo* of a garage tow truck. The analyst had to keep in mind that this was the first hour and that any response to the material must be based on the meaning of the beginning phase of the treatment to the patient. True, there is the leitmotiv of the passivity conflict that later appeared fully developed. But it would have been an error to concentrate on the problems of her passivity outside the context of the beginning relationship; a context that primed her fears of receiving help, her concern lest she resign herself to the treatment and let the therapist influence her, and her anxieties about her fantasied obligations to the analyst.

Here is a brief second example: A young teacher whose marital difficulties in three marriages and whose work inhibitions were a source of concern to him had come to the end phase of his treatment. Although no date had been set for termination, the imminent ending was influencing the process. One day he reported that he felt unexplainably angry with his analyst. He was reminded of all the teachers and bosses who had annoyed him. But his annoyance paradoxically seemed related to the conciliatory efforts of those people. The analyst, aware of the patient's early history, his parents' frequent changes of homes, their incompatibility and subsequent divorce, and mindful also of the process of ending, commented on the patient's reluctance to allow himself to become deeply attached to people, since separations are inevitable and despair would follow. The therapist appreciated that the anticipated ending primed this theme and he was thus prepared to help the patient master the disruption of a real separation without resorting to his patterns of impotent fury at fantasied repetitions of old rejections. It helped the patient to separate

himself from the analyst without having to become angry, as he had many times in the past.

I hope I have made clear what I believe to be the core difficulty in teaching psychotherapy to beginners. I have tried to show the importance of appreciating the psychotherapeutic relationship as a process viewed from three vantage points: within each hour, between hours, and within the formal stage of the psychotherapeutic relationship.

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THE ANALYSIS OF RAGE REACTION IN A CASE OF CORONARY THROMBOSIS

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The patient to be described suffered an attack of coronary thrombosis one year after terminating a psychoanalysis which had lasted four years. Shortly after the attack, extreme rage reactions, anxiety, and angina pectoris developed for which the patient again sought psychoanalytic help. This paper will discuss the patient's second analysis, and especially the technical problem of dealing with the patient's rage reactions in the context of his serious physical illness.

Arlow's study of patterns in angina pectoris[1] concluded that there "is nothing specific or organically distinctive about the anxiety associated with angina pectoris. The defenses mobilized against this anxiety are the same as those employed against anxiety generated in any other situation." Though fear of dying played a part in the anxiety experienced by the patients studied, "fears of loss of love, or being abandoned, and of aggressive and homosexual impulses were also observed."

The present case is consistent with Arlow's conclusion about the nonspecificity of the anxiety associated with angina pectoris. Nor did angina pectoris seem to serve at any time as a release or drain for either the patient's anxiety or rage. Rather the rage and anginal symptoms seemed to appear concomitantly as expressions of unresolved conflicts. Several complicating factors in the second analysis included the patient's use as resistance, of insights and technical knowledge gained during his previous analysis and his attempted control of the analyst by threats that his rage might lead to a second, perhaps fatal, coronary thrombosis. The threats impressed the analyst as real enough and played a significant role in the countertransference, coloring the analyst's decisions about the timing of interpretations in order to strike a balance between interpreting unconscious material in the interest of promoting the analysis and offering the patient active support to allay his rage. At times the patient was so beset with rage and anginal pain as to seem inaccessible to analytic interpretation. Yet his condition so fluctuated that occasionally within the same hour the analyst reversed his opinion of the patient's accessibility. Re-examination by the therapist of his own fears of provoking an

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attack of coronary thrombosis also contributed to these reversals of opinion.

History

The patient is the youngest of three children and the only son of a poor family. When he began treatment, both parents were in their seventies. The mother was authoritarian, swinging sharply from seductive behavior to fierce, often physically punitive outbursts. The father was described as quiet, gentle, and nonsupportive, but on rare occasions, vividly recalled by the patient, would fly into terrible rage. Once, when the patient was five, the father attacked some boys with a big stick because they were beating up his son. The memory recalled not the support given, but rather the patient's terror in witnessing his deceptively passive father explode into violence.

The patient was breast-fed until the age of four or five. During these years, the mother helped the father run a candy store, behind which the family lived, and it was a common occurrence for her abruptly to withdraw the breast and leave the patient to wait on customers. He recalls biting her nipple when he was two, and being shoved away as she cried out in pain. Until his third year the patient shared his parents' bedroom and has clear recollections of witnessing the primal scene. Once, he recalled, while lying in bed with his mother, his father angrily flung him into his crib with such force that the crib toppled and tumbled the patient to the floor.

At three he began sharing a room with his two sisters; he was bathed with them and given the same Buster Brown haircut as they until he was seven. He thought of himself during this period as "one of the girls."

In his eighth or ninth year, he began to earn money at odd jobs after school and watching parked cars during week ends. He would sometimes return at 2:00 A.M. when "Mama was waiting in her nightgown, sitting on the kitchen chair. I would deposit my money into the lap of her gown," which she accepted with praise for his good work. Throughout his school years the patient was never unemployed. The ability to earn money had become established as the badge of the patient's manhood and his father's ineffectiveness.

The patient's testes remained undescended until he was 15. He was acutely sensitive about this, explained his undescended testes with a story about "having been kicked in the nuts," and compensated by participating vigorously and competitively in athletics, and associating with local track and football "heroes." The eventual descent of his testes did not allay his anxiety or embarrassment, and he remained tense, overactive, and always on the run. Through his teens he bit his fingernails to the quick and his face was scaley from severe dermatitis, which once required hospitalization. At home he learned he had to be "a quiet, good boy" or to leave the house in defense against his mother's savage temper.

While in college he met and courted his wife whom he described as "a miniature of Mother," aggressive and domineering. She concentrated on intellectual and cultural activities, resented housework as drudgery, and always dominated social conversations so that the patient felt himself to be a "second-class citizen." After graduating from college, he worked for a liquor distributing company, advancing from office boy to national credit manager.

In 1942, he joined the Navy as a gunnery officer and performed creditably. After the war he accepted a position as sales manager of a large distributing company. He felt bitterly hurt and disappointed when his former boss, from whom he sought career advice, made no attempt to dissuade him from leaving the firm.

He became acutely upset with severe tension and depression accompanied by suicidal thoughts and sought help from a psychologist. After a few weeks of psychotherapy "without results" he went to a psychiatrist who administered six or eight electroshock treatments. The patient terminated this treatment, which was also unhelpful, and sought out a psychoanalyst.

Four years later, after terminating this apparently successful analysis, the patient started to become aware of a conflict between his hostile feelings toward his employers and his wish to please them. He continued to direct the company's salesforce skillfully, but the owners, by consistently rejecting his proposals for meeting competition, made him feel ineffective and angry. Increasingly loathe to approach new customers, he would often schedule a golf game to avoid such meetings. But during the time of his mounting personal distress, the company's business increased tenfold.

During a golf game with close business associates in July, 1953, he became enraged when one of his friends questioned his score, which he interpreted as an insinuation that he had cheated. He felt intense anger, deep shame, and, simultaneously, paralyzing, constricting pains in his chest. He was hospitalized and a diagnosis of coronary thrombosis was made.

While convalescing at home, the patient was visited several times by his former analyst upon whom he focused intense anger. The analyst's very appearance in the room would set off a rage reaction. Intellectually he understood the irrationality of blaming his analyst for the attack, but this knowledge did not diminish his indignation. They agreed that further treatment was indicated but with someone else.

Course of the Analysis

The patient was first seen by the writer six weeks after his coronary attack. He was 43 years old, had been married twenty years and had a 13-year-old daughter. Slender in build and expensively groomed, he was ingratiating and urbane in manner with a quick wit and an outward grace which readily accounted for his success in a highly competitive business. He consumed much time during his first hours acrimoniously discussing his schedule and fee, with long philosophic interpolations about analytic theory. He berated his bosses for not supporting him, attacked his first analyst for failing him, and accused the present analyst of being in league with the former: "I can't trust you any more than I

could trust my father, who hit little boys with a big stick." His mounting hostility precipitated further anxieties and anginal symptoms. Threaded among his angry outbursts were gestures of obsequious courtesy with which he expressed his need for therapy and for the analyst. The first dream was told during the 17th hour:

> "I am walking down a long corridor and see a competitor in my business. I approach to shake hands but he keeps both hands in his pockets and makes no move to shake hands with me. I tell him: 'I always emerge victorious, but I always like my opponent.' I have the feeling of being used again."

His associations concerned his inability to express anger, even in a dream, and that it was the aggressive, angry, hostile part of himself which was unable to tell his competitor that the hands in the pocket irritated him. The patient thus confirmed the initial impression of reaction formation against his needs to be dependent in his retreat to the castrated dependent position (the feeling of being, or the wish to be, used) and in his stating: "I always like my opponent."

His associations to the dream led to his recalling his reading of *Jean-Christophe*[12] in which the oppressed becomes the oppressor. It became clear that in the dream he wished to become the oppressor, but did not dare to be other than the oppressed. While still experiencing anginal pain the patient continued to associate and the stream of thought was not interrupted.

These early developments foreshadowed the major theme in this psychoanalysis: the relationship of the patient to his father, in which intense feelings of disgust, fear, love, and rage were invested. In the first analysis, the castrating role played by the aggressive, seductive, phallic mother had been so well worked through that only peripheral attention to it was necessary in the second analysis. But whatever insights the patient had gained into the nature of his "meek, passive, innocuous father" were held only intellectually. Yet it was clear that the factor that brought him into each of his analyses was unresolved conflict about his father. The first analysis, following a breakdown, was precipitated by his disappointment in his father-boss; the second, triggered off by the coronary thrombosis, was provoked by similar feelings of rejection by father-figures. This account, therefore, deals almost exclusively with the working out of this theme.

In the next hours, the anginal symptoms reappeared, together with the

anxiety and rage as the patient was discussing with his bosses a program to expand the business. Recognizing his fears of rejection and using various machinations to gain approval, he was inwardly in raging conflict but outwardly affable and industrious, trying to please everyone.

He fantasied beating up men, including the analyst, but particularly his former analyst. He constantly talked of men who threatened him, whining that he did nothing to deserve such treatment. He identified his rage toward the analyst with his hostility to his father, whom he recalled as never praising him but only standing docilely by, permitting the mother to scold, punish, and seduce the boy.

The patient complained continually about cardiac symptoms. He went frequently for checkups but showed little satisfaction with his internist's findings of steady improvements. After such checkups, he would stalk into his hour, bristling with anger at his internist who had asked, "How is your pain? Are you feeling better?" The patient protested, "Why couldn't he just have said, 'How are you?' instead of suggesting there might be something wrong." Once the internist ordered him to bed because of his physical complaints. Though all tests, including an electrocardiogram, showed his condition improved, he continued to warn both therapist and internist that he might have a second attack of coronary thrombosis.

Throughout this first phase of the analysis, the patient had paradoxically courted death in defiant disregard of the internist's advice. He drank frequently and heavily, increased rather than decreased his smoking, and stayed away from home all night, becoming self-righteous if friends or family showed concern: "I have a right to do what I please with myself. There's plenty of insurance." He reported a dream in which he was on a balcony discussing death with the analyst. "I tell you death should be a predetermined part of life and intelligent people should allow death to happen. I accuse you of being a victim of your own indoctrination. You get confused and the more confused you get, the more effective I feel." At the point when the patient was ordered to bed, the analyst, believing him to be inaccessible to interpretation, attempted only to give active support and, in order to allay the patient's fears of being abandoned, visited him at his home.

In the light of subsequent events it seems doubtful that this effort to support the patient's shaky equilibrium was really necessary. But neither did it seem to disturb the subsequent course of the psychoanalysis. The

patient received the analyst's visit with apparent pleasure and it seemed to have the quality of an inadvertent, social contact, an "exception" to the usual analytic relationship which was shortly to be resumed when the patient was allowed to come to his appointments.

For all his agitation over being "negated" in his job situation, the patient felt a strong, dependent attachment to the company which he was soon to sever. During this period he recalled his nursing days with great tenderness. His associations and recollections clearly showed how the early pattern of oral deprivation formed his character, for side-by-side with the memories of Mama's warm milk were those of being deprived of the breast when she dumped the nursing child to wait on customers. The pattern of denying his need for love, because of his experience that love could be brusquely withdrawn, had persisted throughout his life.

After 120 hours of analysis, the patient was offered a new job with higher pay and increased responsibilities. Once again he was so torn by conflict that he could make no decision. By rising at three or four o'clock each morning, he managed to hold both jobs for awhile. Anginal symptoms and anxiety recurred, but he functioned with unbelievable inventiveness, industry and zeal. "Coronary patients," says Dunbar,[4] are remarkable in the apparent strength and extreme brittleness of their defenses." He was again struggling to hold on to mother's warm, secure breast, represented by the first company, and needing to run from the rejecting father, represented by the boss. That the threat of castration and his passive feminine wishes were paramount in this situation was shown in the following two dreams.

> "I meet with the president and another executive. I am holding some flowers, but I do not give them. I start to talk to the president and realize this is Father. I ask him what he's doing here. He says, 'I'm supposed to be here.'"

> "Two partners are selling our company product. There is a large shepherd dog on a leash. I look about and see I can just make the door. A horse comes down the street. I am frightened by it. There is no sense in being frightened. The dog too is not so fierce. I enter and see the partners. They don't know me. I put on an apron and try to talk to them. I tell them I am the sales manager."

The therapist felt that, despite clinical symptoms of angina, the patient's positive transference and insights into the meaning of his hostility justified the risk of probing and interpreting his feminine passive wishes to be dependent on the kind, warm father. The docile, flower-

giving, apron-wearer of the dream was the little boy castrated in punishment for his wish for mother. There was now no further reason for father to hurt the helpless child.

Within a short time, the patient decided to change jobs and there ensued a period of vigorous haggling over termination salary, remarkable for its pettiness. He again recalled the men in his life who had disappointed him, particularly his old boss at the liquor distributing company who had refused to dissuade him from leaving the firm—a disappointment that precipitated his first severe depression. Unconsciously he was revenging himself upon the father who would release him so willingly.

Before assuming his new job, the patient decided to combine a business trip with a visit to his parents, his first in several years. The prospect of seeing them brought a new surge of anxiety, accompanied by feelings not heretofore experienced, the need "to tell mother" about his new job. This was interpreted as a love offering (a sexual wish) for mother, similar to that which he had offered as a little boy when, having brought home his earnings at 2:00 A.M., he had dumped them into his mother's lap. The patient hoped that this time father also would be happy about his success, and for the first time spoke of his father as "a sweet, gentle guy." His anxiety was interpreted as anticipation of sexually winning mother and wanting to appease "that sweet, gentle guy" who threatened castration. His apprehensions were dramatized in the following dream:

> "I'm in a foreign country with someone else—a fellow close to me. We are swimming in a pool. We dress and go to a chalet or hut. There is a meadow and a herd of cattle. They stampede in the direction of a group of tourists; my friend and I are unable to get into the chalet. The door is shut, so we run into an alleyway. I wonder if the cow can get in and at us. One of them does and wants to devour us. Somehow Papa appears in the frame. I tell my friend to kick the cow and frighten her. I kick and the cow's upper lip curls over my leg. I awaken from the dream frightened."

The job change brought a return of the old pattern, and the patient again experienced himself working for a boss who screamed for results but offered no support, and the old fear of the castrating father was now too palpably reinforced in reality. He felt he could only retreat into a state of passive dependency, and again intense anxiety and somatic symptoms accompanied charges that the therapist was doing nothing for him. The analyst attempted to interpret the patient's contribution to his difficult work situation, stressing his need to destroy the bad parent

as reflected in intercurrent suicidal thoughts. In response, the patient developed some insight into his pattern of provoking others to attack him.

Thus, despite his wrath at being stymied on the job, he felt guilty for not producing. He overlooked no opportunity to fawn for the boss's favor. He began taking an active role in running a religious camp which his boss sponsored, to compensate for what he felt he could not do on the job. His assumed role of "official host" was exaggerated to the extent of waiting on the waiters.

Eventually he understood that his anxiety was evoked by a castrating father-figure whom he must please to avert punishment. He recognized that his obsequious façade served to disguise his hostility. Many dreams during this period illustrated oral-dependent yearnings which provoked fears of retaliation:

> "Baby is drinking from a milk bottle. It is so filthy that I scream 'NO!' and awaken from the dream."
> "I am shooting people with my BB gun. I am frightened by what I am doing. The fear wakes me."
> "I am demonstrating to my boss what I can accomplish for him."
> "Penises are stacked in combination with vaginas. People pick them up, squeeze them and urine comes out. I plead with all the people not to do this."
> (A long dream with myriad details about driving an automobile which careens down a steep hill and fears of people getting killed.) "I return to see if anyone knows I started the whole thing. I have the feeling they know I am guilty and that retribution of some kind will follow."

As the job situation deteriorated, the patient's somatic complaints intensified. He took to retiring early, withdrawing from social engagements and he came to his hours pleading for relief. At home he told his wife, mainly through macabre puns about death and despair, how nice it would be to die, and was preoccupied with a scheme to get himself fired. He argued that there was nothing to do—no one was interested in him. Nevertheless, through habit, he continued reporting to work well ahead of time and was unable to discuss the situation with his boss. The prospect of speaking up again raised the danger of expressing hostile feelings to the father-figure. Fantasies of being fired brought feelings of gratification for having retreated psychologically to a less vulnerable position. *He* would no longer be the aggressor.

Interpretation of this constellation was accepted by the patient and a period of relative calm followed. Anxiety diminished, home life was more

gratifying, and he felt no guilt about accepting his pay. He could telephone his boss and tell him he had no work to do. "I feel Father is pretty well disassociated from me and I can now sit down and talk with my boss."

However, on an unconscious level, the aim of talking with "father" was still to get fired (become castrated). A period followed of working through his need to give himself up, to be made helpless, allowing him to be loved and taken care of by the therapist, and with it ensued a dream:

> "I am in a swimming lagoon, a lake or a pond. There are ducks in it. I am tempted to lay my head on their backs. I need to swim to them and turn on my back. The sharp bills frighten me. I am warned: These are wild fowl and might bite in a formidable (vulnerable?) spot. There are lovely swans there too, but I try for the ducks. I awake with a feeling that I am about to be castrated by the snapping duck."

This demonstration of latent homosexual conflict was interpreted to the patient as his wish to be close and intimate with father, and with men, and his fear of retribution for such a wish.

When finally the patient succeeded in getting himself fired, his hours again became stormy with tirades against his boss. He discovered he missed the boss's screaming rages for the sense of exciting contact these gave him with the father-figure. He recalled when his father told him his mother objected to his marrying. He had felt angry, frightened and that father was really warning him he couldn't have mother. The event seemed to signify that father was emasculating him for his oedipal pretensions and that he was responding with feminine wishes.

The patient remained jobless for several months. He received a number of flattering offers, spent much time carefully investigating each proposal, but hesitated about a decision. These demonstrations of faith in his abilities comforted him but he was nevertheless driven by anxiety. He became wary of his wife's solicitousness, wondering what she was "really" thinking about his joblessness and would not permit himself to trust or enjoy gestures of warmth from either wife or daughter. He rigidly kept himself from leaning on friends, but quickly detected any faltering of their interest in him. He sneaked off alone from the house, an act that recalled how as a child he used to slip home silently to grab a ball and bat and run off without answering his mother's calls.

Because his anger and anginal pains were exacerbated markedly, the analyst at first attempted to be supportive, which paradoxically only

aggravated the symptoms. Angrily he charged, "You are not letting me use my coronary to destroy myself." The interpretation was made that the anginal symptoms represented the means by which he could destroy his parents by precipitating another attack of coronary thrombosis. He responded with a flood of angry feelings to the discovery of his "secret."

Clearly, direct support offered by the therapist gave no relief and it proved necessary to probe deeply into the unconscious material to interpret the hostility underlying his need to destroy himself by bringing on another attack of coronary thrombosis. As the patient began to work intensively with his feelings about no longer being the sole support of the family, and to understand the castration threat inherent in achieving success, he was able to accede to his wife's wish to take a job and to begin to accept his own dependency needs. "I am beginning to eliminate the equation: money = love. I can still achieve love: I don't have to carry home the money to dump in Mama's lap."

With this development came a marked diminution of the anginal symptoms and anxiety, and the analysis was finally terminated. He obtained an out-of-town job at the camp in which he had been active.

Dynamics

Like the warp running through the woof of this patient's job history, was his pattern of choosing jobs requiring superior salesmanship which provided opportunity to impress and dominate others, but also fed deep anxieties about retaliation. Selling provided him not only an outlet for his hostile wishes toward his father, but also a disguised vehicle for his passive oral strivings. His successful sales efforts (unconsciously equated to "I have won Mother") triggered off the threat of castration by the ordinarily passive father who might explode into rage if the child came between him and mother.

"Success," Arlow[8] points out, "does not bring with it a sense of gratification or relief from tension. The individual is constantly drawn into new situations in which he recreates the original situation of competition, which he attempts to master by identifying himself with his superior."

To the patient, maleness meant hostility. He sought to balance this wish to be aggressive by identifying himself with the passive, feminine side of his father, but continued in emotional turmoil because his father was, at the same time, perceived as a punitive figure. The unconscious wish to replace father was ego-alien. The patient wished father to be strong, approving and loving. But how could father love a child who was

hostile to him? Guilt followed, and his superego exacted the penalty of a coronary thrombosis. The patient was thus also drawn to identify himself with the feared, envied parent, and the "focal conflict with authority cannot be said to have been successfully repressed. Identification with a feared and envied parent," Arlow[8] points out, "has not solved the problem."

He also had to deny identification with his father's passive and feminine aspects, an identification which, nevertheless, manifested itself as a conflict over longings to be a girl. Being a girl meant being loved by mother as she loved and dominated father with her aggressive masculine behavior. This wish to be feminine and passive could be seen clearly in his insistence that he was ineffective, even while in reality he was remarkably effective.

Thus this orally-fixated, dependent boy strove for his Sheba—the beautiful, powerful mother, "fair as the moon, warm as the sun, but terrible as an army with banners." The glorious Sheba seduces, but the penalty is castration or death. The anginal symptoms, with their threat of death, can be equated with the woman, Sheba, who beckons her lover to "eat of my pleasant fruit"—who maintains life—and ends it.

Death for the patient meant rest and peace on mother's breast. The fear of death was the opposite side of the wish to join mother in the grave, or warm bed. The anxiety and anginal symptoms accompanying the thoughts of death were the danger signals to his ego of the threatened breakthrough of the dependent oral strivings. The symptoms, in turn, contained the castration threat from father if he succumbed to the wish for mother, or allowed the wish to be expressed.

The wish to achieve and the fear of achieving were exemplified vividly in his job experiences. As he became more successful, his unrest and irritations mounted. Arlow[8] notes that "the compulsive striving for achievement and mastery never seems to end. Neither in the psychic nor in the somatic sphere is the patient ever at peace."

Follow Up

Three months after termination, a follow-up interview was held. The patient's experience at the camp had been disappointing, all the more as he had taken this lower-paying job out of an idealistic hope of making a social contribution. He had found himself stymied by a difficult superior (a fact corroborated by his wife who was also employed at the camp and left because of the intolerable situation). This time the patient did

not react with rage or anxiety to the castrating father-figure. He felt neither bitterness nor rejection when he left the job. "I saw right away the boss was my father with the big stick." The impact of this insight carried with it an intense excitement. "I know we've been talking about this for three years, but it feels different to me now."

It is apparent that he had begun to integrate in his emotional life the insights so long held intellectually. He took a job as manager of a large business concern, feeling confident of the future, and displaying none of the tensions earlier noted in similar situations. He was able to enjoy his relationship with his wife and daughter, and to accept their warmth without feeling threatened. Prior to coming to his last hour, he had a complete physical checkup, which showed him in excellent condition and with no residual scars from the coronary thrombosis. He accepted the "loss" of his cardiac condition with real pleasure and a sense of well-being.

While there is no doubt of the considerable and gratifying improvement in his symptoms, their intensity and long duration have been such that, to paraphrase Kafka's sorry hero, he may well yet "fear he will outlive his neuroses." In all likelihood, then, the patient will need to return to therapy from time to time to consolidate further the integration of the insights he has gained in two separate courses of analysis.

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THE PERCEPTION OF MOTION IN INFANCY
RELATED TO DEVELOPMENT OF PHYSICAL THEORY OF MOTION

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It is proposed to discuss an infantile mode of perception of motion and to suggest a relationship between this perceptual pattern and the problem of absolute versus relative motion in physical theory.

The importance of the child's clinging to its mother has been highlighted most systematically by Imre Hermann,[1] who also discussed the implications of this clinging for adult symptom formation and for the entire problem of the so-called "dual-unity" of mother and child. It might be added that infantile clinging has an anatomical basis: The infant's surprisingly great capacity to "hang on"—for example to a finger—is due to the fact that the *palmaris longus* muscle, which usually atrophies in the adult, is a highly functional muscle in infancy and locks the infant's grip, enabling it to cling and to hang on with a minimum expenditure of energy. The presence of this functional muscle in the infant primate enables it to cling to its mother's fur while she is climbing and leaping from branch to branch.

It is a psychoanalytic truism that the child learns relatively late to differentiate between itself and its mother and that the duality aspect of the initial dual-unity pattern predominates only in emotionally mature individuals. Hence, the scientific problem is no longer the proving of the reality of the mother-child unity, but the exploration of its qualitative and quantitative aspects.

The present essay seeks to demonstrate that the mother-child unity includes within its scope early infantile forms of perceiving motion.

Clinical Data

An intellectually superior, but depressive and dependent, young man dreamed in part that, together with his married sister, he stood in a very long hallway. One end of the hallway—toward which his back was turned—was some 50 feet distant from him. The end of the corridor in front of him was so distant as to be invisible. Suddenly floating lights began to move toward him and his sister, illuminating the corridor, and revealing that the corridor was not rectangular, but tube-like and composed of rings, "somewhat like a trachea." (Subsequent associations revealed that the tunnel resembled a vagina more than the trachea.)

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The immediate impetus for this dream was the fact that, the preceding day, he and his sister had revisited the house in which the analysand was born and where he had lived until the age of four. The patient discussed in great detail the corridors, elevators, dumb-waiters and light shafts as well as the incinerator, whose opening was on the roof and which reminded him of "a Nazi crematory for Jews, because this is a Jewish holiday and I am Jewish." In speaking of the elevators, he described in detail the manner in which the approach of the elevator is heralded by the gradual lighting up of the small windows of the outer elevator doors, as well as by red and green arrows on the button panel. "These windows are very high . . . far above the eye level of a small child. As a child, I could have seen into them only if someone carried me."

When his attention was directed to the fact that these lights were somewhat similar to the floating lights in his dream, the patient—who knows a great deal of physical science—said: "In other words, I do not know what moves: I myself, or the environment. It reminds me of the fact that, in childhood, when I sat in a train which began to move imperceptibly, I often did not know whether the train in which I sat was moving or whether the train on the neighboring track, which I could see through the window, had begun to move. I have a feeling that children carried by their mothers feel that they are so much a part of the mother that, since the mother is obviously not moving with respect to the child, they perceive the environment as moving with respect to them."

It is beyond the scope of a clinical note, which deals exclusively with the problem of the perception of motion in childhood, to present a detailed analysis of this dream. For the purposes of this note it suffices to stress that the patient had a great many dreams of traveling through tunnels or in the subway, or of standing on a subway platform. In all of these dreams there were hints of a distorted perception of *relative* motion and the same distortion was also present in his numerous elevator dreams. Moreover, in most of his dreams involving cars, the manifest content of the dream included elaborate references to movement in the *wrong* direction: Going the wrong way into a one-way street, driving on the wrong side of a two-way street, parking a car in such a way that the hood pointed at the wrong angle in the wrong direction, etc. The interpretation of this element of inverted motion, in terms of the inverted psychosexual tendency which it implied, effectively terminated the "inverted motion" series of dreams and the conflicts which pertained to it, permitting the emergence of memory traces of infantile modes of perceiving relative motion in the dream under consideration.

Scientific Implications

It is well known to the historians of physical science that the transition from the concept of absolute motion to the concept of relative motion was a relatively late development, which gave rise to many philosophical-scientific debates about the nature of motion itself. Its current "final" solution, implying the acceptance of the idea that all motion is relative, is represented by the theory of relativity.

Briefly recapitulated, the history of the physical problem of motion is as follows: Early theories—such as those of some Greek philosophers and scientists—saw the earth as stable; the heavenly bodies were in "absolute" motion with respect to the absolutely stationary earth. Similar modes of perception even with respect to nonmoving objects are echoed by such colloquial expressions as "I drove so fast that the telegraph poles *flitted past me.*" It seems possible to correlate this type of expression, which reflects a genuine sensation of the body, with the fact that once our own body is in *steady* motion and therefore—due to the inertia of movement—has no sensation of motion, we effectively have the feeling of being stationary; it is the environment which seems to move. In such cases, the conveyance—airplane, elevator, train—is experienced as an extension of ourselves. This sensation of stability is especially strong when the velocity of the conveyance exceeds the maximum speed of which a human being is capable (train, airplane), or when the direction of the movement is abnormal in terms of man's usual motion (elevator).* The fact that the illusion of one's own stability occurs chiefly when one is transported in a manner which is incompatible with the potentialities of one's own movement (great speed, upward or downward direction) may hearken back to the dual-unity sensations of the child carried by its mother—or in her womb.

Another psychological phenomenon closely related to difficulties of deciding whether one's own body or the environment is in motion is clearly reflected in dreams in which one runs without advancing at all.

* This type of hallucinated motion—or motion in dream—was analyzed in another publication,[2] where it was demonstrated that imaginary motion is sometimes accompanied by imagined bodily sensations which are contrary to those which one would experience were the body actually moving in the imagined direction, *i.e.*, in descriptions of hallucinated "levitation" one finds references to body sensations which would occur not if one were actually "rising," but only if one were "descending."

One of the most striking, and probably the most ancient of such dream sensations, is described in Homer's *Iliad* (XXII): Hektor, pursued by Achilles, runs for his life. "And as in dream one fails in chase of a fleeing man—as the one fails in his flight and the other in his chase—so failed Achilles to overtake him in the race, and Hektor to escape." It is the sensation of running on a treadmill, in a direction opposite to that in which the moving band of the treadmill moves.

It is conceivable that intellectual insights and observations had to be reinforced by sensations, or by unconscious memories of dream sensations of this type, before later philosopher-physicists were able to develop the conception that despite our subjective sensation that the earth is stationary, while the sun and the moon seem to be moving, in reality it is the sun which is "stable" and the earth which moves around the sun. In fact, some such unconscious memory-trace of passive movement must be supposed to have played a role in this discovery, since otherwise the illusion of the senses, suggesting the stationariness of the earth, would have prevented the triumph of intelligence over illusory sense data. This first "dethronement" of man as the immovable center, with reference to which the rest of the universe is moving, represents, on the one hand, a major triumph of the reality principle over the pleasure principle and over narcissism as well, and corresponds to the stage of psychosexual development in which the mother-child relationship becomes more of a duality than a unity, on the other hand.

However, the problem of "absolute" versus "relative" motion continued to be a major problem, which neither Newton nor Leibnitz could completely resolve. One of the most decisive physical discoveries in this field was the so-called Doppler-Fizeau effect: The spectrum of an approaching luminous body shifts toward the violet; that of a departing body shifts toward the red. The realization that all bodies accessible to observation by whatever means (telescope, etc.) are in relative motion to each other forced Einstein to develop a new kind of physics, in which all observations are made at the observer. Its basic philosophy is that what we study—because that is really all that we are able to study—happens "at" (near) the observer and to (in) his instruments: Eye, telescope, etc. Thus, in enunciating the Fitzgerald-Lorentz principle that bodies in motion "contract" along the axis of the direction of their movement, all that is meant is that, from the viewpoint of observers not located on this rapidly moving object, the object in (relative) motion seems to be shorter "at" the (outside) observer than it would seem to the observer on that

moving object, since all his yardsticks would give the same measurement, whether the object is in motion or stationary. Epistemologically speaking, there is not much difference between this view of the physical universe and Mark A. May's well-known definition: "Personality is the stimulus-value of the individual"—*i.e.*, his effect upon (at) the observer.

At this point the "duality" completely supersedes the "unity" between mother and child. The existence of the outside world is so completely independent of the observer that the latter admits that all he knows about the outside world is what is happening to (and at) him, as a result of the existence of the outer world.

This, needless to say, raises the whole problem of the intelligibility of the outside world. Whitehead affirms that "Nature is closed to the mind." Einstein,[3] on the contrary, states that the only (philosophically) unintelligible thing about the external world is precisely its intelligibility. Even this intermediate position with regard to intelligibility is negated by the philosopher-ethnologist, Lucien Lévy-Bruhl,[4] who rightly denies that the intelligibility of the world is unintelligible.

Summary

It was demonstrated that an adult patient experienced in dream his own motion in space in such a manner as to feel that his own movements, if any, corresponded to passive movement (being transported, as in the mother's womb or arms) and that sometimes he felt that not he (who was in reality in movement) was moving, but that the (stationary) environment was moving in relation to him.

These data were correlated with the "dual-unity" experiences of the small child and their development was further correlated with the development of the physical theory of motion (from "absolute" to "relative") and with the transformation of man's concept of the universe, from geocentric to heliocentric, and then to the "expanding universe" world view.

It was suggested that this slow triumph of the reality principle and of the secondary process over the pleasure principle (related to narcissism) and the primary process (largely informed by deceptive body-sensation) was made possible by the human being's ontogenetic development from "dual-unity" to "duality" and then to "object-relation" types of perception of the self and of the "other."

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PSYCHIATRIC CASUALTIES FROM OVERSEAS PEACE CORPS SERVICE*

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Since its origination in the summer of 1961, the Peace Corps has selected, trained and dispatched overseas nearly 8,000 Americans. This has been done with an awareness that a certain number of Peace Corps Volunteers would be unable to fulfill their pledge of two-years overseas service. Anticipated were the inevitable problems of adjusting overseas, physical and emotional illnesses, and situations at home necessitating compassionate returns.

Early predictions were that anywhere from 20 to 50 percent of the Volunteers sent overseas might be unable to complete a two-year tour in the assignments that were being programmed. To minimize this attrition, the Peace Corps called upon psychologists and psychiatrists to develop intensive selection procedures. These procedures have been and are continually being reassessed and refined on the basis of increased experience.

This paper deals with one phase of that experience which is of particular concern to the psychiatrist. With his clinical background the psychiatrist is specially concerned with the problems of morale and mental health of the Volunteers. While failure to adjust on general terms is his concern, he has a special interest in that category of failure classified as "emotional casualties" from overseas service.

Through March 31, 1964, of all the 7,979 Volunteers who have departed for overseas service, 648 (eight percent) have returned prematurely. When one examines the record of only those Volunteers for whom the expected two years of Peace Corps service was completed by March 31, 1964, one finds a slightly higher return rate. Of this latter group, who entered Peace Corps training on or before April 2, 1962, and who comprise the first 1,178 Volunteers sent overseas, 137 (11.6 percent) terminated prematurely for all reasons. This 11 percent figure, representing

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the return rate from that part of the Volunteer population which has been in service for the full two years of their obligation, parallels the findings of the first detailed study of early returning Volunteers. That study noted a rate of five percent returning per man year of service (or ten percent over a two-year period).[7]

The greatest number of early returnees have returned as a result of problems in personal adjustment, resignations, and administrative problems. This group comprises approximately five percent of the 7,979 Volunteers sent overseas. The medical returns, for physical and emotional illness, now total more than 100, or about 1.3 percent of the total number of Volunteers sent overseas. Emotional, or psychiatric casualties, comprise roughly half of the medical returns.

The "emotional casualty" is that Volunteer whose inability to continue effective functioning overseas is associated with significant symptoms and signs of emotional disorder, as identified by a Public Health physician detailed to the Peace Corps staff overseas, and confirmed by a psychiatric evaluation in the United States. As of April 30, 1964, a total of 54 such Volunteer casualties had been returned prior to completion of their obligated Peace Corps service. This total represents 0.7 percent of the total number (7,979) of Volunteers who have gone overseas. That this percentage is fairly constant, is indicated by the fact that of those 1,178 Volunteers whose two years are up, there were nine psychiatric casualties (0.7 percent).

With few exceptions, all prematurely returning Volunteers have been evaluated in Washington by a Peace Corps staff member or consultant psychiatrist. Patients requiring hospitalization have been treated by a cooperating university hospital psychiatric service in Washington, or at a United States Public Health Service facility.

Characteristics of Returnees

The Volunteers who have returned for psychiatric reasons range in age from 19 to 41 (at the time of their return), with a mean age of 24.3 years for both men and women. The mean, range, and distribution of age of the psychiatric returnees are roughly the same as those of the over-all Peace Corps population, although there are Volunteers in the field as old as 75. The psychiatric returnees are evenly divided between males and females, differing somewhat from the over-all Peace Corps distribution, where the male : female ratio is 3 : 2. The incidence of psychiatric casualties is fairly evenly divided over the world, although there appear

to be relatively more returnees from the Far East Peace Corps countries than would be anticipated, and fewer from the African countries to which Volunteers have been assigned.

The average time served overseas by this group of 54 returnees was 8.67 months, with a range of from one week to 19 months actually spent overseas. There appear to be two periods when there is a clustering of increased psychiatric returnees—during the first four months overseas, and again between the eighth and twelfth month overseas. Outside of these periods, the distribution of emotional casualties according to months of overseas service is fairly even.

The psychiatric symptomatology presented by Peace Corps Volunteers includes the full range of psychopathology, with depression being by far the most common symptom. Other common symptoms are anxiety, withdrawal, somatizations, and projection; and there have been a few overt attempts at self-destruction. Analysis of the diagnostic formulations reveals psychoneurotic reactions as the most frequent pattern of emotional decompensation affecting 33 Volunteers (61 percent of the psychiatric casualties) to the point that their effectiveness overseas was compromised. Depressive reactions were the primary diagnoses for 22 patients; the other eleven neurotic reactions were manifested as anxiety reactions, phobic reactions, obsessive compulsive reactions, and mixed pictures. Nine people (17 percent of the psychiatric returnees) experienced a decompensation of psychotic proportions, with significant loss of reality contact, diagnosed as a schizophrenic reaction, psychotic depressive reaction, or paranoid reaction.

Another nine Volunteers were returned because of personality limitations which significantly impaired their ability to adjust themselves, and which were seen as potentially decompensating into a severe emotional reaction. These individuals were formally diagnosed as having a personality disorder, *e.g.*, schizoid, passive-aggressive, or narcissistic. Three persons returned with psychophysiological problems, presenting definite medical illness, but with emotional components considered to be the primary determinant force behind the illness. Of these three, one had recurrent headaches, another asthma, and the third, gastrointestinal difficulty.

More than half of those returned for psychiatric reasons were hospitalized for evaluation. Thirty were admitted to psychiatric services; three required hospital care for medical or surgical conditions. Four of the psychiatric patients required moderately prolonged hospitalization. Of the remaining 26, the average hospital stay was about 12 days, with a range of from two to 28 days.

Numerous screening measures are utilized in Peace Corps' assessment of emotional stability. Among these measures are specific questions on the Peace Corps application about previous illness; estimations by the Volunteer's personal references of his emotional stability and over-all suitability; and psychiatric interviewing of selected Volunteers during training. Only one Volunteer, of those who subsequently returned as psychiatric casualties, reported a previous emotional illness at the time he applied. Seven others with a history of significant emotional difficulty did not acknowledge that difficulty on the questionnaire. One had been in psychotherapy for two years during college; five had made some kind of suicidal gesture.

Figures are not available on the number of Volunteers with a known past emotional problem who have been able to function successfully in their overseas assignments. Such Volunteers have been sent overseas after psychiatric review in training. In addition, some notable deceptions have been accomplished despite the careful scrutiny of the selection process which includes utilization of a full-field investigation by the Civil Service Commission. One Volunteer, who was subsequently separated from the Peace Corps prematurely for administrative reasons, had concealed a history of two previous suicide attempts, an illegal abortion, and a period of hospitalization on the psychiatric service of a metropolitan hospital.

The comments of personal references—peers, teachers, employers, family physicians—are utilized in the formulation of an over-all "assessment" rating given to each Volunteer applicant. This rating is based on individual job skills and past functioning, as well as the references. Review of the original assessment ratings of the psychiatric casualties reveals more than twice as many marginally assessed candidates in this group as in the general population of overseas Volunteers. Nearly 40 percent of the psychiatric casualties were given a marginal assessment rating, as compared to approximately 15 percent of the overseas Volunteers.

Psychiatric Interviews

Psychiatric consultants at the training sites review, to some degree, all the Peace Corps Volunteers who go overseas, but they do not routinely

see each trainee in a formal diagnostic interview. In the early days of Peace Corps selection, the individual interview was a routine practice, but after eight months' experience diagnostic interviews with every trainee were discontinued. They were not sufficiently reliable, and were found to be wasteful of psychiatric manpower. Interviewing is now carried out on a selective basis, operating on the assumption that in the intensive six-days-a-week, ten-hours-a-day training program, an individual's significant emotional disturbances will soon become apparent. Formal psychiatric interviews are now held for anywhere from ten to 40 percent of all trainees, depending upon the size of the training program and the character of the participating psychiatric consultant. The over-all average of trainees now interviewed psychiatrically is about 20 percent.

Of the 54 people returned because of emotional illness, 23 (roughly 40 percent) had been given a formal diagnostic interview by a training-site psychiatrist. This means most of the Volunteers who later became psychiatric casualties (31 of the 54) did not present sufficient problems during training or in their background to warrant a special referral to the psychiatrist. The 23 individuals who were interviewed do represent a slightly greater proportion than one might anticipate would have been interviewed on the basis of current interviewing practices. Even so, of these 23, significant doubts about the capacity of the Volunteer to function effectively overseas were expressed for only five individuals. In the other 18 Volunteer interview reports, the psychiatrist saw no reason to anticipate any significant problem. In a number of cases, he had been, indeed, quite optimistic. When considered in terms of the average time served overseas, there is no apparent difference in the average length of overseas service of (1) those Volunteers who were interviewed and considered good risks, (2) those interviewed and considered doubtful risks, and (3) those not interviewed at all by a psychiatrist during the training experience.

The identification during training of Volunteers who will not be able to get along effectively overseas is a considerable challenge, particularly for the psychiatrist. He is expected to work in an unfamiliar "field" setting, outside his office, with "patients" who are generally healthy and highly motivated and have already gone through a self-selection and fairly careful administrative screening process. The psychiatrist is expected to estimate the probable response of the Volunteer to assignment

in an overseas situation which the psychiatrist usually knows nothing about. Besides, at the time of this evaluation, the "patient"-trainee-prospective Volunteer may be supported by a highly-structured training program involving a group of people, whereas in all likelihood he will be assigned overseas to an unstructured or poorly-defined job in a situation where he may be isolated from most of his compatriots.

Any Volunteer may be assumed to have mixed feelings about his commitment to the Peace Corps, with high motivation to achieve the ideals, and at the same time anxieties about the separation from home and familiar sources of satisfaction and support. Volunteers who return prematurely from overseas are people whose negative feelings about the experience (in a broad sense) finally predominate. Psychiatric casualties might be characterized as people in whom the negative forces have not been consciously recognized or effectively handled by the Volunteer, and have appeared as irrational feeling, thinking, or behavior.

Case Illustrations

Some illustrative cases follow: first, two cases where there was some advance indication of problems which might develop; then, one case where there were last minute indication of the impending decompensation; finally, two cases where the problems developed after the completion of training.

1. A 21-year-old, single, white male entered training for the Peace Corps with a history of an emotional reaction three years earlier. At that time, just out of high school, he had entered the Air Force. After a week, he received a depressing letter from his girl friend and experienced a "mental breakdown." The Air Force reported he had "crying spells," "blackouts," moodiness and agitation. With a diagnosis of a neurotic depressive reaction in a schizoid personality, he was discharged.

At the time of his Peace Corps training, he was seen by two psychiatrists. One reported that "with his rigid superego mechanisms this individual can be counted on to perform in a conscientious and even dedicated fashion. Although (he has) a shaky masculine identity, there seems little likelihood of the same constellation of pressures as he encountered in the Air Force recurring."

The second psychiatrist observed, "There is no indication of depression at this time. My opinion is that the experience in the Air Force was a transient situational depression. He is idealistic. He is warm emotionally. . . . He shows no emotional handicap at this time. I believe the rewards of working in the Peace Corps will meet his particular needs, which needs were not met in military service."

Within one week of his arrival overseas, following the breakup of a romance with a girl whom he had met in training, he told friends that he was going to

commit suicide; he drank excessively, and took an overdosage of aspirin. After considerable consultation, he remained overseas in a carefully supervised assignment. Three months later, when the girl friend returned to the city in which he was stationed and again refused to accept an engagement ring from him, he made a second suicide gesture, again taking ten to 20 aspirin. At that time he was returned to the United States for treatment.

2. A 30-year-old, single, white nurse entered training for an assignment overseas in her professional work. She had been raised in Europe during World War II and had many early experiences of deprivation and stress. Once in the United States, she had achieved her nursing education and had an effective work history. During the Peace Corps training, she was noted to have some difficulty, and was seen by the psychiatrist who met with her on several occasions to help her resolve some of the anxieties and pressures she was experiencing.

Once overseas, she was assigned to work which was in keeping with her background training and her preference. After an initially favorable reaction, she began to have a feeling of revulsion to the poverty, squalor, and disease which surrounded her. This revulsion increased to the point of panic within two weeks. She was unable to tolerate or even accept the ill, the poor, the needy. She felt that things were "closing in" on her, and she could not stand the sight of the host-country people. She blamed herself for cowardice and failure, wept copiously, and was extremely tense, feeling that she could not continue in her Peace Corps assignment. Thus, three weeks after her arrival overseas, she was evacuated to the United States. With her return home, her anxieties were markedly reduced. Although she still presented some evidence of the acute and nearly disorganizing reaction she had experienced overseas, she was getting it under control and was able to survey more realistically what had happened.

3. A 23-year-old, single, white male, an only child, entered Peace Corps training three months after his graduation from college. During training, he was noted to be somewhat retiring, but he presented no unusual or inappropriate behavior. His Minnesota Multiphasic Personality Inventory was completely within normal limits, and his interview with the clinical psychologist-assessment officer was unremarkable. He was not called to the attention of the training-site psychiatrist since there was no special concern about him.

After the final selection board, one observer noted that this Volunteer appeared a bit different, with his face constricted, "like his necktie was too tight." Thirty-six hours before the final home leave, he saw the general medical consultant at the training site, complaining of periorbital pain. The medical examination was negative; the optometrist noted a mild refractive error, and glasses were ordered. While on home leave, he went to see his family physician, complaining of limping and an inability to walk, which he attributed to an injury incurred in training (an injury about which there were no records at the training site). At the time of his departure overseas, the medical consultant did talk to the Volunteer, wondering about "gangplank fever." However, there appeared to be nothing to warrant detaining the Volunteer, so he departed with his group overseas.

Within one week overseas, his fellow Volunteers reported to the Peace Corps physician that this fellow was manifesting unusual behavior, waking up in the middle of the night and turning on a blaring radio in the hostel where all the Volunteers were staying. He began expressing ideas that people had something against him, and implied he knew what was really "meant" by certain trivial events, *e.g.*, a dog's wandering into the hostel.

Gradually, over the ensuing two weeks, he became more paranoid, with disorganization of thinking, ideas of reference, hostile outbursts toward the girls in the group, insomnia, withdrawal, and a complete lack of insight. He manifested an overt decompensation into a paranoid schizophrenic reaction, only six weeks following his "clearance" by the final selection board, and just three weeks following his arrival overseas.

4. A 29-year-old, single Negro, born and raised in the South, trained for a Peace Corps project at a northern university. A Catholic, he had earlier been a seminary student before concluding that he could not accept that as a life role. He finished college at a segregated southern school and taught briefly before entering the Peace Corps. During training he met and became seriously interested in a young, white, female Volunteer, with a Protestant upbringing, whose home was also in the South. The girl initially reciprocated his feelings. After they went overseas their relationship continued and became increasingly intense. The girl then decided that it could not work out, and she broke up the relationship. This rejection came suddenly and provoked a response from the fellow that was increasingly frantic. He tried desperately to regain contact with her, became more sensitive and withdrawn, developed overtly aggressive thoughts toward the girl and others which he feared might be translated into action.

His thinking began to show distortions, which were evident in letters he wrote to the girl, but which he did not acknowledge. His work performance, previously above reproach, began to deteriorate. He became involved in some inappropriate acting out which precipitated his return to the United States for evaluation.

5. A 19-year-old, single, white farm boy successfully completed training for a rural development project. His assignment and initial adjustment overseas were unremarkable. Three months after his arrival a rebellion took place in the area to which he was assigned. His closest host-country friend, whom he admired considerably, was killed and he was taken hostage. For approximately two days, with several others, he was held prisoner and threatened with execution. After his rescue, because of his first-aid training, he was placed in the position of serving as the "medical officer," ministering to the wounded.

Several days afterward, he began to experience symptoms of anxiety and depression with a preoccupation about the events which had taken place. He began to have obsessive wonderings about whether his life had been worth the lives of soldiers who had been killed in the assault which led to his rescue.

After some psychiatric interviews overseas, he improved. In addition, his assignment was changed and he had a short vacation. Subsequently he was able to do some work, but he continued to experience anxieties, with nightmares and general restlessness.

Approximtely five months after the rebellion, he manifested somatic complaints that led to his hospitalization for orthopedic and neurological assessment. Returned to the United States, he underwent further medical and surgical study, which was negative. However, it was observed, "It is noted that it is possible that this patient may be suffering from an emotional or personal problem in his assignment, and it might be wise to review this area before returning him to his previous station." Indeed, the underlying anxieties, precipitated by events nine months earlier, were quite apparent in the psychiatric examination.

Discussion

In view of the initial, dire predictions and anxious concern for the staying power of young Americans in Peace Corps settings overseas, the actual rate of return of between eight and 11 percent for all reasons, and only 0.7 percent because of emotional illness, seems impressive.

Comparable figures against which to reflect this experience do not exist. There is no completely comparable group of such idealistic, highly-motivated, self-selected, generally well-educated individuals, of predominantly young adult age. In addition to the foregoing characteristics, this group is made unique by the careful training and selection prior to overseas assignment, a fair degree of overseas support, and a commitment for two years' service in an economically less-developed country which involves commonly a dramatic change in their mode of living.

Although about two years younger on the average, and not strictly comparable for other additional reasons, the over-all college student population in the United States is estimated to have a 10 to 15 percent rate of clinical impairment due to emotional illness, with some three percent requiring long-range treatment.[2, 5] The age group 20–29 in the Midtown Study,[6] a random sample of persons living in one area in a large metropolitan city, revealed 16 percent "clinically impaired" by psychiatric disorder.

Some private voluntary service organizations sending young people overseas have reported an incidence of psychiatric returns roughly comparable to the Peace Corps.[4] While there has been a limited study of some of the adjustment problems experienced by United States State Department employees overseas, these findings are difficult to relate to the Peace Corps experience.[8] The incidence of emotional illness in Junior

Foreign Service Officers is roughly the same as in Peace Corps Volunteers. While this group is similar in age and commitment to their job, they live under considerably different circumstances overseas.[9]

The dearth of information about similar experience in other agencies and organizations makes it difficult to assess the full significance of the Peace Corps system of selection as well as the performance of the psychiatric consultants within that system.

This paper, as a study of the effectiveness of psychiatric screening in the Peace Corps, approaches that problem with a negative bias, *i.e.* by examining only a group of "failures," and only those adaptational failures whose maladjustment could be characterized under the rubric of "emotional illness." Some additional perspective is provided by the review by Thomson and English[7] of all the Volunteers prematurely returned in the first 19 months of Peace Corps experience. However, to put these findings in proper perspective, data should be gathered regarding the emotional reactions in a sizeable random sample of all Volunteers, not only those who have returned early. In addition, it might be helpful to study further a sample of the "marginal" Volunteers, to determine factors that contribute either to their succeeding overseas, or returning prematurely.

Some reference has been made to the problems faced by the training-site psychiatrist in trying to predict which trainees will not be able to adjust effectively overseas, and which trainees may experience an emotional decompensation under the stress of their Peace Corps assignments. This study touched upon some of the clues that might be gleaned from historical data or training-site performance of the prospective Volunteer. The psychiatric interview does not seem to be particularly effective in anticipating the psychiatric decompensations which actually occur overseas, since only five of the 23 returnees who were previously interviewed were anticipated as problem cases. How well the psychiatric interview may anticipate other problem cases in general adjustment cannot be determined from these data. The limited reliability of the interview in the area of emotional decompensation, however, suggests that it continue to be applied sparingly to all trainees.

Other factors which may limit the effectiveness of the psychiatric interview in training, besides those referred to previously, are the extremely high motivation of the Volunteer-trainee to pass the "selection board," so that he manifests a kind of boardsmanship; and the occasional tendency of the psychiatric consultant to become overinvolved in "help-

ing" the appealing and dedicated trainee to get past the "selection" hurdle.

Because of the high motivation of the trainee and his need often to deny his limitations or his conflicting feelings, it is imperative that the psychiatrist and others at the training site be alert to the subtle communications of negative or conflicting feelings about the anticipated experience. The trainee should be confronted with any evidence of profoundly conflicting feelings or behavior, and the implications reviewed with him. Ideally, he should be aware of the ambivalent strivings so that he can better control his behavior. At the same time, he should be helped to accept his limitations. While all Volunteers undergo a generally beneficial maturation as a result of their Peace Corps experience, the Peace Corps cannot necessarily be prescribed as "therapeutic" to a marginal candidate.

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RARE BOOKS AND MANUSCRIPTS OF THE MENNINGER FOUNDATION

A collection of rare and historic books and manuscripts pertaining to the history of medicine, with particular attention to psychiatry and psychology, was first initiated by Dr. Karl Menninger and Dr. Bernard Hall a number of years ago. Visits to collections and libraries in London and Vienna increased their interest in extending and maintaining a permanent collection of such material in the Museum of The Menninger Foundation for safekeeping, display and for research purposes.

The dream of an American collection of this specialized type was given great impetus by the Stacy G. Carkhuff family of Topeka who made possible a number of the more costly and rare acquisitions. Mr. Willard King, Chicago, who is the chairman of the Board of Governors Committee responsible for the Museum and Archives, was also of great help.

In February 1964, the History Committee of the American Psychiatric Association met in Topeka and inspected the collection. Some of the members expressed the opinion that the collection was already unique in its field in the United States.

In order to indicate the nature of this collection, which rests in its own air-conditioned room, somewhat remote from main thoroughfares, the *Bulletin* will publish a series of notes and articles featuring specific items, subjects, and new acquisitions, in order that members of the Foundation family may enjoy some of the adventure of preserving and reviewing these long-ago treasures of the mind.

WITCHES AND WITCHCRAFT

It is one of the tragic ironies of history that the new learning which ushered in modernity was accompanied in the fifteenth, sixteenth, and seventeenth centuries by the darkness and horror of a revived superstition and the smell of the burning bodies of accused witches. Throughout history times of change and transition are often, indeed generally, accompanied by spasms of a reactionary clinging to ancient errors. Thus in the Renaissance with a recovery of the knowledge of ancient Greece and Rome, with the rebirth of trade and commerce, and with the rise of cities and universities and of the modern nation-state, there was the frightful witchcraft hysteria which the Periclean Greeks would have scorned. This is particularly interesting to the student of the history of medicine and of psychiatry since it tended to sweep aside previously

gained psychological insights since, as Gregory Zilboorg[1] points out, "Not all accused of being witches and sorcerers were mentally sick, but almost all mentally sick were considered witches or sorcerers, or bewitched."

The shelves of the rare book room in the Tower Building of The Menninger Foundation contain an excellent selection of historic volumes on witchcraft which could be the sources for a monograph. Virtually the textbook for the witch-craze was the *Malleus Maleficarum* published originally between 1487 and 1489. The book was written by two Dominican monks, Henry Kramer and Louis Sprenger, who had been appointed Inquisitors by Pope Innocent VIII in 1484. *The Malleus Maleficarum* or "The Witches' Hammer" posed a simple and horrible triadic thesis: The "proof" of witches and witchcraft; reports of recorded cases; and how to legally examine and sentence a witch. The period or exclamation point was put to the thesis by the formula that people who did not believe in witches were "plainly heretics."[1] And as printing disseminated the Bible and the new learning, so it sped the thoughts of Kramer and Sprenger to those who, frightened in time of change, always welcome a scapegoat. The book went through ten editions before 1669. The edition of the *Malleus Maleficarum* in the rare book room is in Latin, and was published in 1604 in Lugduni (Lyons).

The Foundation's collection also includes a very rare volume of Angelus de Gambilionibus' *Tractatus de Malificiis* (15th century) and Albertus de Gandino's *Tractatus Malificiorum* (13th century) bound together and published in Venice in 1494. These treatises by two famous Italian lawyers present a general discussion of witches and criminal law.

Despite the blows of the "witches' hammer" there were some brave enough to protest. Among the first and most important was a Netherlander, Johann Weyer, who studied in Paris under Cornelius Agrippa.[1] He became physician to the Duke of Cleves and in 1563 published his famous and courageous *De Praestigiis Daemonum* wherein he denied the reality of witchcraft and witches. He insisted that "witches are mentally sick people" and Gregory Zilboorg believes that in achieving "an intimate blend of humanism and naturalism (he) stands out as the true founder of modern psychiatry and as a true revolutionary genius in the science of man."[1, 2] In our collection is the 1568 Basel edition of *De Praestigiis Daemonum* and the 1579 Geneva edition of *Histoires disputes et discourse des Illusions et Impostures des Diables.*

In the dark history of witchcraft it is sad to sometimes find one's heroes

badly tarnished. Jean Bodin, the great humanist, political scientist and historian who was famous for his liberalism and his great *Republic* (1577), in 1580 wrote *De la Demonomanie des Sorciers.* He held up publication to add 65 pages "refuting" Weyer as a "protector of witches," and in his arguments evolved the distinction still retained between "medical" and "legal" insanity.[1] The rare book room has the first edition.

In 1584, Reginald Scot, a Justice of the Peace in England, became disgusted with cases of witchcraft brought before him and wrote *The Discoverie of Witchcraft.* One of Scot's headings was "not witchcraft but melancholie" and he lamented about his work that "my greatest adversaries are young ignorance and old custom."[3] It is interesting that one hundred years after his book appeared the last witch was hanged in England. The rare book room has the first edition.

King James VI of Scotland published his *Daemonologie* in 1597 to refute Scot and republished it in 1603, when he was James I of England. He ordered Scot's books to be seized and burned. In 1604 he issued a new Witchcraft Act which was harsher than the Elizabethan Act of 1563.

> "Although James' fervor naturally whipped up enthusiasm for witch-hunting it led paradoxically in the long run to progress. More supposed witches and bewitched, accused and accusers, came before the courts, but were now subject to closer scrutiny for fear of wrongful conviction in face of the drastic penalties. So much importance came to be attached to the whole issue of witchcraft that, apparently for the first time in criminal charges, medical evidence was called; . . . In this way James created unprecedented opportunities for careful and prolonged study of individual cases."[3]

The edition in the rare book room is marked London, 1616, but actually appeared in 1620.

In 1677 John Webster courageously reacting against the new waves of witchcraft fever during the Restoration wrote *The Displaying of Supposed Witchcraft.* The rare book room has the first edition of this work wherein Webster said about charms and incantations that their "causality and efficiency is solely in the person imaginant and confidant of receiving help."[3]

There are two additional volumes of importance on witchcraft in the collection: Didacus Gomez Lodosa's *Iugum ferreum Luciferi* (Valentiae, 1676); and Pierre Masse's *De L'Imposture et Tromperie des Diables.* Recently acquired is a pamphlet, *An Account of The Trial confession and condemnation of six witches, at Maidstone in The County of Kent, be-*

fore Sir Peter Warburton. . .To Which is added The Trial, examination and execution of Three witches executed . . . September 1645 (London, 1837). This is one of only 200 copies printed.

A somewhat startling reminder that demonology is not as dead as one might suppose is the book *Evidence of Satan in the Modern World* by Leon Cristiani, published in this country in 1962 by Macmillan (originally published in France in 1959). The book referring to "terrifying figures" observes on page 14 that one authority estimated that 50,000 were executed for witchcraft in Germany, France, and Belgium. On the other hand, Cristiani, who is honorary Dean of the Faculty of Letters of the Catholic University of Lyon, proceeds to cite numerable cases in the 19th and 20th centuries of "diabolical infestation, possession and temptation," "actual appearances of the devil," the process of "exorcism," and "whole nations under the domination of Satan to the degree that they undergo collective possession." It seems probable that books on witchcraft, Satanism and demonology in general, both objective and biased, will continue to be published for many years in the future.

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The staff of the professional library of The Menninger Foundation was most helpful in making materials in the rare book collection available to the writer. Mrs. Rebecca Breeden, cataloguer, extended much assistance in the research involved.

READING NOTES

We have received and placed in the library a copy of the *National Program to Conquer Heart Disease, Cancer and Stroke* as proposed by the President's Commission. This ambitious and important project is worthy of study, even by us psychiatrists who think it is somewhat peripheral to our immediate interests. I was unaware of the size of the Commission and the extremely large number of agencies, organizations and "witnesses" involved in its preparation.

* * * *

Franz Alexander, who died last year, had an important relationship with the Menninger Clinic. He was the personal analyst of both Doctor Will and myself, and taught others of our earlier staff.

He came to the United States in connection with the International Congress of Mental Hygiene in Washington, 1930. He was heralded as a new, young leader who had won Freud's acclamation. Some American physicians had already gone to Europe for psychoanalysis with him, including Lionel Blitzsten and Tom French, good friends of ours in Chicago. In the fall of 1930, Alexander came to the University of Chicago as a visiting professor. Dr. Helen McLean, Dr. Leo Bartemeier and I were among the psychiatrists he analyzed there that year.

Alexander was so successful in attracting the interest of students and faculty that a wave of reaction swept him out of the medical school. The next year he went to Boston; the following year he gathered Blitzsten, Hamill, French, Helen McLean, Bartemeier, myself and others together and with the aid of our contributions and some larger ones from other friends he organized the Chicago Institute of Psychoanalysis. He conceived and built it, and he directed it energetically for the next quarter century. Doctor Will, Robert Knight, Robert Morse, Douglas Orr and many others of our organization were analyzed and trained at that Institute. For five years some of us went up to Chicago for every other weekend.

As Therese Benedek says in her very objective memorial notice in the *Journal of the American Psychoanalytic Association* for October, Alexander's "expansiveness, the source of his indefatigable productivity, made him restive." First psychosomatic syndromes, then the controversial "brief psychotherapy," then the concept of a "corrective emotional experience," then the "manipulation of transference intensity" successively

interested him. Benedek thinks that perhaps by moving to Los Angeles he "hoped to recreate an experience of the past, his early (exciting) years in Chicago, by a new beginning."

We here owe much to Franz Alexander for having developed our interest in psychoanalysis. He helped us in the founding of our Society and our Institute. He gathered many new friends and had many circles of acquaintance, necessarily leaving behind some of the older ones. I shall always remember my travels in Europe with him and Mrs. Alexander, his introduction of me to Professor Freud, our attendance at the Lucerne Congress, and many other pleasant occasions. I think both he and I regretted that this closeness could not have continued. But both our territory and our thinking separated. To him, I think, we here seemed conventional and overly conservative. To us he seemed saltatory and aligned with aberrant and dissident exponents. But he will always be remembered as our teacher, and *the* teacher of psychoanalysis to American physicians: he probably analyzed more of them than all other training analysts put together, up to about 1945.

* * * *

Lawson G. Lowrey was my friend, and my guide and teacher. He launched me in psychiatry. He introduced me to Southard. I owe him much. He lived a brilliant, erratic, stormy, stimulating, irritating, disappointing life. Many young psychiatrists owe their start to him. Many social workers ascribe the growth of psychiatric social work with children to his support. Some credit him with developing the team concept in psychiatry. And for all this, he is almost unknown to present day psychiatrists.

Child Guidance: Lawson G. Lowrey Memorial Volume (Arno Press, 1964) contains a brief biographical sketch of Lowrey by Dr. Simon Tulchin, a note of appreciation by psychiatric social worker Frederika Neumann, a brief but eloquent letter by David Levy, and 36 selected papers thought by the editors to be representative of the work and the associated workers of Lowrey.

This book is a labor of love; a tribute put together with indefatigable persistence by Lowrey's great admirer and loyal friend, Simon Tulchin.

* * * *

A book which I prize highly but have placed on indefinite loan with the rare books department of our library is an account of the founding

and a list of the rules and regulations of the Josephinium. Since both Doctor Hall and I, at different times, spent a large number of shillings trying to find the Josephinium, which no taxicab driver seemed ever to have heard of, let me give its full name: The Josephinish Medical-Surgical Academy of the University of Vienna. The Josephinium was a medical school for the training of military surgeons. It was named after its founder Joseph II, a weak but highly-intelligent, socially-minded son of Maria Theresa.

Two years after it was founded, a bound volume stating the purpose of the school and the rules of operation was published. This is the book we have. We obtained it through an exchange with the present Josephinium which now houses the medical history library of the University of Vienna. It was here that the famous medical historian Max Neuberger taught and built up the Institute of the History of Medicine. It is now presided over by Frau Professor Doctor Erma Lesky whom we had the pleasure of meeting there a few years ago. If you go to Vienna you must see it; any physician or professor can tell you where the Josephinium is, but don't ask a taxi driver. Tell him "Währingen Strasse 25."

* * * *

Early in my college days—I can't remember exactly where or when—I acquired a part of my basic scientific credo the magic phrase "ontogeny repeats phylogeny." Anything pertaining to *phylogeny* was *phylogenetic.*

The other day I was reading something learned and the word *phyletic* turned up in a context that made it clear that the author "should have" used the adjective *phylogenetic*! Maybe he is just economizing on syllables, I thought, maybe the printer slipped. I looked it up and the dictionary definition threw me into amazement. Something about leaves! Then I realized that I was looking under *phyllogenetic,* so I backed up one el (l) and found *phylogenetic.* But do you know how that differs from phyletic? or phyllitic? or phyllous? or phylic? (Not to mention Phyllis and Phillis which are *not* the same.)

Maybe 5,000 readers will see this note. The editors of the *Bulletin* and I would like to know how many people look these up out of sheer curiosity, and let us know that they did.

K.A.M.

BRIEF BOOK REVIEWS

Psychiatry for Students. By DAVID STAFFORD-CLARK. $5.75. Pp. 277. New York, Grune & Stratton, 1964.

The author appears to have struggled unsuccessfully to prepare a text which is both short and comprehensive. In spite of his considerable descriptive skills and novel chapters on Psychiatric Emergencies, Puerperal Psychosis, Psychiatry and the Law and Clinical Psychology, his over-simplified, "cookbook" approach to psychiatry belies his apparent earnestness. One would prefer to see a larger text whose dynamic basis was expressed less defensively. The book would also carry greater conviction, in its multidetermined approach to etiology, if some changes could be made in the need to be all things to people of all etiological persuasions, perhaps by emphasizing more relevant causes. (Ian Graham, M.D.)

The Act of Creation. By ARTHUR KOESTLER. $8.95. Pp. 751. New York, Macmillan, 1964.

A simple thesis undergirds this immensely satisfying, edifying and stimulating work: creativity can occur when two different "matrices" of thought (or sensory experience) form an unexpected or as yet undiscovered combination ("bisociation") and produce, in their confrontation with each other, a new synthesis. This scheme is applied with many brilliant illustrations to the comic, the scientific and the artistic pursuits of man, between which Koestler sees many parallels, analogies and continuities. Laughter occurs when matrices collide; in scientific discovery several matrices are integrated, and from their juxtaposition arise aesthetic experiences. Essay, exposition, and sustained argument are cleverly interwoven, not as orderly as one might want but always readably, to produce a book which is not only about creativity, but is itself a demonstration of it. Mr. Koestler's use of scientific and historic data in support of his thesis is impressive, and even when he takes psychologists to task for their biases or their neglect of interesting topics, he does so as an amiable critic to whom psychologists may well turn for inspiration, if not at times education. (Paul W. Pruyser, Ph.D.)

Patienthood in the Mental Hospital. By DANIEL J. LEVINSON and EUGENE B. GALLAGHER. $5.95. Pp. 265. Boston, Houghton Mifflin, 1964.

Congratulations to the authors for a courageous beginning. They have read widely, have observed patients on wards, and (most difficult of all) have designed a method for examining patient's attitudes toward their hospital treatment. Within the acknowledged limitations of questionnaire methods, the authors have begun the study of "patienthood" (their term for the patient's role) which bridges the gap between studies of the patient's personality (and psychopathology) and studies of the mental hospital as a social structure. Many of us interested in hospital treatment but hesitant about leaving speculations behind in order to make studies subject to statistical methods, will be further discouraged by the relatively sparse results of much valiant labor. The authors' muddy style is also discouraging but their conclusions are worth careful consideration. (James B. Horne, M.D.)

Mental Retardation: A Review of Research. HARVEY A. STEVENS and RICK HEBER, eds. $12.50. Pp. 502. Chicago, University of Chicago, 1964.

In 12 chapters, experts in various disciplines survey crucial theories, research studies and statistics pertaining to mental retardation. The project as a whole was authorized by the American Association on Mental Deficiency Project on Technical Planning and the result is, as far as I can judge, a very useful and exciting research compendium which is chockful of questions and problems needing further study. Despite the specialized nature of each chapter, some panoramic sense of the whole of mental retardation, and the interrelatedness of different disciplines when applied to the retarded, comes through. (Paul W. Pruyser, Ph.D.)

Abundance for What? and Other Essays. By DAVID RIESMAN. $6.50. Pp. 610. New York, Doubleday, 1964.

This is a collection of essays, mostly written in the past nine years, many of which have been previously published and some of which were previously delivered as lectures. The principal unity, the author states, lies in the assumption that this country is becoming an "affluent society." The organization of the essays into four parts indicates much about the ideas involved: "The Impact of the Cold War"; "Abundance for What?" "Abundance for Whom?" (a re-evaluation of Thorstein Veblen's ideas); and "Social Science Research: Problems, Methods and Opportunities." This is the author of *The Lonely Crowd* at his scholarly, incisive, provocative and wryly humorous best. (Lewis F. Wheelock, Ph.D.)

The Psychoanalytic Study of the Child. RUTH EISSLER and others, eds. $10. Pp. 493. New York, International Universities, 1964.

All psychoanalysts look forward to this annual collection of selected essays on psychoanalytic theory, psychopathology and clinical observations. It is a necessary reference work, toward which end an index would be a valuable addition. The topics covered in this issue are a score in number beginning with a classic by Heinz Hartmann, first printed in German in 1927. Lampl-de Groot's essay on "Genesis and Structure" is also important. It would be invidious to select additional names for special mention.

In re this series, we discover that Volume 18 (1963) was not reviewed by us through an oversight. In it the articles of Anna Freud on "The Concept of Developmental Lines," Masud Khan on "The Concept of Cumulative Trauma," Jay Katz "On Primary Gain and Secondary Gain" and illustrations by Humberto Nagera of Anna Freud's developmental profile struck this reader as especially interesting. This is no reflection on a score of other interesting articles. (K.A.M.)

Culpa Y Depresion. By LEON GRINBERG. Pp. 247. Buenos Aires, Paidos, 1964.

One of the leading personalities of the Argentinian Psychoanalytic Association here presents an interesting and original analysis of the normal and pathological aspects of guilt and depression. While following in the tradition of Melanie Klein, he incorporates into his analysis the findings of the modern

ego psychological orientation, and suggests some new hypotheses concerning depression. He distinguishes "persecutory guilt" from "depressive guilt," the former being an earlier and more pathological form. Depressive guilt, in his conception, refers to a higher level of affective development taking place in relation to a strong ego and implying a potential for further growth and development. At some points, his analysis appeared to this reviewer to approach Bibring's, Jacobson's, and Sandler's analyses of depression as affect states of ego. He explicitly states that the classical Kleinian model referring to paranoid and depressive anxiety as two clear-cut levels of development is oversimplified. In the reviewer's judgment, this contribution is clinically and theoretically a very significant one. (Otto F. Kernberg, M.D.)

Preconscious Foundations of Human Experience. By TRIGANT BURROW. WILLIAM E. GALT, ed. $5.50. Pp. 164. New York, Basic Books, 1964.

In the days when psychoanalysis was first making itself known in America, the voice of Trigant Burrow was often heard. What he said was thoughtful and persuasive but also slightly mystical, poetic, intuitive and indefinite. I recall my frustration in trying to grasp the message he so earnestly presented. Nathan Ackerman thinks Burrow anticipated Freud's later views by early emphasizing the aggressive element in sexuality. (K.A.M.)

Clinical Neurology. By FRANK A. ELLIOTT. $12.50. Pp. 688. Philadelphia, Saunders, 1964.

The author has rather carefully produced a comprehensive handbook of neurological disorders, including those of muscle, which is reasonably up-to-date. There are no chapters on basic anatomy or physiology, but these subjects are woven into some of the clinical discussions. This text can give good service as a quick initial reference for interns and residents, for whom it is specifically designed, and it provides bibliographies for those who would look further. (Joseph Stein, M.D.)

Psychosomatic Neurology. By HARRY A. TEITELBAUM. $13.75. Pp. 414. New York, Grune & Stratton, 1964.

This is an ambitious book in which the author combines a description of psychophysiological processes, personality development and psychosomatic aspects of neurologic disturbances and diseases. It includes a comprehensive discussion of the relevant literature, and illustrative cases from the author's own broad experience. With a background in psychophysiological research along Pavlovian lines, Dr. Teitelbaum uses a syntax and vocabulary with which this reviewer had some difficulties. Unconscious processes and anxiety are dealt with, for example, in terms of neurone impulse integrative processes and homeostatic integrative systems. The book repays careful reading. (Russell M. Wilder, M.D.)

Schizophrenic Women: Studies in Marital Crisis. By HAROLD SAMPSON and others. $4.95. Pp. 174. New York, Atherton, 1964.

This collection of articles, previously published independently in social work and psychiatric journals, is the outcome of a study of 17 married mothers

who required hospitalization for the treatment of schizophrenic reactions. The authors undertake the ambitious task of integrating the patients' intrapsychic and environmental conflicts. The individual chapters are, for the most part, interesting and enlightening clinical presentations, but they do not quite achieve the hoped for synthesis. (William Tarnower, M.D.)

The Montessori Method. By MARIA MONTESSORI. $6.50. Pp. 377.
Spontaneous Activity in Education: The Advanced Montessori Method, Vol. I. *Ibid.* $6.50. Pp. 355.
The Montessori Elementary Material: The Advanced Montessori Method, Vol. II. *Ibid.* $8.50. Pp. 464.
Dr. Montessori's Own Handbook. Ibid. $5. Pp. 121.
Republished in 1964 and 1965 by Robert Bentley of Cambridge, Mass.

Maria Montessori, the first woman ever to be granted a medical degree by an Italian University, became the directress of a state supported school for defective children following her training in psychiatry. There, having been greatly influenced by the work of Itard and Seguin, she developed materials and methods that were so effective that the defective children achieved education in an unprecedented way. Subsequently she applied similar methods to underprivileged preschool children in slum areas in Rome and gradually developed her system of "Scientific Pedagogy." The Montessori Method was introduced in America early in this century but, partly due to the adverse criticism of John Dewey, interest in the system was short-lived.

Recently there has been a resurgence of interest in the Montessori System due largely to two factors, namely, (1) the recent speeding up of education in mathematics and the other sciences and (2) the current national concern with affording more optimal stimulation to children in underprivileged areas.

The resurgence of interest has led to the republishing of four books by Montessori which originally appeared early in this century. *The Montessori Method,* published first in America in 1912, gives the history of the development of the Montessori System up to that time, presents the philosophy of education of this deeply religious woman and details methods which she used with children from three to six years of age. *The Advanced Montessori Methods,* Vol. I and Vol. II, titled respectively *Spontaneous Activity in Education* and *The Montessori Elementary Material,* deal with the "scientific pedagogy" of children from seven through eleven. *Doctor Montessori's Own Handbook* presents more succinctly than any of her other books both her convictions and her methods. This well-illustrated book presents lucidly the steps in muscle training and the materials such as form boards, sandpaper letters large and small, etc., used in stimulating growth of tactile and visual discrimination, all of which enabled preschool children "spontaneously" to write and read.

All of these books are permeated with the idealism of Montessori who wanted through her system of education to liberate the potential, the "inner force" not only of the individual child but also, perhaps, of the race by creating for the child an atmosphere of well-ordered tranquillity in which he could acquire "self-discipline" and could at his own pace, with spontaneity and freedom, educate himself through the use of carefully planned sequences of "self-corrective" materials to which he would be guided by the dedicated, unobtrusive,

but never the less authoritarian teacher. There is a persistent emphasis on useful, meaningful work in counter-distinction to play. Freedom is conceived as "the absolute freedom to choose that which is right" but the authoritarian teacher has the absolute freedom to decide that which is right.

This system of education would not be a panacea for emotionally-disturbed children since "useless or dangerous acts must be suppressed, destroyed." Montessori was prepared to expel from the "Children's Houses" those children who proved "to be incorrigible" or those children whose parents were not willing to give their support to the educational venture. (Dorothy S. Fuller, Ph.D.)

Contact with Jung: Essays on the Influence of His Work and Personality. MICHAEL FORDHAM, ed. $8.50. Pp. 245. Philadelphia, Lippincott, 1964.

This is a collection of brief essays written by 42 Jungian analysts from seven countries in reaction to Jung's death. Some examine current prospects of analytical psychology in various parts of the world, some are studies based on Jung's ideas, but the most interesting selections recount memories of personal encounters with Jung. Such contacts give a fascinating, if biased, glimpse of Jung's enigmatic genius. Needless to say, those looking for scientific criticism of Jung's view will not find it in this volume. There are several selections in German and French which are untranslated. (Philip Woollcott, Jr., M.D.)

Passivity: A Study of Its Development and Expression in Boys. By SYLVIA BRODY. $4. Pp. 184. New York, International Universities, 1964.

This small book is an attempt to trace the origins, development and manifestations of passivity in boys. In the first half, the author presents the history of two child analyses in some detail with particular emphasis upon the patients' hypnogogic dreams which allowed for a fuller understanding of the meaning of passivity in these two prepuberty boys. The second half of the treatise concerns itself with a more comprehensive discussion of the hypnogogic phenomena as well as the relationship of experience in all psychosexual stages of development to the development of abnormal passivity. Despite the occasional excessive use of psychoanalytic jargon, the clinical material is excellently presented and all professional persons interested in child development will find it of value. The sets of hypotheses offered to explain determinants of passivity are thoughtful and deserving of experimental regard. (Marvin Ack, Ph.D.)

Family Insights Through the Short Story. By ROSE M. SOMERVILLE. $1.75. Pp. 102. New York, Teachers College, Columbia University, 1964.

This booklet, written by an educator, is of value to all teachers who wish to use imaginative literature as one way of helping their students gain rich insights into family life. Doctor Somerville describes in syllabus form the value of using fiction to increase the student's capacity for empathy, insight, warmth and intellectual curiosity. The course content is outlined carefully and certain stories selected and summarized which are of value in highlighting important aspects of behavior during critical phases of the individual's development in his family. Unfortunately, there is a mechanical, "cut and dried" quality to the course outline, which seems to leave little room for feeling, spontaneity and

imagination, the very qualities the author wishes teachers to convey to their students. At the end of the booklet, there is an excellent bibliography of the short story. (Arthur Mandelbaum, M.S.W.)

Psychoanalytic Concepts and the Structural Theory. By JACOB A. ARLOW and CHARLES BRENNER. $4. Pp. 201. New York, International Universities, 1964.

Arlow and Brenner carefully define and illustrate what is meant by the topographic theory and by the structural theory of psychological structure in this the third Monograph sponsored by the journal of our national association. They compare the two theories, offer criticisms of both and discuss in the light of these theories the meaning of primary and secondary process. The final chapter, "The Psychopathology of the Psychoses," is better than its title which assumes that every one know what *the* "psychoses" are. (K.A.M.)

International Resources in Clinical Psychology. By HENRY P. DAVID. $7.50. Pp. 236. New York, McGraw-Hill, 1964.

Doctor David has prepared an informative and useful survey of training and practice in clinical psychology around the world. For each of a wide range of countries he devotes a section to the general situation of clinical psychology, followed by sections on graduate university training, supervised practice and experience, professional roles, emerging trends, and relations with psychiatry. This book will be particularly helpful to students seeking advanced training outside of their own countries and to psychologists seeking overseas challenges or sabbatical experiences. (Harry Levinson, Ph.D.)

Neurosis and Psychosis, Ed. 3. By BEULAH CHAMBERLAIN BOSSELMAN. $6.50. Pp. 201. Springfield, Ill., Charles C Thomas, 1964.

This book is the third edition of one published 15 years ago as an introductory book for medical students and general practitioners. It is well written and amply fulfills the expectations set out for it by its author. This reviewer recommends it to anyone in need of a clear, concise presentation of the field of psychiatry. The section on psychosomatic medicine, however, remains one of its few weaknesses. (Roman N. Borsch, M.D.)

The Mentally Ill Employee. By THE AMERICAN PSYCHIATRIC ASSOCIATION, COMMITTEE ON OCCUPATIONAL PSYCHIATRY. $2.95. Pp. 110. New York, Harper & Row, 1965.

With the collaboration of Nina Ridenour, the APA Committee on Industrial Psychiatry has turned out an easy to read, informative guide to acute mental illnesses and the use of the psychiatrist in industry. This book will be widely read, particularly by supervisors and middle management people. Its factual, reassuring, supportive tenor will help them act more reasonably and more constructively with employees who have or who have had emotional illnesses. Industrial nurses will feel they have been left out and industrial psychologists will feel they have been treated condescendingly, particularly when they read in this volume that psychological tests should not be used unless clinically-trained individuals are available to administer them. (Harry Levinson, Ph.D.)

Parents Not Guilty! Of Their Children's Neuroses. By EDMUND BERGLER. $6.95. Pp. 283. New York, Liveright, 1964.

In this provocative and persuasive volume, Dr. Bergler argues that parents cannot be blamed for their children's neuroses, and that for too long parents have been burdened with damaging feelings of unjustified guilt. He believes that all children have a tendency to elaborate their own unconscious distortions, regardless of their environment, and the masochistic degree to which they do this determines the severity of their neuroses. Dr. Bergler marshalls a wealth of clinical data from his enormous analytic experience to prove his thesis. The point he drives home with such vigor and erudition is a valuable counterforce against those who indiscriminately blame parents for all emotional disturbances in their children. It is regrettable, however, that Dr. Bergler must base his argument on evidence largely gathered from the analysis of adults, rather than the direct experience of treating children and their parents. The style of the writing is sharp, stimulating and challenging, making for quite rewarding reading. (Arthur Mandelbaum, M.S.W.)

Interpersonal Psychoanalysis: The Selected Papers of Clara M. Thompson. MAURICE R. GREEN, ed. $8.50. Pp. 398. New York, Basic Books, 1964.

Clara Thompson left what she experienced as the confining limitations of classical Freudian theory to become the guiding light of the William Alanson White Institute and the Washington School of Psychiatry. Whatever one chooses to call her—"deviant," "culturalist," "eclectic," "neofreudian"—he will find her an astute clinician and a keen observer of the rugosities of character development, emphasizing the "human" qualities or "personal reality" of the doctor-patient relationship. In these papers one discerns clearly the influences of Ferenczi (tender nurturant aspects of analysis), Sullivan (interpersonal communication), Fromm ("authentic selfhood") and similarities to and divergences from Horney. Most psychoanalysts will find the interpersonal emphasis sacrifices too much of drive influence and intrapersonal motivation. (Jerome B. Katz, M.D.)

Psychoanalyse und Alltag. PAUL FEDERN and HEINRICH MENG, eds. Pp. 298. Bern, Hans Huber, 1964.

The editors have skillfully brought together contributions of recognized authorities in the field of the application of psychoanalysis to mental health problems. There are interesting contributions of Meng and Federn themselves on sexual education and, among the other contributors, Anna Freud's article on problems of puberty and August Eichhorn's article on the rehabilitation of antisocial characteristics are of special interest. All articles deal with the problems of prevention, and of early detection of psychological problems requiring treatment. The level of the articles is generally that appropriate to popularization, which is the main purpose of the book. Most of the material is well known to specialists in the field. This book should make for interesting reading for the intelligent, although uninformed, German speaking layman. (Otto F. Kernberg, M.D.)

Artistic Productivity and Mental Health. By EDRITA FRIED and others. $6.50. Pp. 177. Springfield, Ill., Charles C Thomas, 1964.

Many psychological studies of the artistic expressions of the mentally ill have been attempted. Seldom has it been possible to study, in the "laboratory," the influence of mental illness upon artistic people. This book evaluates the effects of treatment on six recognized artists and attempts to verify the authors' assumption that one does not have to be neurotic to be creative. It sets the specific goal of assessing personality development, productivity and work habits and appropriately avoids passing judgments upon the works of art themselves. By the use of periodic questionnaires to both psychotherapists and patient-artists, the authors are able to collect impressive evidence that increased mental health improves artistic work habits and frees creative energy. (Don Jones)

Civilization in Transition: The Collected Works of C. G. Jung, Vol. 10. Bollingen Series XX. R. F. C. HULL, tr. $6.75. Pp. 609. New York, Pantheon, 1964.

In this volume Jung applies his theoretical views to various aspects of twentieth century civilization. Some of his explanations of social psychopathology (*e.g.*, the Nazi phenomena) are ingenious and thought-provoking, but his thinking can be frustratingly obscure at times, especially when he plunges into metaphysical speculations. Jung seems to find some highly abstract skeletons in the closet of man's unconscious. It is curious that for one who spent a lifetime studying man as a psychological being and as a *homo religiosus,* he has so little to say of human love (or hate) at the interpersonal level. He speaks rather of the "individual" or the mass (the "collective"). There seems to be little about children in his psychology. (Philip Woollcott, Jr., M.D.)

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RORSCHACH, HERMANN: *Gesammelte Aufsätze.* Bern, Hans Huber, 1965.

SCHORR, ALVIN L.: *Social Security and Social Services in France.* Washington, D.C., U.S. Dept. of Health, Education, and Welfare, 1965.

TOURNIER, PAUL: *The Healing of Persons.* New York, Harper & Row, 1965.

WOLFGANG, MICHAEL S.: *Male and Female Sexual Deviations.* Los Angeles, Sherbourne, 1964.

WOLSTEIN, BENJAMIN: *Freedom to Experience.* New York, Grune & Stratton, 1965.

PUBLICATIONS BY MEMBERS OF THE STAFF

HARTOCOLLIS, PETER: Some Phenomenological Aspects of the Alcoholic Condition. *Psychiatry* 37:345–348, Nov. 1964.

The paper is based on the assumption that drinking allows for more gain than pain. The advantage, which may account for the strength of the alcoholic addiction, lies in the fact that drinking enables its subjects to have the illusion that they are what they would like to be. Eventually, drinking, often an ego-dystonic symptom, establishes and perpetuates the alcoholic condition—a largely ego-dystonic syndrome. The latter involves a number of feelings and ideas, attitudes and beliefs, which alcoholics nurture about themselves and others. All this amounts to a certain sense of identity, which is threatened by psychiatric treatment. Alcoholics may find it expedient to subscribe to the psychiatric notion that their condition is an illness, but privately maintain the conviction that it is rather a chosen, even if mistaken, mode of life, about which others have no right to complain.

ROSS, JACK L.: Alcoholics Anonymous: A Neglected Adjunct to Hospital Treatment. *J. Kans. Med. Soc.* 66:23–27, Jan. 1965.

This presentation, made to the professional staff of the C. F. Menninger Memorial Hospital, invites a re-examination of Alcoholics Anonymous as a useful but neglected adjunct to psychiatric hospital treatment. The thesis is presented that Alcoholics Anonymous can be made a valuable part of the dynamically-oriented treatment program of the hospitalized alcoholic patient. A brief review of the history, basic principles, and therapeutic aspects of the program is included, along with an approach to referring the hospitalized patient to Alcoholics Anonymous.

LEVINSON, HARRY: Reciprocation: The Relationship Between Man and Organization. *Administrative Science Quart.* 9:370–390, March 1965.

The concept of reciprocation, which focuses attention on the relationship between a man and the organization in which he works, offers the possibility of integrating a wide range of data and concepts from industrial psychology, sociology, and clinical psychology. It explains the psychological meaning of the organization to the man and vice versa, an area so far almost untouched by psychological investigation in industry. It therefore provides the basis for better psychological understanding of morale and motivation studies, of leadership and training problems, of job evaluation and personnel selection, and of research on role performance. It also offers the psychological clinician the possibility of access to a wide range of data, which, heretofore without a dynamic base and unrelated to the psychology of the individual, had little relevance for him.

KLINK, THOMAS W.: The Natural History of Faith. *J. Religion & Health* 4:146–153, Jan. 1965.

The phenomenon of religious faith has a natural history with definable stages; this essay outlines a normative sequence of phases. A musical analogy of resolution of conflicting themes illustrates the active work involved at every stage. Initially, faith is an extension of infantile narcissism. This is preserved by projection onto a benevolent "Other," a powerful Servant. Psychoanalytic and religious understanding are parallel up to this point; dissimilarity in regards later stages hinges on divergent understanding of the ultimate nature of anxiety. Faith in its mature form is a radically new cognitive organization of the experience of anxiety, ontological support for the compromise formations by which the individual maintains a balance between contradictory drives, reinforcement for the rapprochement between the search for pleasure and the frustrations of reality. The difficult metaphor of miracle is dramatic statement of the latent congruence between "inner" and "outer."

KERNBERG, OTTO F.: Notes on Countertransference. *J. Amer. Psa. Assn.* 13: 38–56, Jan. 1965.

Countertransference may be helpful in evaluating the degree of regression in the patient and clarifying the transference paradigms during severe regression. Patients with the potential for severe regression and whose conflicts center around pregenital aggression tend to foster serious countertransference compli-

cations, especially "counteridentification," related to the partial reactivation of early ego identifications and early defensive mechanisms in the analyst. Counteridentification is a serious threat to the analysis, and predisposes the analyst to the development of "chronic countertransference fixation." Signs of chronic countertransference fixation and characteristics of "concern" as a general trait of the analyst are described.

SWORD, RICHARD O.: Adjunctive Therapies Offer Diagnostic Clues. *Ment. Hospitals* 16:126-129, April 1965.

In a clinical study, where the skills of the adjunctive therapist were utilized in a diagnostic setting, the following conclusions were reached: Early participation, by a hospitalized patient, in adjunctive therapy activities will lead to a more accurate diagnosis. On the ward attention is focused on a patient's illness; in the A.T. clinic attention is directed toward his remaining health. Although the activities prescription is an essential ingredient of a well-planned milieu treatment program, an adjunctive therapist does not need it in order to interact with a patient in a diagnostic setting.

MURPHY, GARDNER: A Cross-Cultural View of Ego Dynamics. *Bull. New York Acad. Med.* 41:268–285, 335–346, 1965.

The more profound studies of personality development in different cultures, both preliterate, Eastern, and Western, suggest that culturally ingrained values, and the conflicts between dissonant elements in each culture, are significant for psychiatry, especially for the study of ego dynamics. It is true that "basic human nature" is essentially the same in different settings, but it is likewise true that these basic components are molded, directed, and set in harmony or discord one with another, by virtue of cultural arrangements. It is therefore important not only to study the dynamics of the individual person, but to study the broad problems which arise from different expressions of these dynamics in different social settings. Implications for education and for therapy in an industrial society are tentatively sketched.

LEVINSON, HARRY: The Future of Health in Industry. *Indust. Med & Surg.* 34:321–334, April 1965.

Three major trends are converging which will constitute a metamorphosis in occupational health and take it to the forefront of medical practice: (1) changes in science as a whole; (2) the historical development of medical practice, and the development of occupational medicine within the mainstream of medicine; and (3) the growing importance of the work organization to the people in it as a product of social change. The occupational physician will have to broaden the study of illness-producing factors to include organizational process and his technique of prevention to include intervention into this process. As a result occupational health will be a more central concern of management and the occupational physician will be a more active participant to the management of organizations. This will pose important professional problems for the occupational physician having to do with his identification and function. Finally, the distinction between occupational and non-occupational medicine will become more and more spurious.