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PHILOSOPHY AND MEDICINE*

By WALTHER RIESE, M.D.† and EBBE C. HOFF, M.D.†

The physician of the past would have regarded the isolation of medicine from philosophy, so characteristic of our time, as a strange and unintelligible phenomenon. In the early days of the Roman Empire, Celsus (*On Medicine, Prooemium*) stated that "at first the science of healing was held to be a part of philosophy; so that both the curing of diseases and the contemplation of the nature of things came in through the same authorities." He believed these authorities to be "those principally requiring this science, who had diminished the strength of their bodies by calm reflection and by nocturnal vigilance." This is a surprising anticipation of Jean Jacques Rousseau's doctrine of the origin of disease and of his views on the disease-precipitating effects of science, expressed in his Discourse: *Si l'établissement des Sciences et des Arts a contribué à épurer les moeurs*" (Dijon, 1750) and his "*Discours sur l'Origine et les Fondements de l'Inégalité parmi les Hommes*." In the latter work we read the following sentence: "*. . . l'état de reflexion est un état contre nature et . . . l'homme qui médite est un animal dépravé.*"

Celsus referred to Hippocratic medicine as the first version of our art to become independent of philosophy. The medicine of Hippocrates, however, still largely utilizes philosophical methods and devices, such as observation according to rules, systematic reasoning, introduction of a restoring principle into the interpretation of morbid phenomena, a doctrine of the origin and causes of disease, and finally a most general view of human nature.

* An excerpt from an article entitled "A History of the Doctrine of Cerebral Localization" by Walther Riese and Ebbe C. Hoff reprinted from the *Journal of the History of Medicine and Allied Sciences* 5: 50–71, 1950. See also, Riese, Walther: Philosophical Presuppositions of Present-Day Medicine. *Bull. History Med.* 30: 163–174, March–April, 1956.

† Medical College of Virginia, Richmond.

vincible hostility? Why then cannot antisocial behavior or revolutionary activity be adopted? Does it represent a need to escape from an intolerable life situation? Why then is there not recourse to the withdrawal and dereism of the schizophrenic, the nomadism of the derelict, or the needle of the drug addict? It is unfortunately the painful truth that as yet we have no satisfying answers to any of these questions.

The act of suicide becomes all the more puzzling if we believe, as does Silverberg[1] that the ego's main purpose and motive is to ensure survival and that this drive for survival is omnipresent, irrational, and not easily foiled or flouted. All of us could cite instances of lives which are seemingly reduced to utter degradation, squalor, ignominy and misery but who, even so, wish to live and are loath to end their lives; for as Bettelheim[2] discovered, even in the horrors of a German concentration camp the majority of persons, even under the most desperate and benighted conditions, will cling tenaciously to life. What then accounts for the ease with which the suicide gives up a life which the rest of us cling to so doggedly? What are the ends and goals which the suicide pursues which are to him stronger than life itself? Most of us are probably in essential agreement with Silverberg and would hold that the wish to live is a powerful and constant force, not to be gainsaid by any series of rational remonstrances and our task is to address ourselves to the problem of just what are the irrational concepts which make the termination of life possible or even desirable.

The view to be presented in this paper is that suicide is not pre-eminently a rational act, pursued to achieve rational ends, even when it is effected by persons who appear to be eminently rational. Rather, it is a magical act, actuated to achieve irrational, delusional, and illusory ends. Magic is used here as defined by Schopenhauer,[4] *viz.*, an objectification of desire outside the causal nexus; an act of attempted control or delusion of such control, of physical forces normally peripheral to human mastery. Suicide, like the other neurotic symptoms which it resembles, is a symbolic, reified solution of a conflict and the purposes of this symbolic solution are largely unconscious and only minimally within the limits of conscious awareness.

The major conflict, which is the primary one that the act of suicide is an attempt to solve, is an identification conflict. By identification is meant that process by which the child during the prelogical stage of his development comes to take within himself, by a process essentially magical and unwitting in character, the habits, patterns and methods of problem solution characteristic of the primary socializers, usually the parents. He obtains by this process, moreover, his basic conceptions of himself as a person. He is unable, owing to his limited past experience and protorational concept formation, to evaluate his own merit, and his conception of his adequacy and worth, and indeed of his very nature, is obtained by an uncritical acceptance of the prevailing attitudes held toward him by his

parents. Hence, if they derogate and reject him, or if they themselves are weak and vacillating, or if they are lost to him for some reason such as death or abandonment, he is almost certain to develop a conception of himself as a debased and inadequate person. Because this is an unendurably painful state of affairs, he reacts with strong hatred and hostility, which usually takes the form of death wishes toward the depriving parent, and in time these themselves evoke strong and often unremitting guilt. Repression is the usual and most pathological mechanism for handling the anxiety, self-hatred, hostility, and guilt which result from this identification dilemma.

It is, of course, obvious that this is an over-simplified schema and that these painful effects may be produced in other ways or take other forms, and, moreover, we know that the parental situation just described need not eventuate in this manner. Also, the identification dilemma outlined is known to be a common antecedent of most disturbed populations and many different kinds of neurotic and psychotic disorders will serve to "bind" and repress the unacceptable affects which such a prior environment might induce. As yet we have only suggestive data on the familial and personal antecedents of a sufficiently large number of persons who attempt or perform suicide to determine what relevance, if any, these factors may have in the genesis of this phenomenon.[3,4]

Suicide, or ruminations about it, are comparable to neurotic symptoms in that they are magical and symbolic attempts to solve an exigent conflict and to achieve comfort thereby. Suicide also resembles other neurotic symptoms in that it is complexly and severally motivated. These motivations seem to vary in nature and in strength and significance from one person to another and they are in varying degrees conscious or unconscious in each subject. Some of the motives in which the magical aspect of suicide is most strongly suggested are as follows:

Firstly, a wish to punish a depriving figure by the induction of guilt. These figures usually prove to be the parents or the siblings but are sometimes the extrapolation of them, *i.e.*, society or mankind. In this connection one is reminded of the story of Mark Twain's *Tom Sawyer*.

> Tom, being painfully frustrated by his aunt was strongly comforted by the fantasy of committing suicide by drowning himself in the Mississippi. He thought to himself of how sad and piteous a spectacle he would make when his body would be brought into his aunt's presence with his curls all wet and how consequently sorry and remorseful she would be. She would then say to herself, "Oh, if I had only loved him more. How differently I would have treated him if I had only known."

We read that this picture brought tears of self-pity to his eyes. There are reasons to believe that fantasies of this character are ubiquitous among children. This appears to be true not only because children have intense expectations and needs from the parents, some of which are bound to be

unfulfilled, but also because they feel inferior and powerless to influence them. They can therefore best repay the hostility which this frustration induces by acts of their own which induce guilt, since they are afraid to express their rage in direct aggression. The entertainment of such a maneuver involves also a denial of death as a finite and terminal act. It is as though they could remain behind to see and relish the discomfiture and remorse their act would induce. Presumably, therefore, when feelings of powerlessness, impotence and inferiority persist far into adult life then the individual, like the child, is more prone to utilize this method of being hostile to others, since a more direct means of aggression is generally impossible for them. For example, in Japan, if one has been unsufferably injured, or if the person who has done this injury is of an unapproachable social class, one still has recourse to the highly aggressive device of committing suicide on the enemy's doorstep. And Malinowski[5] describes that among the Trobriand islanders there is a similar reaction to an inadmissible affront. There the aggrieved person climbs a high palm tree and after haranguing the audience on the evils of the affronting person he dives, head foremost, to his death. Also suicide for such a motive is by no means isolated from our own culture. Presumably in these instances the wish for revenge by inducing guilt and remorse exceeds the desire to live and is seemingly related to a denial of the infinitude and irreversibility of death.

A second motive for suicide is the wish to reduce personal guilt which is, by general concurrence, the most painful of all affect states. These suicide attempts seem to be usually an act of self-punishment; an attempt to expiate the fantasied act of murder (death wishes) by operation of the law of Talion. It must be remembered that in the unconscious the thought is equally comparable with the deed and is equated with it. It says in effect, "You wish the death of a person and therefore you must die." Often subsequent stresses in a patient's life trigger off and actuate latent, repressed conflicts of this nature which then sum with the current stress and produce a resultant act of physical self-destruction. Zilboorg[6] has commented on the interesting phenomenon of persons who commit suicide on the anniversary of their parents' or siblings' death, as though to expiate through their own demise the parental death which they unconsciously perceived as resultant from their death wishes. The wish had then become hypostatized and equated unconsciously with the deed. It appears that expiation of personal guilt and achievement of a hostile wish by guilt induction are almost invariably present in every suicidal attempt or act.

A third motive, and one more recondite, is the employment of suicide as an aid in coping with an overpowering thanatophobia or fear of death. Suicide in this sense serves as a reaction formation to the morbidly feared eventuality of death by embracing it rather than in running from it. An

example is an adolescent boy who had a prolonged history of an intense fear of death and who attempted to hang himself. He accounted for his actions by saying he tried to find out if death was as bad as he had been told. He had resolved to be a man and face the thing he feared. A more complete explanation of his act revealed, of course, that it was much more complexly motivated but it developed that in part he unconsciously felt towards death as do children who play "cops and robbers," *viz.*, that death is a reversible and temporary rather than a permanent and irreversible process and therefore, not "really dangerous." These magical aspirations may constitute largely overlooked motives for suicide.

One cannot truly understand the deeper dynamics of suicide until he comprehends its relationship to death, and the unconscious significance and meaning which death has to us. There are cogent reasons to believe that unconsciously we do not consider (as most of us do consciously), death to be the end of our existence or a permanent state from which there is no returning. But rather because of the innate unconscious narcissism of the ego, our own demise is not considered even to be a possible eventuality. In our deepest selves we believe, as did the psalmist who said confidently, "A thousand shall fall at thy right hand, ten thousand at thy left, but it shall not come nigh thee." Hence, most of us do not fear death because on the deepest level we cannot even conceive of it. We have created a vast number of philosophical and religious systems which convince us, no less than they did the ancient Egyptians, that we cannot ever cease to exist but that instead we are merely translated from one form of existence to another. This denial of death and conviction of immortality the religious person entertains consciously, but the remainder of persons appear to entertain it unconsciously, however strongly they may protest and believe that they are reconciled to an eventual termination of their existence.

This may be an answer to the question phrased previously, namely, how can the suicide value life so cheaply when there are so many manifold examples of lengths to which the average man will go to preserve his life? Can it be that death may be perceived in a different fashion by the suicide, that he is able to encompass his self-destruction because unconsciously he does not perceive death as the to-be-avoided thing which most of us so regard it? There is evidence from some of my own cases that the manifestly deprived and frustrated person who is more prone than others to employ grandiose fantasies of a compensatory character, exalts thereby his sense of narcissistic immortality and omnipotence. Death then, by one's own hand, not only serves the motives of expiating self-guilt and inflicting it on others, but is not even conceived in the usual terms of fear and dread. The possibility of his own not-being is unconsciously so distant and remote that he can entertain and effect an act of self-destruction without the sense of self-preservative horror which it so commonly induces in others.

"Good creatures, do you love your lives
And have you ears for sense?
Here is a knife like other knives,
That cost me 18 pence.
I need but stick it in my heart
And down will come the sky
And earth's foundations will depart
And all you folk will die."

Like Sampson in the temple, the suicide may unconsciously believe that by an act of self-destruction he is encompassing the destruction of myriads of others, who, by ignoring the irrational expectations which he has placed on them to be his substitute parents, have earned his hatred and his anger. The suicide when he dies, kills not one person but many. He commits not only suicide but vicarious matricide, patricide, sororicide, fratricide, and even genocide. Did Medieval man not subliminally realize this when he made an attempt at self-destruction a legal crime? Indeed it was entitled *felo-de-se* and it still remains such in the British Law books. To the 15th Century man the suicide was treated legally, as unconsciously he may have been, as a murderer, and his body would be carried nude through the streets to be buried at a crossroads with a stake driven through his heart. Apparently the citizens of five centuries ago were expressing the baffled rage which they must have felt at this person whom they regarded as a murderer and so deserved death, but who had escaped.

But perhaps the saddest thought of all is to see the suicide as he really is, a forlorn, beaten and deprived person who has peopled his emptiness with malefactors and villains of his own making. His small ingrown self becomes an empty cosmos peopled with his tormentors and detractors. In an immense moment of fantastic grandiosity he lays them, and all the world, to ruin. But instead of leaving the world as he fantasies it, desolated and sere, stricken and laid waste by the magnitude of his act, he gains only a personal surcease from pain and a small footnote on the inside pages of a newspaper. He goes out not with a bang but with a whimper, a dupe to the irrationality within himself.

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PSYCHOLOGICAL FACTORS IN THE CHOICE OF MEDICINE AS A PROFESSION*

(Continued)

By KARL MENNINGER, M.D.

In part I of this paper, the discussion of the motives for choosing medicine as a profession was confined to medicine in general. The complexity of techniques of diagnosis and treatment in the practice of medicine, however, has resulted in specialized subdivisions which seem to have become almost separate disciplines. As we speculate about some of the reasons for the selection of specialties, I would emphasize that we do not know about the full and final facts about these things and any similarity between our speculations and the actual facts must be regarded as possibly coincidental.

Pediatrics is a branch of medicine characterized by the fact that all the doctor's patients are children. A pediatrician may see in his patients little replicas of his siblings or playmates of his formative years. In his professional work he has a continuous opportunity to undo in all sorts of magical ways some of the serious conflicts of childhood. Arnold Gesell, the child psychologist, was the eldest of five children, and was held responsible for his younger siblings when he was a boy; he says, understandably enough, "I have always been interested in children."

Everyone has observed in some doctors a pronounced tendency to mother their patients, treating all of them, regardless of their actual age, as if they were little children. Not only in their manner and attitude but also in their procedures, doctors of this type seem to play the maternal role, lavishing attention upon diet and bowel movements in a way strikingly reminiscent of the mother training her child. I once knew a physician who insisted upon giving his patients enemata himself, not occasionally, but daily. And as he tended them thus, he would admonish and scold them exactly as some mothers do.

How much this permeates the entire medical profession generally, we do not know, but in pediatrics the maternal role is sometimes conspicuous. Many pediatricians would probably not resent being called "proxy mothers." Perhaps in some instances the pediatrician is a man in whose own childhood there was physical illness of importance to which the mother ministered in a way which, many years later, the pediatrician repeats with a higher degree of technical skill and knowledge.

A combination of specialty interests occurs not infrequently. A number

* Portions of this article were read at the Brill Memorial dinner meeting of the New York Society for Clinical Psychiatry on January 27, 1955. It also appears in *The Quarterly of Phi Beta Pi* 53: 12–23, Oct. 1956.

of psychiatrists have told me that they had narrowed their choices to pediatrics, internal medicine and psychiatry, and "nearly" chose pediatrics or internal medicine before they finally settled on psychiatry.

In *obstetrics* the childhood longing to know where babies come from is repeatedly and directly gratified. But perhaps even more significant here than curiosity is the factor of identification with the mother. Historically obstetrics developed from the passive art of midwifery (the Latin word *obstare* means merely "to stand [watchfully] before"!), practiced by women, to a highly technical skill in which the obstetrician plays almost as active a role as the mother herself. Indeed it is difficult in watching a modern delivery (in which the mother is unconscious and paralyzed, and the baby drawn instrumentally through a surgically enlarged opening) not to assume that the obstetrician, rather than the mother, is delivering the child! In no more thorough way could the obstetrician gratify his unconscious infantile wish to become the mother. In certain primitive societies this wish is given open ritual recognition, as in New Guinea, where the puberty rites for boys include the imitation by males of child-bearing.[1]

The agonies of childbirth are described in exceptionally florid terms in some of the standard obstetrical textbooks as if obstetricians felt compelled to emphasize or even exaggerate the sufferings of motherhood; this might be the expression of an unconscious wish, a residue of early infantile rage and hostility against the mother. The urge to relieve maternal pain has been so pre-eminent that until the recent development of relatively harmless obstetrical anesthetics, relief was achieved at the cost of considerable risk for the infant.

In view of the foregoing, it is hardly surprising that obstetricians have been inclined to take a rather dim view of the modern *laissez faire* trend in obstetrics, many specialists refusing to deliver their patients without anesthesia even when the mothers request it. One specialist who had been persuaded by a particularly importunate young mother to deliver her without medication revealed the degree of his identification with his patient when at the end of the delivery he said, "Never again! I can't stand it!"

Certain factors in connection with *gynecology* involve psychoanalytic speculations rather complicated for simple generalization.

Perhaps the *urologists* are the frankest and, in a sense, the most unrepressed of all the specialists. They have been twitted so much in regard to some of the implications of their specialty that they seem to have become immune to ridicule and this leads them to be unusually open-minded. Many urologists acknowledge that impotence in the male is primarily a psychological and not a structural condition, and is best treated by psychological means. To be sure, some of them continue to believe that instrumentation is a type of psychotherapy, and as a matter of fact they

have pragmatic justification for this, because it frequently "works" as such. My impression is, however, that many of the urologists know in a general way why it works. They may not recognize the fact that substitution of another form of punishment often relieves the individual of the need for self-inflicted symptoms, but they do recognize that the patient often wants to be hurt, and they do it for him cheerfully, skillfully and harmlessly—which is more than can be said for a good many mothers, judges, and psychiatrists.

Why urologists should have elected that specialty and what unconscious satisfactions they find in it is not easy to say. Urologists in general have a frank attitude toward sex. From the nature of their practice, one might assume that they believe the penis is the most important organ of the body, which is what every human being believes *at one stage in his development*, the so-called phallic period.

The function of urination is of great interest to every child, and many special feelings and attitudes are connected with it. For most children it is for a certain period of time a substitution for less approved uses of the genitals. Some of the individuals may be expected, in adulthood, to find satisfaction in devoting themselves to the maintenance of the most efficient functioning of the urinary apparatus.

Proctology is so obviously connected with what we refer to as preoccupations of the anal phase of development that certain other features might easily be overlooked. The social taboo on anality in our culture is peculiarly sharp and inconsistent; we Americans are proud of our money, our bathrooms and our plumbing and many other aspects of our civilization which seem clearly related to anal erotism, while we are highly fastidious regarding smells and cleanliness and erect strong taboos on excretion and the structures related to it.[4] This makes the proctologist perforce a humble man indeed, whose patients—like those of the psychiatrist—are ashamed to admit they need him.

Surgery is associated with the idea of cutting, of giving pain in order to relieve pain. The conscious association of pleasure with the inflicting of pain is considered perverse, but, properly sublimated, this becomes a kind of heroic mercifulness. We all know—or suspect—that some physicians and some surgeons, like some candlestick makers, are cruel—cruel to their patients and sometimes to their wives and other people. It cannot be denied that medicine, and particularly surgery, afford a unique opportunity to conceal conscious or unconscious sadism. In the fantasies of children, and of mentally ill patients, one often encounters the wish to mutilate the living body of some foe. The intensity of the revulsion ordinarily evoked by such ideas indicates how strongly most of us repress them. Yet the extreme popularity of the uncouth Mickey Spillane books suggests

how widespread is the craving for some sort of vicarious expression of such destructive thoughts.

It is no reflection upon the surgeons to say that a connection exists between fantasies of mutilation and the skilled, tender handling of body tissues by the trained operator. It does not follow that surgeons are more sadistic than other people, or more driven by blind impulses toward cruelty; in fact, just the opposite may be true. The chances are that surgeons have less unconscious guilt about their sadistic proclivities than most people and hence do not need to repress them, but use them constructively. They can sublimate sadistic impulses in a closely related but enormously more approved form of behavior. That this form appeals to the public is obvious in the dramatic interest which attaches to the surgical operation, in the romantic interest which (so often) attaches to the surgeon. He becomes the great life saver, the performer of miracles, the very incarnation of curative science.

This makes it the more understandable that surgeons sometimes seem inclined to establish their own ethical systems, and take the law into their their own hands as it were—or permit their fellows to do so. I so interpret the casualness with which some surgeons treat the ugly fact of mercenary and unnecessary operations, as even recently again exposed by the College of Surgeons under its courageous and outspoken leader, Dr. Paul Hawley. But here again one should observe that it was the surgeons themselves who first fought this temptation, officially repudiated it, and set up standards and practices to eliminate it.

There is an entirely different aspect of surgery which has nothing to do with pain, cutting, cruelty, and so forth. Some people—and who of us does not have friends like this?—feel more confidence in their hands than in their tongues and voices. Many have asked why Albert Schweitzer, already a theologian, a philosopher and a musician, should have turned to surgery. It is not a complete answer, but it is his own, expressed very simply in *Out of My Life and Thought*: "I wanted to be a doctor that I might be able to work without having to talk. For years I had been giving myself out in words, and it was with joy that I had followed the calling of the theological teacher and preacher. But this new form of activity I could not represent to myself as talking about the religion of love, but only as an actual putting of it into practice."[2]

Dermatology, like psychiatry, deals to a large extent with perverse expressions of emotional disorders. The psychiatrist listens for hours to verbal descriptions of internal, invisible lesions; the dermatologist makes an almost instantaneous visual grasp of external, visible lesions. The psychiatrist relies chiefly upon his ears, the dermatologist upon his eyes. One wonders if a statistical study would show that psychiatrists lean more toward the

appreciation of music and dermatologists toward the appreciation of the graphic arts.

At any rate, they have much in common. The patients of the dermatologist, like those of the psychiatrist, are under a cloud. The public suspects them of being untouchable and loathsome and guilty of exaggerating their suffering. Psychiatrists, who are so often portrayed as enriching themselves by pampering hypochondriacal old ladies with nothing wrong with them, can sympathize with the dermatologists, who are accused of making meaningless Latin diagnoses and applying placebo ointments to inconsequently ill patients.

For all these similarities, however, there is one striking difference between dermatology and psychiatry. We have considerable data about the psychology of psychiatrists, but we have no source of information about any characteristic psychology of the dermatologists. I have not personally analyzed a physician specializing in dermatology or even having a particular interest in it, and I know of no one who has.

My friend, the late Dr. Paul O'Leary, distinguished head of the Department of Dermatology at the Mayo Clinic, took the trouble to inquire for me of quite a number of his dermatological colleagues regarding their original interest in dermatology. Nearly a third of them had physician fathers, none of whom were dermatologists. The reasons ascribed for the choice of dermatology varied widely: the challenge behind the obvious was mentioned oftenest. Dermatological diseases are puzzling, obscure, often difficult to diagnose and still more difficult to treat. The ostentatious pride with which some doctors announce their ignorance of dermatology (and psychiatry) seems to stimulate some others to attempt to fathom the mystery. Only one colleague mentioned the fact that dermatological patients usually do not die. Quite a number mentioned the influence of an enthusiastic teacher, or the desire to exploit a good visual memory.

But all that this really adds up to is that even the conscious reasons for electing dermatology are as unknown as the etiology of some dermatological lesions.

Finally we come to ourselves. What about us? Why are we *psychiatrists*?

At the Menninger School of Psychiatry, we have had the rich experience of selecting several hundred young doctors from among a much larger group and following them through their training years, month by month, with written reports from their teachers and supervisors on into their early clinical years. How good have our selections been? How accurate were our implied predictions? The findings of Holt and Luborsky, who conducted a seven-year research, have encouraged us on the one hand and kept us

humble on the other hand. With the aid of psychological tests and numerous interviews, we can do significantly better than chance but it is impossible to be highly accurate.

For our present purposes the more important part of this research was the light it threw upon the ideals, purposes and motives of men entering the field of psychiatry. That psychiatrists differ from their medical colleagues in certain conspicuous respects is well known. One of the ways which is frequently mentioned by the public is that there are among psychiatrists more members of minority groups than is the case with physicians and surgeons generally. By this is usually meant foreign physicians and Jewish physicians. We have no statistics and know of none on this point, but it is an impression which might well be true.

This corresponds with the psychiatrist's professional interest in lonely, eccentric and unloved people. It is one of our axioms that such an interest is apt to be a projection of one's own problems, and the speculations we have applied to members of other specialties must now be applied to ourselves. The implication is that psychiatrists, more than members of other specialties and more than the average man, have at some time suffered overmuch from a sense of loneliness, unlovableness and rejection. In the sense that the doctor constantly heals himself by his ministration to others, this aspect of the determining factors in an interest in psychiatry is prominent. In deadly fear of misquotation by the casual listener or the hasty reader, I want to emphasize the fact that what I have referred to is usually a strongly *repressed* self-concept, almost totally unconscious. Translating this into the positive, I would say that the young men I meet who seek to enter the field of psychiatry are, by and large, just as charming, socially at ease, self-confident and "regular" as any other group of young men of the same general group, perhaps more so. Naturally I refer now to "appearances."

Unconscious voyeurism has been ascribed to psychiatrists for the obvious reason that they find in their professional lives much opportunity to learn about the sexual behavior of others. I am sure that the public would seize upon this as most characteristic of us, yet I would like to suggest that it is probably *least* characteristic of us, among physicians. We are just a little less self-conscious about it, that is all. Do not forget that the essence of Freud's discovery was that psychiatrists did *not* investigate these areas as they should. It was possibly *just because* Freud and other psychoanalysts were less critically and frantically magnetized into immobility by this subject that they were able to investigate it more casually and more impartially.

I think rather, that one should look in the depths of the psychiatrist's mind for some greater interest in function than in form, some greater concern with behavior than with organs, some greater interest in human relationships than in human anatomy. Let us hasten to renounce any special credit for what seems to us a more progressive and sophisticated position here, remembering that according to our best beliefs this is a matter of some special kind of childhood experience.

There is a great temptation for the psychiatrist to indulge in a kind of secret arrogance for, in the sense that things of the mind and of the spirit transcend those of flesh and bone, our professional preoccupations as psychiatrists would seem to be on a higher level than those of some medical colleagues. This disputes our holistic theory, but we cling to it secretly. No one can say that the flower is more important than the stem, or the living room than the basement, but through the centuries many doctors have apparently taken the position that the prolongation of a relatively pain-free existence was the sole goal of their endeavors. But if we believe that life has a meaning and our existence here a purpose, what a man does with his body (including his brain) is more important than the fact that he possesses it, or even that he enjoys it.

If a psychiatrist is less of a voyeur, frotteur, than some of his colleagues, is he less realistic? Is it really more difficult for him to face or touch reality, as is sometimes jokingly suggested? Would this indicate that his capacity for fantasy is the greater or the lesser? What are the presumptive differences between the reactions of psychiatrists to the basic problem of castration fears and the loss of parental love as compared to his colleagues?

One gets valuable leads about this from the conscious fantasies of the laymen about mental illness. What do *they* think? They think, for one thing, that mental disease is hereditary. Part of this we have taught them, but part of it means that they consider mental illness either a punishment of God or else a curse of nature. Another thing which laymen believe about mental illness is that our patients are wild and dangerous. Here again is a suggestion of uncontrolled aggression for which punishment is the ordinary expectation. Another thing laymen believe is that mental illness is related to masturbation, if not indeed "caused" by it.

All these fantasies are vigorously and continuously refuted both by our words and by our actions. We all want to correct the laymen's absurd ignorance. It may be that our evangelical zeal in this respect, fortunate as are its consequences, derives from the residuals of our own early fears and fantasies.

But now I have the uncomfortable feeling that you will think I have led you through a chamber of horrors from which, with excellent judgment, we doctors and psychiatrists have run in a terrorized flight, into evangelism. And it would certainly belie the spirit of modern psychiatry to end on this negative note. The practice of medicine is more than merely a lifelong penance for the fantasied sins of infancy, or a thinly disguised perpetuation

of them. It is more even than an effort to save ourselves by saving others. To assume that the positive is only a reaction to the negative is one of our professional psychiatric fallacies. There are positive motivations in the human spirit not born of fear and guilt and hate, but of life and love. The life instinct not only battles against the death instinct, it has an autonomy and purpose of its own.

What is that autonomy of the ego or that element of the life instinct which fights, strives, aspires—which is more than the negation of evil? With Whitehead, Weiman, Hartshorne and others, I think we can usefully call it creativity. Healing is more than repairing, more than not destroying; it is creating. It is an article of faith with us, and one without which we doctors cannot work or live, to believe that things can be improved, that the patient can be helped, and that we ourselves can always be better than we are. We must improve ourselves in order to improve those who seek our help. This aspiration is in itself creative.

David Rapaport cites a story of ancient wisdom in his own able discussion of the same topic.[3] A certain king had heard about the great, wise leader, Moses, and sent painters to paint his portrait. When they brought it back, the king called his phrenologists and astrologers. "Look at this portrait and tell me the kind of a man it is," he commanded. So the phrenologists and astrologers studied it long and earnestly and came forth with this report: "Oh, king, this Moses is a cruel, greedy, self-seeking, dishonest man. We see it in his portrait."

The king was puzzled. "Either my painters cannot paint or there is no such science as astrology and phrenology." To decide this dilemma he went himself to see Moses. At the sight of Moses, the king cried out: "The painters painted well. There is no such science as astrology or phrenology."

Now when Moses heard the king speak thus, he was surprised and asked him to explain it. The king did so. Then Moses only shook his head and said, "No, great king, your phrenologists and astrologers are right. That picture is what I *was*. But I fought against it, and won! That is how I became what I *am*."

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PSYCHOTIC EPISODES HERALDING THE DIAGNOSIS OF MULTIPLE SCLEROSIS*

By KONSTANTIN GEOCARIS, M.D.†

The high incidence of behavioral disturbances in patients suffering from multiple sclerosis and other demyelinating diseases has been widely known for many years.[8] There are several reasons why this group of diseases has become increasingly important to the psychiatrist. Firstly, among the theories about the etiology of demyelinating disease, notably multiple sclerosis, are those which say that localized changes in the vascular tree of the central nervous system are intimately related to the patient's deep-seated emotional problems and could result in plaque formation.[2, 13] Secondly, even those investigators who do not consider multiple sclerosis a psychogenic illness, admit that there is abundant evidence of a definite relationship between psychological stresses and exacerbations of the neurological symptoms.[2, 4, 10] They feel that everything possible should be done to help the patient with multiple sclerosis avoid psychological stresses and tensions.[5]

Thirdly, numerous reports stress the importance of psychiatric treatment as an integral part of the rehabilitation program in multiple sclerosis.[5, 11, 15] In studies by Langworthy[11-13] and by Harrower,[7, 8] most patients showed signs of serious behavioral disturbances. Langworthy found that at least one of every twelve patients required placement in a psychiatric hospital during the course of his demyelinating illness. There are also reports advocating not only supportive but also expressive or corrective psychotherapy for these patients.[4, 5]

Fourthly, there has always been the problem of differential diagnosis early in the course of multiple sclerosis. Because of the ephemeral and fleeting neurological symptoms, many patients are treated for some time as if they had conversion reactions or other neurotic syndromes. Further confusion results from the fact that some patients with multiple sclerosis and its concomitant neurological deficits also have conversion symptoms.[13] The scope of this paper will be primarily concerned with this fourth point.

The commoner psychiatric disturbances associated with multiple sclerosis have been described by many authors in neurologic and psychiatric tests and journals. In essence, it is felt that there is no such entity as the typical multiple sclerosis personality, even though there may be striking similarities in the underlying personality structure and orientation as described by

* Written to meet a requirement of the Scientific Writing Course in the Menninger School of Psychiatry.

† Director, Psychiatric Clinic, Hillcrest Medical Center, Tulsa, Oklahoma.

Harrower[7] and by Grinker and Robbins.[6] Furthermore, the behavioral changes are usually functional and not caused by organic impairment per se, except in fulminating or severe, advanced or terminal cases. Multiple sclerosis probably serves as a varying stress on the personality structure. Braceland and Giffin[1] put it as follows:

"In summary, it appears that multiple sclerosis does not put a specific characterologic imprint on the personality organization of the individual patient, but that, rather, the reverse is true. The individual as a whole reacts to the disease in a manner which to some degree depends upon his personality make-up. The reaction is modified by such factors as the number, extent and location of the neuropathologic lesions, the social importance of the incapacity of the individual, and the economic, marital and environmental significance of all these to him."

Some investigators like Langworthy[12] think that in some cases it is impossible to differentiate multiple sclerosis in its early course from conversion hysteria, not only because of the inconstancy of neurological findings in the early course of multiple sclerosis but also because these patients often show many neurotic traits in their behavior. The "*belle* indifference" so common in the hysterical patient's attitude toward his incapacity is not much different from the massive denial, complacency, and even cheerfulness of many a patient severely incapacitated from multiple sclerosis; this has been called *euphoria sclerotica*.

It has been shown repeatedly that the behavioral symptoms associated with the onset of demyelinating disease run the gamut of neurotic and characterologic nosologic categories.[1, 8, 10] Severe types of personality disintegration, the psychotic reactions, are scarcely mentioned in the literature of multiple sclerosis, except in association with the terminal stages of the illness where there has been considerable brain damage, or occasionally in those acute, fulminating cases which have a precipitous course toward early death. There are, however, sporadic reports of psychotic behavior complicating the course of multiple sclerosis early in the illness. In 1937, Malone[14] reported ten such cases; in three of these, the psychotic behavior anteceded the onset, or perhaps, the detection of neurological symptoms. Malone differentiated between the "primary" symptoms, which he attributed to the result of the organic lesions of the demyelinating process, and the "secondary" or "incidental" symptoms such as confusion, delusions, and hallucinations which depended on the personality and mental make-up of the patient.

Within two years, four patients were admitted to psychiatric hospitals in Topeka, who from referral and upon initial evaluation were thought to be suffering from fairly typical psychotic syndromes and who required the security of locked wards. In these cases, the psychiatric diagnosis was

confirmed, but within a short time, varying from two weeks to six months, each patient showed signs of neurological damage which was subsequently felt to have resulted from multiple sclerosis. A description of these four patients will form the substance of this report.

Case Reports

Case 1. N. R., a 40 year old, married, business-man, was admitted because of bizarre, inappropriate behavior, hyperactivity, and a severe thought disorder. Premorbidly, he was an affable, friendly, retiring man. A predominantly passive, dependent person, he seldom expressed hostility toward anyone. He had entered the family's business ostensibly to fulfill his parents' expectations. About two years prior to his admission, his wife began divorce proceedings because she resented having to make all of the decisions, because of the patient's inefficacy and passivity, and because she wanted to marry another man. The patient's sexual adjustment was never entirely satisfactory, and he had become impotent during the last year of the marriage.

Following the separation, he began consulting a psychiatrist for support and reassurance. While visiting his wife in an effort at reconciliation, he discovered another man in her apartment, and he had a rage reaction, for which he later apologized to everyone and for which he made amends by inviting the other man out to dinner. Shortly after this, his psychiatrist became aware of increasing disorganization in the patient's thought processes and behavior, and recommended immediate admission to a closed psychiatric ward.

The patient's history suggested that he had experienced some weakness and involuntary movements of his right ankle when he was in high school. Also, three and four years before the present illness, he had been admitted to a hospital for two short febrile illnesses suspected to have been encephalitis. There were no apparent sequelae.

On admission, the psychiatric diagnosis of a schizophenic reaction was confirmed clinically and by psychological tests. No evidences of organic impairment of mental functions were noted.

Physical and neurological examinations, however, showed the patient was ataxic. All deep tendon reflexes were hyperactive, more so on the right side. Sustained ankle clonus and a positive Babinski sign were present on the right, and to a lesser extent on the left. All abdominal reflexes were consistently absent. The complement fixation tests for encephalitis were negative. The electroencephalogram suggested a disorder in the left temporal region. The neurologist felt that a diagnosis of multiple sclerosis was indicated. During the course of hospitalization, an increased weakening of the patient's legs with some spasticity occurred; these symptoms subsequently showed a partial remission.

Case 2. K. B., a 30 year old, married bricklayer, was admitted with a history of bizarre behavior, marital discord, and excessive preoccupation with religious matters. Prior to admission his religious ideas seemed to have become frankly

delusional, and he seemed to be responding to hallucinations, when his behavior would become maniacal and combative.

The third of five children, he was reared in a poverty stricken home where, because of his father's inadequacies, his strictly moralistic mother had to run the household on her own earnings. From an early age, the children had to buy their clothing with the funds they could earn from odd jobs.

In school he was shy and retiring, and he had difficulty learning to read. During World War II he was a prisoner of war for about five months. On his way home following an honorable discharge from service, he said he unknowingly became involved with a homosexual while drinking and considered this the greatest sin of his life. He soon re-enlisted, and while abroad had an acute psychotic episode following a minor operation. His hallucinations and thought disorder seemed to have undergone a quick remission, and following his medical discharge he returned home, took training as a mechanic, and married.

About a year prior to his admission, he joined a small, strict, fundamentalistic religious group, and spent all his spare time memorizing Bible quotations. His obsession with religion interfered with his work, and he lost his job. His domestic life also began to suffer, as he became increasingly seclusive and condemning of his wife's worldly interests. On several occasions he experienced visions representing the "fight between heaven and hell." He began suspecting that his food and his body were contaminated by "the odor of the asp," and on one occasion he attempted to injure his landlord, whom he felt to be "the messenger of evil."

A diagnosis of schizophrenic reaction, paranoid type, was made after clinical evaluation and psychological testing. The physical and neurological examination on admission revealed no abnormalities, despite the history of occasional feelings of numbness of his fingers and left calf.

In four months, the patient had improved sufficiently to go home on a trial visit, where he made a marginal adjustment. He returned to the hospital after two months with complaints of paraesthesias on the left side of his body, and ataxia which seemed to have followed a febrile illness. Neurological studies revealed bilateral Babinski signs, increased deep tendon reflexes, intention tremor, asthenia, and nystagmus. He also had some difficulty in voiding. A secondary diagnosis of multiple sclerosis was made.

Since then there have been remissions and exacerbations of the neurological symptoms. His behavior improved to the extent that he has adjusted himself to open ward care with occasional visits home. He does not complain about his physical symptoms but attributes them in various ways to his delusional system.

Case 3. R. D., a 37 year old woman, was referred to the hospital from a diagnostic center with the diagnosis of "psychosis, unknown type." Symptoms included crying, slovenly appearance and habits, and defecating in bed or on the floor. She had been referred because her behavior had become unmanageable and because it was felt she needed electroshock treatments.

An only child, the patient recalled little about her early years, except that then her mother had been bedridden. She described herself as having been timid,

quiet, and terrified of older men. At best an average student in school, she rarely participated in extra-curricular activities or social functions.

At 21 she married the first of her three husbands, all of whom she divorced as she found each to be alcoholic, unfaithful, and irresponsible. She had two children from her third marriage. She said that she had never enjoyed sexual intercourse. The onset of her illness, a year prior to admission, seemed related to difficulties prior to her last divorce.

The patient had been described as an energetic, busy, and enthusiastic housewife and mother. However, with the onset of her illness, she seemed to lose interest in cooking or caring for the house. Her personal appearance began to suffer. She found it difficult to perform her duties because she felt weak and exhausted. One morning she awakened and felt there was something wrong with her vision and "things looked hazy and far away."

She was admitted to the diagnostic ward of a general hospital. Though she spent most of her time in bed, she was soon found lying about on the floor. The patient cried frequently, seemed to become more regressed in her behavior and defecated or urinated on the floor or in bed. She also became overinterested in men patients and created so many management problems that she was transferred to a psychiatric hospital.

On admission, the patient appeared cadaverous from weight loss and asthenia. Hypotonia was noted in all extremities. She spoke with a tremulous tone. Bilateral nystagmus was present. There was an absence of associated movements, rebound phenomena was present in both arms, and abdominal reflexes were absent. Because of the neurological findings and the history, the neurologist made an unequivocal diagnosis of multiple sclerosis. Behaviorally the patient seemed to be suffering from a severe infantile personality with psychotic episodes. It would appear that the neurological symptoms preceded the onset of serious psychiatric symptoms, but that the asthenia, impaired coordination and visual disturbances occurred insidiously. The patient began to fail regularly at tasks which had been previously easy for her. She reacted to her incapacity by making it seem as if she did not care, that she could do things but was not in the mood. In the hospital, the patient frequently made overtures to men despite her physical incapacity. Because of her impulsive tendencies, she required closed ward care.

Case 4. C. G., a 28 year old unemployed mechanic, was committed to the hospital because his parents and wife complained that the patient's behavior was becoming increasingly bizarre, impulsive and threatening and because he was drinking heavily. It was also reported that the patient suffered episodically from delusions and hallucinations during the year preceding his admission.

The patient was the older of two children reared in a strict home in a rural community. The father had never realized his ambition to become a minister and worked as a file clerk away from home, visiting his family only on occasion.

The mother was the dominant figure in the family constellation. A review of the patient's developmental years revealed little information except that he seemed overly dependent on his parents, was fearful of violating their edicts, and that he occasionally rebelled against them covertly. His two years service in the Army during World War II were unremarkable. Following his separation from the service the patient drank a great deal, drifted from one job to another, and lived with his parents. He was married a year after leaving military service, but he and his wife continued to live with relatives and to depend on others for their support. The marital relationship was chaotic, but the wife refused to divorce the patient for religious reasons.

The patient's general behavior became increasingly irresponsible and inappropriate. While drunk he would carry weapons around the house, terrorizing the family. On occasion, while seemingly responding to hallucinations, he would run naked from the house, climb a tree, and describe "giant sheets of flame in the east, destroying the earth."

During the initial evaluation, it was felt the patient was suffering from a paranoid schizophrenic reaction. The physical and neurological examinations were normal. In view of a limp, however, which the patient attributed to an old injury, and in view of his history of heavy drinking, further tests were ordered. The electroencephalographic tracing was normal, the neurologist's examination revealed no neurological disease, but in the psychological testing there was a "suggestion of organic deficit" which was attributed to the effects of alcoholism. A thought disorder suggesting schizophrenic reaction was confirmed by these tests.

The patient did not improve during hospitalization. He received electroshock and insulin coma treatments, participated in the milieu program, but his behavior continued to vacillate. He masturbated openly and his erotomania was of such degree that women personnel had to keep their distance. His speech became progressively thicker, he became incontinent, his limp became more of a stagger, and mental deterioration seemed to be present. Neurological tests and consultations at this point revealed a diffusely abnormal electroencephalogram, multiple foci of central nervous system damage, and unmistakable evidences of organic impairment on repeated psychological tests. The diagnosis of multiple sclerosis with intellectual impairment was made.*

* C. G. has rapidly and progressively deteriorated, behaviorally, intellectually, and physically. He is bed-ridden, totally incontinent, and totally blind (optic atrophy). Because of the devastating course of the illness, one neurologist feels that the diagnosis of multiple sclerosis is untenable, and that the patient probably has a severe form of diffuse sclerosis, possibly Schilder's disease. Some investigators have suggested that Schilder's disease is but a variant of multiple sclerosis. Frequently the differential diagnosis between acute, fulminating multiple sclerosis and diffuse sclerosis or Schilder's disease cannot be made ante mortem.[16]

Discussion

Many reports in recent years, notably those of Harrower,[7, 8] point out that there is no such entity as the "multiple sclerosis personality." Certainly, in the four cases presented in this report, no particular personality type or psychotic syndrome could be discerned which could in any way be considered typical. The patients reported here could not, from psychiatric histories and mental examination, be differentiated from other psychiatric patients on closed wards, whose behavior disturbances were not complicated by multiple sclerosis. Harrower has, however, noted some personality deviations which occur commonly in a large group of patients with multiple sclerosis. Namely, many such patients have been passive-dependent most of their lives; they were significantly less concerned about body symptoms than normal persons, or patients afflicted with poliomyelitis or other incapacitating neurological diseases; they appeared calm, compliant, and apparently free of anxiety; finally patients with multiple sclerosis were cheerful and seemed to have a pleasant outlook on life and their fellow man.[8]

In the four patients presented here, strong passive-dependent strivings were evident in the premorbid personality. For example, all four lived with or were dependent on their parents long after they had reached adulthood and married. The phenomenon of running back to mother was common. Though all patients had married and had children, their marital and sexual adjustments were chaotic. The striking frequency of impotence and frigidity cited by Langworthy[12] in his observations of patients with multiple sclerosis was confirmed in the cases reported here. It might be difficult to assess whether the impotence or frigidity was caused by emotional immaturity or by the disease. However, none of the patients reported here seemed to have ever achieved a good sexual adjustment. With the onset of their illness, things only got worse in this respect. The sexual incapacity of patients with multiple sclerosis is probably contributed to by both organic and psychogenic factors. The first two patients reported seemed to have little if any concern about sexual matters, in a sense employing the mechanism of denial. The latter two seemed to try to overcompensate for their lack of sexual prowess by an inordinate and inappropriate interest in the opposite sex or by the frank erotomania of the fourth patient.

The original title of this study was "Psychotic Episodes Heralding Multiple Sclerosis," but it was felt that it would be incorrect. Though the patients described were admitted for purely psychiatric illnesses and before the diagnosis of neurological disease was made, a careful review of their past medical history suggested in every case that some symptoms possibly referrable to the central nervous system had occurred months and

years before the onset of symptoms of severe mental illness. These early neurological symptoms or "soft-signs" had apparently been transitory or evanescent. *One can only speculate as to whether they were premonitory symptoms of multiple sclerosis.* N. R. (case No. 1) had been admitted twice for brief periods to a general hospital three and four years prior to his psychiatric hospitalization for acute febrile illnesses associated with somnolence, headache, and asthenia. At the time, neurological examination suggested pathology in the central nervous system, and the patient was given a diagnosis of encephalitis. Subsequent complement fixation and agglutination studies revealed no reaction for the commoner forms of encephalitis, however. Furthermore, he gave a history of incapacitating weakness of his right foot and ankle for a period of months while in college; here again no cause had been found.

K. B. (case No. 2) had early in his psychiatric illness, long before hospitalization became necessary, complained of "visual distortions" and "strange odors everywhere" and incorporated these quickly into his delusional system as "visions" and "the odor of the asp." Even when frank paralyses of extremities occurred, these too were attributed to, "They are poisoning the water I drink."

Though R. D.'s (case No. 3) behavioral adjustment was tenuous for many years, she had, nevertheless, carried on reasonably effectively despite many characterologic defects. Decompensation, however, was heralded suddenly by dimness of vision, tiredness, and poor coordination. She rationalized her incapacities by an attitude of "I could do it if I really wanted to, but I don't care to." Her incontinence was initially thought to represent "deterioration" rather than organic dysfunction. She herself contributed to this erroneous impression.

One of the earliest symptoms of C. G. (case No. 4) was seeing flames and bright lights. His description of these flames and lights sounded similar to those seen in organic lesions of the temporoparietal area affecting the optic radiations. The patient possibly elaborated these into the flames that were destroying the earth, the fantasies of world destruction so commonly seen in schizophrenic patients.

This would immediately raise the question of cause and effect, and which came first, the multiple sclerosis or the psychological decompensation. It might well be asked if perhaps in such cases as are reported here, there is not simply a coincidence of two unrelated conditions. This area of thought is beyond the scope of this report. The area is even more complicated inasmuch as we are discussing two kinds of illness in which: (1) there is no clearly understood or generally accepted etiology, (2) no specific syndrome or set of symptoms is typical or characteristic, (3) the course of the disease is capricious and seldom predictable, (4) no specific treatment is known.

Downing[4] has suggested that the rapid and often confusing variations in neurological symptoms early in the course of multiple sclerosis occur because the patient uses conscious cortical control to compensate for a deficit induced by a lesion in the subcortical area whose functions were not previously conscious. However, the cortical control is not "automatic" and is more subject to emotional stress. The course of the demyelinizing process is often slow and insidious. The shift from automatic (subcortical) to higher, conscious (cortical) centers may occur without the patient's awareness. Under emotional pressure, cortical control (possibly cathexis) is withdrawn, and the effect may be similar to putting a tabetic into a dark room.

Summary and Conclusions

Four cases have been presented where patients with psychotic reactions were admitted to psychiatric hospitals and who, it was subsequently found, were concurrently suffering from multiple sclerosis. These patients' psychological illnesses could not be differentiated from those of patients on locked wards whose illnesses were not complicated by neurological disease. The patients reported were not classified into any single type of psychotic reaction in the nomenclature. No correlation could be made, in this series, between type of psychiatric diagnosis, severity and course of psychological incapacity, and the severity and course of the multiple sclerosis. Though no characteristic personality or nosologic type could be drawn, all four patients seemed to have had strong passive dependent patterns, emotional and sexual immaturity, and poor marital relationships. All patients suffered from forms of impotence or frigidity. Associated with the onset of psychiatric illness in all four cases were divorce, separation, or serious consideration of both.

This report re-emphasizes the importance of a careful neurological evaluation of every psychiatric patient, with a careful review of the past medical history. It is recommended that neurological evaluations be repeated regularly if there has been any history of unexplained neurological symptoms, or if certain physical complaints or apparently unimportant neurological findings on initial examination are not specifically accounted for.

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ACTIVITIES AT THE MENNINGER FOUNDATION

In an important development in psychiatric education, Dr. Earl D. Bond became The Menninger Foundation's first Alfred P. Sloan visiting professor in psychiatry. Doctor Bond began his appointment in mid-March. The plan was for him to remain in Topeka for several weeks, spending most of his time meeting informally with individuals and small groups of Fellows in the Menninger School of Psychiatry.

The visiting professorships were established by a grant from the Alfred P. Sloan Foundation. Their purpose is to bring to Topeka, for varying periods of time, men and women of outstanding achievement in psychiatry, in order to enrich the professional education of the physicians studying in the Menninger School of Psychiatry.

In announcing the appointment of the first Sloan professor, Dr. Karl Menninger said, "It is from contact with great individuals and great teachers that the young student is inspired toward great purposes and lofty ideals. I can imagine no one more suited to give this kind of leadership than Doctor Bond. He combines extraordinary breadth and clarity of thinking with an unusual capacity for inspiring others. He will bring to his position a sum of experience which can hardly be matched by any other living American psychiatrist."

Doctor Bond, a former president of the American Psychiatric Association, is now in his 49th year in the profession. During the past 44 years he has been actively associated with Philadelphia's Pennsylvania Hospital, for the past 21 years as its physician-in-chief and as director of training for the University of Pennsylvania Graduate School of Medicine. Doctor Bond is to give several lectures to Fellows in the Menninger School of Psychiatry, including a review of the history of American psychiatry in which he has played so prominent a part. In accordance with the general plan of the Sloan professorships, approximately half his time is available to him for the pursuit of his own research and clinical interests.

* * *

Approximately 150 physicians will be enrolled in the Menninger School of Psychiatry during the school year beginning July 1. Of these, 130 will be resident physicians in Topeka psychiatric hospitals and an additional 20 will be serving interim staff appointments in other institutions in the state of Kansas. Three and a half months before the beginning of the new term, the School's registrar had received more than 420 inquiries from physicians interested in coming to the School. It is planned to accept a total of 47 of these into the incoming class—25 of them to be residents at Winter VA Hospital and 22 at Topeka State Hospital.

The Foundation recently received word from the U. S. Public Health Service that a grant has been awarded to its research project on "Clinical Problems of Thyroid Gland Dysfunction." This study, which uses radio isotope tracer techniques, has been made on a small scale during the past several years by Robert S. Wallerstein, M.D., in association with Philip Holzman, Ph.D.; Richard Siegal, M.A.; Nathaniel Uhr, M.D.; Homer Hiebert, M.D.; Frank Hoecker, Ph.D.; and H. W. Barrett, Ph.D. Doctors Hoecker and Barrett are members of the Department of Biochemistry of the University of Kansas, and Doctor Hiebert is a practicing radiologist in Topeka. The other members of the group are from the staff of The Menninger Foundation.

The project is concerned with a group of patients, recently identified through the use of radioactive-iodine tracer studies, who present the usual "psychoneurotic" complaints symptomatic of Graves' disease, but whose thyroid glands have normal over-all functioning. The tracer studies show, however, that their thyroid glands do have small, localized spots of overactivity called "hot nodules." This phenomenon poses a number of questions, including these, culled from Doctor Wallerstein's initial report on the study: ". . . are these patients in an early and previously undetectable stage of thyroid disease, or do they represent a quite different disease picture which will help explain some illnesses which have hitherto been considered psychological in origin? Are there common factors in the medical, social, and psychological histories of these patients which might provide more definite clues as to the causes and onset of the illness?"

Thus far, an initial group of 15 "hot nodule" patients have been studied by means of psychiatric and psychological tests, in addition to physical examinations and laboratory studies. Plans have been made to undertake similar comprehensive psychiatric, physiological and radiological surveys of the following groups: (1) patients with primarily psychiatric complaints who, on coming for psychiatric evaluation, present personality features in common with the hot nodule patients, (2) patients with primarily somatic complaints who have similar medical histories to those of the hot nodule patients but no suspicion as yet of thyroid gland dysfunction, (3) patients with clear-cut hyperthyroidism, and (4) a symptom-free control group to assess the incidence of hot nodules in the normal population.

* * *

In February, the Foundation's Division of Industrial Mental Health held its second seminar, "Toward Understanding Men," for business executives. Approximately 22 presidents and vice-presidents of major U. S. companies participated in the week-long program. In March a similar program, also under the leadership of Dr. Harry Levinson, was held for a group of 22 industrial physicians. It is planned to continue these programs annually.

BOOK NOTICES

The Psychological Basis of Education. By E. A. PEEL. $6. Pp. 303. New York, Philosophical Library, 1956.

Although the author shows an admirable erudition, this book consists of sorties into psychological theories which are too diverse to provide any unity. In discussing learning theory, the author picks and chooses from Hull, Tolman, and Gestalt theories. While "personality" is discussed as if all an individual possessed was an intelligence quotient, the "structure of the mind" consists of linear combinations found by factor analysis. And the teacher is to explain "emotional life" by innate "propensities" and Kretschmerian somatotypes. It is difficult to see what the student of education can obtain from this book other than confusion. (Charles M. Solley, Ph.D.)

Psychoanalysis of Behavior. By SANDOR RADO. $7.75. Pp. 387. New York, Grune & Stratton, 1956.

Rado's collected papers are here divided into (a) contributions to classical psychodynamics, (b) the quest for a basic conceptual scheme, (c) the development of adaptational psychodynamics. The considerable change in content, concepts and tone as the author moves from classical to adaptational psychodynamics is epitomized in his statement (p. 123) that "psychoanalysis has advanced the psychiatrist towards the attainment of his foremost goal, that of being the efficiency engineer of the human mind." Rado combines some features of psychoanalysis with Cannon's concept of emergency behavior with considerable sacrifice of basic psychoanalytic theory. Instinct theory is well-nigh denied; ego psychology is grossly neglected, the distinction between the pleasure principle and the reality principle is made light of in the global concept of "hedonic control," seen as a supreme organismic principle. The critical tone against Freud increases as one reads on. Perhaps there is some loss when psychiatrists become efficiency engineers. (Paul W. Pruyser, Ph.D.)

Essentials of Psychology. By WERNER WOLFF. $6.50. Pp. 385. New York, Grune & Stratton, 1956.

By presenting interrelationships among data, this introductory textbook aims to give students new viewpoints about men rather than about mechanisms. It is correspondingly heavily weighted in the area of clinical psychology. However, the wide range of concepts covered within a modest number of pages makes the problem of synthesis a staggering one. One might paraphrase the author's criticism of psychoanalytic theorizing (p. 331): "The basic fallacy of this, along with many introductory texts, is their oversimplification on the one hand, their overcomplication on the other hand, and their overgeneralization in both respects." (Gerard Haigh, Ph.D.)

Psychology General—Industrial—Social. By JOHN MUNRO FRASER. $7.50. Pp. 310. New York, Philosophical Library, 1956.

Though it was intended as an introduction to general psychology for executives, there is no mention in this book of the unconscious in the dis-

cussion of motivation. No mention is made of Kurt Lewin's work, despite its importance in contemporary social psychology. "The complete personality," mechanistically viewed, is covered in fifteen pages. (Harry Levinson, Ph.D.)

Physique and Delinquency. By SHELDON and ELEANOR GLUECK. $6. Pp. 339. New York, Harper, 1956.

In the painstaking and step by step fashion of a "whodunit," the authors analyze their data and come up with many surprising findings. This book is a must for the many people who still continue to seek for one single magical cure for the delinquency problem. (Povl W. Toussieng, M.D.)

Psychotherapy and Culture Conflict. By GEORGENE SEWARD. $6. Pp. 299. New York, Ronald Press, 1956.

The importance of a comprehensive understanding of "cultural" factors in psychotherapeutic work is illustrated by four clinical case histories of individuals representing various "sub-cultures"; a professional person of lower class origins, a Negro musician, a female woman hater (considering women as representing a cultural "minority"), and a Jewish "Fascist." Unfortunately, the book advances this point of view as reflecting the "new look" in psychoanalysis, introduced by the "neo-Freudians," and presumably slighted by classical psychoanalysis. The theoretical sections all suffer from this bias. (Robert S. Wallerstein, M.D.)

For Husbands and Wives. By PAUL H. LANDIS. $3.95. Pp. 260. New York, Appleton-Century-Crofts, 1956.

No new contribution to the field of marriage and family relationships is made in this volume which is a sort of sketchy review of much of the material that is already available in other good sources. For couples not getting along together, the material is too general and too documented from sociological and Kinsey studies to be widely helpful. (Robert G. Foster, Ph.D.)

Dynamic Psychiatry in Simple Terms. By R. R. MEZER. $2.50. Pp. 174. New York, Springer, 1956.

It takes considerable courage to write a text of dynamic psychiatry in simple terms. It takes wisdom and humility of some readers to realize that they have obtained a dangerous half-truth; it will take considerable unlearning on the part of others who would like to know more about dynamic psychiatry. (Paul W. Pruyser, Ph.D.)

Suicide and Homicide. By ANDREW F. HENRY and JAMES F. SHORT, JR. $4. Pp. 214. Glencoe, Ill., Free Press, 1954.

This study examines the phenomena of suicide and homicide in their correlation with sociological variables and economic factors, and from these relationships attempts to study some of the economic, sociological, and psychological aspects of aggression. Correlations are made between suicide and homicide, on the one hand, and age, sex, race, income, location, and variables in the business cycle, on the other. From these correlations, the authors make assumptions and postulates—some of them questionable—regarding the aggressive meaning of homicide and suicide, and then try to validate these assumptions by further correlations. The statistics are interesting. The inadequacy of the study is most obvious in the section

where it examines the psychological aspects of aggression on the basis of statistical data. (Joseph Satten, M.D.)

Manual of Child Psychology. LEONARD CARMICHAEL, ed. $12. Pp. 1295. New York, Wiley & Sons, 1954.

Each of 19 chapters in an encyclopedic compendium of research in this field, attempts to give a definitive survey of its area of research up to the time of writing. Analysts and psychiatrists would find useful not only the first six chapters, which have rich material on infant equipment and learning in infancy, but other chapters, *i.e.*, on language development, and on emotional development. That the book is tragically lacking in a psychodynamic orientation and even in any consistent cultural orientation (Margaret Mead's chapter might have been completely unknown to the rest of the authors) does not exempt us from the responsibility to be acquainted with the documentation of such conclusions on the capacity of the neonate to learn by conditioning, and the individual differences in sensory thresholds in early infancy. An extensive index makes the book more manageable than its nearly 1300 pages would otherwise lead one to expect. (Lois B. Murphy, Ph.D.)

Psychiatry in General Hospitals. By A. E. BENNETT, E. A. HARGROVE and BERNICE ENGLE, eds. $4. Pp. 178. Berkeley, University of California, 1956.

The authors have written an interesting, concise and informative book about operating a psychiatric ward in a general hospital, basing their information on their own experience and on a survey of psychiatric units in United States and Canadian hospitals. Among several chapters contributed by authorities, Dr. Ewen Cameron's The Day Hospital is outstanding. The authors state that unavailability of competent personnel is a major obstacle in efficient operation of psychiatric departments. They advocate training programs in every psychiatric department, but are too sanguine about the problem and fail to stress sufficiently the connection between providing good training programs and securing adequate numbers of a well-trained staff. Proper staffing of our present psychiatric hospitals is difficult enough; to properly staff a large number of psychiatric units in general hospitals seems almost an impossibility now. (Irving Kartus, M.D.)

The Doctor and the Soul. By VIKTOR E. FRANKL. $4. Pp. 280. New York, Knopf, 1955.

This book was originally published by Deuticke in 1952. The jacket quotes various people to the effect that this is extraordinary, epochmaking, a step forward, and so on. I do not agree! It is a running reproach to some medical men for not being more spiritual or more concerned with nonmedical facts about their patients, but it is singularly cavalier in regard to psychoanalysis and completely silent regarding the medical ministry of many general practitioners who have been doing what the author describes for a long time. (K. A. M.)

Principles of Psychological Examining. By FREDERICK C. THORNE. $6. Pp. 494. Brandon, Vermont, Journal of Clinical Psychology, 1955.

It is not necessary to agree with Thorne's preference for eclecticism, basic science and factor analysis to describe this as a thorough, systematic

and broad textbook. It is singularly unphilosophical in its treatment of many thorny problems, but even this can be refreshing at times. It deserves a place on desk or shelf as a corrective for many partisan or just very original books, but in turn, needs the greater inspiration often found in the latter. (Paul W. Pruyser, Ph.D.)

Alcoholism. George N. Thompson, ed. $9.50. Pp. 548. Springfield, Ill., Charles C Thomas, 1956.

Written by eleven specialists primarily for physicians and interested laymen, this book purports to cover all aspects of alcoholism: public health, social, pharmacologic, physiologic, medical, neurologic and psychiatric. The author terms the book a condensed monograph. The most comprehensive and informative sections are those dealing with public health and social aspects, the pharmacology of alcohol, and alcohol and brain physiology (including an excellent discussion of Antabuse). Fifty pages each are devoted to the effects of alcohol, and to the electroencephalogram. The chief author and editor contributes a chapter of thirty pages entitled "The Psychiatry of Alcoholism." (Nathaniel Uhr, M.D.)

Mental Health and Mental Disorder. By Arnold M. Rose. $6.50. Pp. 626. New York, Norton, 1955.

Contributions to this collection of 38 articles were made by Members of the Society for the Study of Social Problems which was organized in 1951. The attempt is to look at mental health and illness from the point of view of a multidisciplined sociological approach. The articles are well written and have a stimulating fresh approach to some old familiar problems. (Clark Case, M.D.)

A Study of Abortion in Primitive Societies. By George Devereux. $6.50. Pp. 394. New York, Julian Press, 1955.

This is an exhaustive anthropological study of the frequency, technique, attitudes toward, and implied meaning of abortion in some 400 primitive societes, with an extensive bibliography. With this material the author further documents the universal validity of psychoanalysis as a general psychology of man rather than of occidental bourgeoise. (K. A. M.)

A Guide For the Study of Exceptional Children. By Willard Abraham. $3.50. Pp. 276. Boston, Porter Sargent, 1956.

This is a practical handbook for parents and teachers who wish to develop workshops and study groups in a community to help lay groups understand the needs of exceptional children of a wide variety, and to guide them to the resources of the community and elsewhere for helping them. It includes bibliographies for different groups, outlines for collecting needed information and other practical helps. It does not attempt to explain or to interpret the causes of these difficulties. (Lois B. Murphy, Ph.D.)

Psychoanalysis and Ethics. By Lewis Samuel Feuer. $4. Pp. 160. Springfield, Ill., Charles C Thomas, 1955.

Professor Feuer of the University of Vermont undertakes the examination of ethical implications of psychoanalysis and Freud's "philosophy."

The subject is recondite enough and the author's style is somewhat involved, so this reviewer is not quite sure what he has read. The author says that "good" can only be psychoanalyzed, not logically defined, by which he presumably means that the concept of good held by a particular individual can be arrived at by psychoanalytic study of that individual. He believes Freud underestimated fratricide as compared to patricide and feels that this distorted Freud's theory of civilization, which Feuer calls a "philosophy of civilization." (K. A. M.)

Judaism and Psychiatry. Simon Noveck, ed. $3.75. Pp. 197. New York, Basic Books, 1956.

This book which arose out of semi-popular lectures follows a plan whereby a psychiatrist and a religionist (both Jewish, we assume) give their comments on a series of problems such as: conscience and guilt, fear and anxiety, depression, self-acceptance and grief. A second part pursues in single papers the psychological values of Judaism. A third part asks whether Judaism and psychiatry can meet and gives some answers. As with other books-of-many-authors, the reader is forced into an evaluative role; he is tempted to applaud one chapter and scorn another and at the end he feels a little guilty while his questions have not been sufficiently answered or clarified. (Paul W. Pruyser, Ph.D.)

Epilepsy and the Law. By Roscoe L. Barrow and Howard D. Fabing. $5.50. Pp. 177. New York, Hoeber-Harper, 1956.

This short, lucid report, subtitled "A Proposal for Legal Reform in the Light of Medical Progress" was written under the auspices of the Special Committee on Legislation of the American League against Epilepsy by a neurologist and a lawyer. It is a highly valuable reference book because it contains, in text and cross-indexed, the laws of each of the United States in relation to epileptics—specifically, laws pertaining to marriage, sterilization, employment and drivers' licensure. Not only are the laws given, but the authors found out how the laws are administered and enforced. In addition, the book is a well-written "indignation" report which should help to remove the legislative stigmata from the epileptic. (William M. Balfour, M.D.)

Mother-Daughter Relationships and Social Behavior. By Rose Cooper Thomas. $4. Pp. 382. Washington, D.C., Catholic Univ. of Am. Press, 1955.

This dissertation for the Ph.D. degree of Social Work brings an excellent and valuable contribution to the study of the psychogenesis of schizophrenia. The author chose as a study group all 18 to 30 year old, colored women committed in the years 1949–1951 in St. Elizabeth's Hospital with the diagnosis of schizophrenia, provided that they had been reared by their mother and had a nonpsychotic sister. Patterns of mother-daughter relationships in regard to the patient and her nonpsychotic sister were thoroughly investigated, as well as the mother's relationship to her own mother. The main finding was the patient's mother's admission that she had rejected her (later schizophrenic) daughter from the time of her birth. Many other important factors were elucidated in a convincing way. (Henri Ellenberger, M.D.)

Metabolic and Toxic Diseases of the Nervous System. Proceedings of Assn. for Research in Nervous & Mental Disease. H. HOUSTON MERRITT and CLARENCE C. HARE, eds. $10. Pp. 604. Baltimore, Williams & Wilkins, 1953.

This volume of the proceedings of the Association for Research in Nervous and Mental Disease maintains the consistently high standards of this Association's meetings. Excellent new material is presented on the changes provoked in the nervous system by alcohol, organic solvents, heavy metals, general anesthesia, disorders of carbohydrate metabolism, disorders of lipide metabolism, disorders of liver function, nervous system changes associated with abnormalities in endocrine gland function, and the nervous system reactions to physical agents, such as, excessive cold, excessive heat and ionizing radiation. Excellent bibliographies accompany each of the individual articles. (D. B. Foster, M.D.)

Understanding and Counseling the Alcoholic. By HOWARD J. CLINEBELL, JR. $3.75. Pp. 252. New York, Abingdon, 1956.

A Methodist minister discusses his understanding of alcoholism, reviews some religious approaches to it, and outlines the minister's approach to it. Material is drawn from "Yale-type" studies, historical research into such movements as the 19th century American abstinence groups, and from the author's questionnaire and interview research with an apparently uncontrolled sample of alcoholics. The volume has potential value for the clergyman seeking a cursory review of the basic historic, ethical, and psychological aspects of alcoholism. Other professional readers may find disturbing the author's easy distortion and dismissal of the "orthodox psychoanalytic hypothesis." Several rich chapters deal with the religious "rescue mission," the evolving program of the Salvation Army, and a historic sidelight on the Emmanuel movement—a pioneering venture of cooperation between religion and medicine. (Chaplain Thomas W. Klink)

Expert Committee on Drugs Liable to Produce Addiction. Fifth Report. Price, 30¢ Pp. 16. Geneva, Switzerland, World Health Organization, 1955.

In addition to reports on special problems in drug addiction, this report contains information regarding the addiction potential of morphine, Narcotine, and synthetic substances of various kinds. (Vesta Walker)

Personality in a Communal Society. By BERT KAPLAN and THOMAS F. A. PLAUT. $3.25. Pp. 116. Lawrence, Kans., University of Kansas Press, 1956.

The Hutterites have been subject to several recent social studies, part of which was aimed at settling a claim that the people of this isolated and tightly organized group were relatively free from major forms of mental illness. Several preliminary papers and lectures cast serious doubt on this claim; the present book sets forth the findings of personality studies within the group and concludes that "the Hutterites have not, over the last four centuries, developed personality characteristics which harmonize with the social pattern to such an extent that mental health problems are either minimal or completely eliminated." (Paul W. Pruyser, Ph.D.)

Alcoholism: Its Psychology and Cure. By FREDRICK B. REA. $3.50. Pp. 143. New York, Philosophical Library, 1956.

The author begins with the proposition that alcoholism is, in most cases, the result of sin, though he acknowledges that it represents a phase at which drinking has become a disease. He ascribes the success of Alcoholics Anonymous as a therapeutic force to its agreement with this concept. "Although Alcoholics Anonymous talks of alcoholism as a disease, it regards the disease as having spiritual and moral, rather than merely physical causation." Treatment is a conversion experience, induced by Alcoholics Anonymous, leading to a new center of personality reintegration in God, since "addiction . . . . is not simply a psychological disease; it is a spiritual disease, a malady of the soul." (Robert S. Wallerstein, M.D.)

The Analysis of Fantasy. By WILLIAM E. HENRY. $6. Pp. 305. New York, Wiley, 1956.

Professor Henry clearly presents the inference process by which he moves from projective test data (stories told about the TAT cards) to psychodynamic descriptions of persons. This explicit formulation of the birth and development of "clinical" judgments is a valuable contribution toward the improved use and eventual validation of projective tests in personality assessment. Henry separately describes the characteristics of the TAT cards and the content and form variables of the stories told. He analyzes interaction between card and story variables to make interpretations about personality, illustrating his method with many test records and excerpts. The focus upon normal personality provides the clinician with a much needed baseline for evaluating the deviations customarily encountered. A comprehensive bibliography adds value to this book. (Gerard Haigh, Ph.D.)

Caring for the Sick Child at Home. By MARION LOWNDES. $3. Pp. 157. Philadelphia, Westminster, 1955.

Most mothers will know or be able to find in various places the information contained in this book; but here it is, interestingly written, and between two covers. It covers all aspects of home care for the sick child, from actual nursing procedures to games or other diversions. The book will be worth its cost for four chapters alone: one on communicable diseases (chapter five) in which the salient facts about childhood diseases are outlined; chapter seven on "Recreations" and the last two chapters on "Safe Conduct" and "Emergency Measures." (Ruth P. Lewis, M.D.)

Clinical Studies of Personality. ARTHUR BURTON and ROBERT E. HARRIS, eds. $6. Pp. 836. New York, Harpers, 1955.

Thirty-four case reports are presented, written by authors with a variety of points of view. The reports are based upon standard and experimental test procedures as well as interview and clinical history data. The cases span the range of personality disorders in adults, reactions due to brain damage, mental retardation, personality disorders in children and some

studies of "normal" persons. Because of the variation in approach and the highly selective presentation of clinical data and test findings, this book should be useful to the advanced student, teacher or practitioner and to these it is highly recommended for the sampling it affords of practice and points of view in the field today. (Herbert J. Schlesinger, Ph.D.)

Clinical Training for Pastoral Care. By DAVID BELGUM. $3. Pp. 136. Philadelphia, Westminster, 1956.

The title of this book is the title of a book that should be written. The clinical pastoral training movement has brought to theological education the experience of supervised clinical work, long a commonplace in medical education. Unfortunately this book mostly implies, by its examples, that clinical pastoral training is offered pre-eminently in general medical and surgical hospitals thus ignoring the older and perhaps more fundamental experience in psychiatric and correctional institutions. Although the main-current in clinical pastoral training has increasingly emphasized the experiential qualities of training, this book reflects only the teaching of skills and techniques. The relevance of clinical pastoral training to the religious goals of theological education are overlooked. Even when a helpful concept is dealt with, as in the chapter on "The Health Team," its value is vitiated by a pre-eminent concern for the status of various professions rather than as a dynamic focus of continuing communication. (Chaplain Thomas W. Klink)

Culture, Psychiatry, and Human Values. By MARVIN K. OPLER. $6. Pp. 242. Springfield, Ill., Charles C Thomas, 1956.

This purports to be a summary of findings from psychiatry and the social sciences concerning the relationship of mental illness to social and cultural factors. Certainly such a discussion would be most useful; unfortunately, Opler presents instead a series of references (poorly annotated!) to studies in and around the field of social psychiatry, with no clear focus on the problem he sets himself. No one doubts that mental health and mental illness are relative to social and cultural context, but this seems the only point made in the discussion. (Charlton Price)

Cybernetics: Transactions of the Tenth Conference. HEINZ VON FOERSTER, ed. $2.75. Pp. 100. New York, Josiah Macy, Jr. Foundation, 1955.

This latest volume of Transactions contains three papers, "Studies on Activity of the Brain" by W. Grey-Walter, "Semantic Information and Its Measures" by Y. Bar-Hillel and "Meaning in Language and How it is Acquired" by Yuen Ren Chao. Unlike the previous Transactions, the present volume lacks the verbatim recording of the actual discussions. An appendix provides a summary of the points of agreement reached in the previous nine conferences. Those who have kept up with movements toward the unity of science will want to read this latest volume. (Herbert J. Schlesinger, Ph.D.)

Energy and Structure in Psychoanalysis. By KENNETH MARK COLBY. $4.50. Pp. 154. New York, Ronald Press, 1955.

The author of this remarkable book subjects current metapsychological theory to such a severe but often sound criticism that the outcome of his critical investigations might well have discouraged his starting on a new metapsychological adventure. The contrary is true. Starting from the valuable insight that drive energy cannot produce the drive aims and that only when specific structural elements are added as being activated by cathexis energy can one begin to speak of drive aims or drive objects, the author attempts to relate theories of psychic energy to theories of psychic structure. This results in the construction of a "cyclic circular model of the psychic apparatus" to replace Freud's tri-partite model. One can differ in opinion on the value of this construction, but this does not diminish the merit of this stimulating book. (H. G. van der Waals, M.D.)

Existence and Therapy. By ULRICH SONNEMANN. $5. Pp. 372. New York, Grune & Stratton, 1954.

Among the newer psychiatric trends, few are as difficult to expound as phenomenology and existential analysis. Sonnemann, who undertook this Herculean task, displays scholarship and considerable knowledge of the subject. Unfortunately, he did not draw a clear line of separation between existentialist *philosophy*, and the *clinical* use of phenomenological and existential concepts for psychopathological research; the reader risks being puzzled, if he is not already acquainted with these researches. (Henri Ellenberger, M.D.)

Facts of Life for Children. ADIE SUEHSDORF, ed. $2.75. Pp. 96. Indianapolis, Bobbs-Merrill, 1955.

Briefly and clearly answered are questions about sex which might be (and are) asked by children ranging from the early years to adolescence. The answers are not meant to be comprehensive but rather to serve as a guide to a way of answering such questions. Thus, sex does not become a "special problem" to be dealt with by "a little talk." Rather it is dealt with as one of the many factors that enter into the entire pattern of development and growth of every child. Eight pages of diagrams entitled "The Facts of Life Illustrated" match the simply and lucidly written text. It is highly recommended to parents and teachers. (Ruth P. Lewis, M.D.)

Final Contributions to the Problems and Methods of Psychoanalysis. By SANDOR FERENCZI, Michael Balint, ed. $6.50. Pp. 447. New York, Basic Books, 1955.

The work of Sandor Ferenczi has been recognized as one of the corner pillars on which the theory and technique of psychoanalysis were established. All Ferenczi's important contributions become available in the English language with the publication of this volume. It contains a wide variety of long and short, abstract and concrete, generally acceptable and hotly controversial articles, topics and views. Papers run from many pages on such important problems as the "Elasticity of Psychoanalytic Technique," to only a few lines on "Cure Finishing" or "Lamaism and Yogi," or just a heading for quotations from Omar El Khayyam, Goethe or Brantome. These "final contributions" provide intimate, fresh and thought provoking ideas, however too unrestrained or even shaking they may seem. (Ishak Ramzy, Ph.D.)

A New Psychotherapy in Schizophrenia. By MARGUERITE SECHEHAYE. $4.50. Pp. 199. New York, Grune and Stratton, 1956.

In these stimulating lectures to the staff of the Burgholzli Clinic, famous for its investigations of schizophrenia, the author attempts a systematic discussion of her treatment method of symbolic realization for which the cure of Reneé serves as a model. Symbolic realization and pre-symbolic magic, actually interventions on fusion or symbiotic levels of adjustment, are described against the background of schizophrenic experience and thinking. In addition to psychoanalysis, the author relies on Piaget's thinking and the contributions of phenomenologists and existentialists. Of the many American contributions during the last ten years, she quotes only Rosen, and of European ones she does not seem to know of Schwing and Federn. (Rudolf Ekstein, Ph.D.)

The Jewish Sect of Qumran and the Essenes. By A. DUPONT-SOMMER. $2.50. Pp. 195. New York, Macmillan, 1955.

Dupont-Sommer, the energetic ex-priest who is "director of studies" at one of the schools of the University of Paris, has written several books on the Dead Sea Scrolls. This new one, "The Jewish Sect of Qumran and the Essenes," is a translation from the French by the Deputy Keeper of the Egyptian and Assyrian Antiquities in the British Museum. It reports the history and teachings of the order and the monastery. The most interesting part to me was the doctrine of the two spirits which Dupont-Sommer seems to definitely connect with the Zoroastrian (Persian) influence. Most of this book is quite intelligible to the average layman. (K. A. M.)

Every Other Bed. By MIKE GORMAN. $4. Pp. 318. Cleveland, World, 1956.

Mr. Gorman has a lively way of presenting facts and figures and has made this book length "fact sheet" into quite compelling reading. He does not hesitate to take sides and this fact accounts for the best things in the book—as when he is pointing out some of the frustrations encountered in trying to secure passage of adequate mental health legislation—and some of the worst—as when he takes up a cudgel against psychoanalytic psychiatrists and any others who do not think the new drugs are the complete answer to the problem of mental illness. Despite its weakness, it is a valuable handbook to be included in the armamentarium of anyone who must speak or write frequently for lay audiences. (Donald Lawder, Jr.)

NOTICE

A cumulative index of authors, subjects, and book notices in volumes thirteen through twenty of the *Bulletin* is now available for $1. Also available for $1 is an index of the first twelve volumes. Together the indexes cover the years 1936 through 1956. Please address orders to the *Bulletin of the Menninger Clinic*, The Menninger Foundation, Topeka, Kansas.