BULLETIN of the MENNINGER CLINIC

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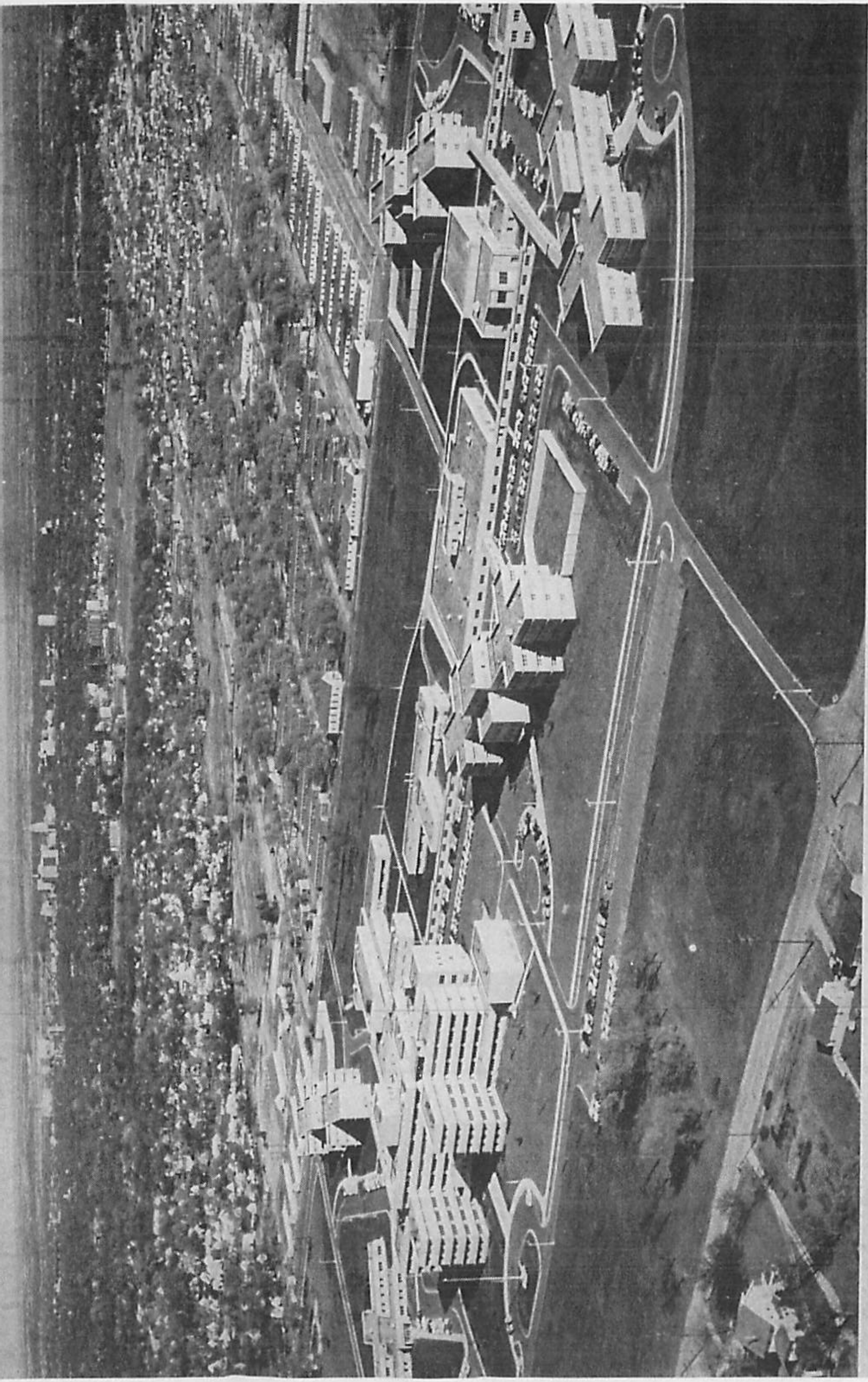

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THE NEW TOPEKA VETERANS ADMINISTRATION HOSPITAL

A new thousand-bed hospital was dedicated by the Veterans Administration on August 24, 1958 in Topeka, Kansas. The dedication was made by Mr. Sumner Whittier, Administrator of Veterans Affairs, Washington, D. C. and the ceremonies were conducted by Mr. David Neiswanger. Among participants in the program were Dr. Roderick G. St. Pierre, Manager of the hospital, Dr. William S. Middleton, Chief Medical Director of the Veterans Administration, Senator Frank Carlson of Kansas, and Dr. Karl Menninger, Chairman of the Medical Advisory Committee of the hospital.

The 21 million dollar hospital is located on a 150-acre tract in the southwest residential area of Topeka. The 21 concrete and brick buildings replace temporary structures built for an Army hospital in 1942 and used since 1946 by the Veterans Administration.

The design of the new hospital is unique in that its unit system permits a patient to remain on one service throughout his hospitalization, but with full access to all of the other available services that he may require. The Psychiatric Service is composed of four units, one for geriatric patients, two for men and one for women patients. Each unit is staffed with psychiatrists, psychologists, social workers, nurses, aides and adjunctive therapists. Other services include Physical Medicine and Rehabilitation, Neurology, Surgery, General Medicine, and there are

The frontispiece is an aerial photograph showing (1) in the foreground, the new hospital (2) in the middle distance, the old Veterans Administration hospital (3) in the far middle distance, Washburn University of Topeka and (4) in the far distance, the state Capitol and downtown buildings.

active units of psychosomatic medicine and neurosurgery. The services are supplemented by laboratories which feature the most modern equipment and include a pharmacy and laboratories for dentistry and medical illustrations.

To provide for the care of a maximum of 783 psychiatric, 78 neurological and 150 general medical and surgical patients, there are approximately 1,100 full-time employees, a large number of consulting physicians, and 450 volunteers who work on a regular schedule. A VA Mental Hygiene Clinic is located on the hospital grounds and provides additional services for outpatients.

The hospital is widely known as a psychiatric training center. A three-year residency program in psychiatry is conducted in affiliation with The Menninger Foundation and under the guidance of a Medical Advisory Committee. All psychiatric residents hold concomitant appointments as Fellows of the Menninger School of Psychiatry.

To extend the residents' experience, the Topeka VA Hospital collaborates with the Topeka State Hospital, the C. F. Menninger Memorial Hospital, the University of Kansas, Washburn University, the Boys' Industrial School, the Shawnee Guidance Center, the Kansas Treatment Center for Children and the Menninger Clinic's Southard School for Children. More than 440 physicians have received training in the psychiatric residency training program since its inception and approval in 1946. An approved one-year residency program is offered in neurology. Specialized training programs are conducted for graduate students of clinical psychology, psychiatric social work, occupational therapy and music therapy. A continuous in-service program is maintained.

DEDICATION

August 24, 1958

By SUMNER G. WHITTIER

We are here to dedicate this fine new Topeka Veterans Administration Hospital.

It is difficult to participate in these ceremonies without a quickening of the heart. What a satisfying group of buildings these are! The best that experts in hospital construction could build. Nearly a thousand

beds. A medical team, offering individual sympathetic attention so helpful toward the recovery of the mentally ill.

A well-integrated group of 21 separate buildings. Up-to-date facilities. The latest equipment. Classrooms for a psychiatric teaching program—a program which, in the 12 years preceding today's ceremonies, trained some 400 young psychiatrists. A teaching program, it may be added, that has earned an international reputation for the best there is in psychiatry.

And underlying it all, the most fortunate kind of foundation. To give it its full name, The Menninger Foundation. The Veterans Administration and the Foundation are old friends.

Back in 1946, we had to take over the Army's Winter General Hospital in something of a hurry. We had to convert it to a new use, with a desperately needed psychiatric training program. We had to train psychiatric residents, psychologists, and nurses and do it with all possible speed.

The Menninger Foundation came to our aid. A psychiatric training program was established. Under the watchful eye of Dr. Karl Menninger a distinguished faculty was brought together. During the first year more than 100 psychiatric residents came into training.

I hope you will pardon this brief dip into the recent past. I wanted to make it clear how happy a relationship all this has been—the "togetherness" of the Foundation and the Veterans Administration.

This new VA hospital, as you know, will be concerned primarily with the care of mentally ill veterans. It will give the closest of attention to what is now America's number one health problem—mental illness.

We of the Veterans Administration are proud that the psychiatric care that will be provided in this newest VA hospital ranks with the best in the world. We are proud that ours is a medically cooperative effort. We work hand-in-hand with the medical profession. Every advance our VA medical research is fortunate enough to achieve, we gladly share with the physicians of America.

I have mentioned the architectural skill that has gone into the making of these beautiful new hospital buildings. But were construction all that goes into the making of a VA hospital, we should have little more today than an attractive assemblage of steel, brick, stone and mortar. The same holds true for our whole vast VA medical structure. It is what we really have in mind when we say: "Department of Medicine and Surgery."

True, we do mean buildings. But we mean also doctors, nurses, technicians—the best to be found. We mean modern teaching programs.

We mean up-to-the-minute medical research. We mean our whole wonderful system of "togetherness" that links in close professional association our VA hospitals and the leading medical schools of the nation. We mean our "share and share alike" system of passing along every new technique—every new discovery—every new "break-through" on a medical frontier, so that ultimately our VA Department of Medicine and Surgery provides benefits not only for veterans, but for the United States, and the entire world.

This new Topeka hospital, marvelous though it be, is but one detail of a tremendous medical picture. Let me fill in that picture, just briefly.

Hospitals—172. Domiciliaries—17. Our clinics, as of today—99. Our average daily patient load during the past fiscal year—114,600. Total number of veterans treated in our clinics or by their own hometown private physicians during a single year—more than 2,000,000. Number of full-time professional personnel in our VA medical system—I mean doctors, dentists and nurses—almost 20,000. Number of physicians participating in our Hometown Medical Program—38,000.

I mention these things because I want to let you see not only the structure, but what animates the structure—what gives it life and significance.

But even this modern—new—Topeka hospital, staffed with able and trained workers, operating with a well-integrated medical team, is still not sufficient for the full purpose we intend. One more indispensable element is needed.

We must have the help of *volunteers*. They must come to this fine new hospital from your own community. Only you can bring into our hospital the encouragement, the fellowship, the warmly intimate feeling of "home" that means so much to a patient starved for just such a visit, just such a visitor.

Some of you here today are members of VA Voluntary Service. I hope many more of you will find out for yourselves how richly rewarding voluntary service in a VA hospital can be.

We are dedicating this Topeka VA Hospital on a Sunday, and for a reason. All new VA hospitals are dedicated on a Sunday. We do it to remind ourselves that in healing, man can go only so far. We do it to remind ourselves of the Great Power above, who decrees life and death, sickness and health. We do it to call upon the Lord's blessed help in speeding the recovery of the sick and distressed.

Healing of the spirit is very often an accompaniment to the healing of the body. The prayers, the fellowship, the warmly human sympathy brought into our hospitals by our chaplains cannot be measured as you would measure the various ingredients that go into a doctor's prescription. And yet the healing of the sick has ever been an essential element of the great religions of this world.

We have learned that one of the prime requisites in getting well is *wanting* to get well. The courage, the patience, the good humored outlook, the cooperation, that help get a patient out of bed and on his feet, are distilled very often from an inner peace of mind that had its origin in the visit of a VA chaplain to the bedside of a depressed and unhappy person.

May the power of the spirit continue to operate in that manner in this new VA hospital.

I know you good people will, as you have in the past, think of this VA hospital as your hospital. Think of it as a proud landmark. Think of it as the symbol on your skyline of an opportunity for service to others. Think of it as a challenge to the best impulses within you. Your visits—your words of comfort and cheer—the assistance you render—the hope you bring—the happy memories that remain after your visits—all these are truly welcome.

And now it becomes my pleasant duty to present this Official Dedication Certificate to the Manager of this Topeka VA Hospital, Doctor Roderick G. St. Pierre, and to solemnly repose in him the responsibility for carrying on the work of healing the sick in mind and heart who enter these doors.

DR. RODERICK G. ST. PIERRE replied:

"In accepting the responsibilities of administering this magnificent hospital, the staff rededicates itself to rendering the finest medical care possible for those entrusted to our care with full respect for the dignity of man and with the purpose of improving our knowledge and skill to the end that we may contribute this knowledge for the benefit of society at large in alleviating illness and suffering of mankind."

DR. KARL MENNINGER concluded the dedication with these words:

"One hundred years ago, the spot upon which we are now standing was a vast, unbroken, grassy wilderness. So it had been for a thousand years. Then, suddenly, a tide of human beings began to flow over it. A farm, a dairy, a cluster of homes, and then a rambling collection of wooden buildings, with trees and flowers and roads, grew up here near a town that had become the capital city.

"In those buildings many sufferers were healed, many people were trained to heal others. Today we are looking at a new home for this not-so-very old hospital, one which many people and groups of people have worked for, and waited for, and hoped for.

"It is an integral unit in two large systems; one, the great chain of VA hospitals stretching across the country, the other a federation of psychiatric clinics and hospitals—city, county, state, private and federal —working together in this area toward a single purpose, the war against mental illness.

"In this continuing fight is enlisted the most intelligent, psychiatrically informed and appreciative citizenry in the world. Included in this are our mayor, our city and county and state officials, our senators, representatives, legislators and governor. But behind them and supporting them is the mass of the people, the people who pay the taxes, and pay them gladly. They know for what the money is being spent. Many of them have worked in these hospitals, paid or unpaid; many more have been treated in these hospitals. This hospital, like the others, belongs to those people. It expresses the highest purposes of their being; it says: 'We care!' This hospital is a visible evidence that many people care, care that those who need it be given special care. This functional symbol of man's concern for his fellow man is, I believe, a reflection of the Creator's concern for us all."

SOME OBSERVATIONS ON INTERVIEWING IN A STATE MENTAL HOSPITAL*

DAVID RIESMAN, LL.B.†

Several years ago, I visited Ypsilanti State Hospital, a large mental hospital noted for its research-mindedness and its effort to use the old words and the new drugs in a combined assault on the back wards, despite the characteristic problems of an over-supply of patients and an under-supply of trained staff (especially, of course, psychiatrists), of funds, and of political support from the state. I went to talk on the sociology of the interview, and Dr. O. R. Yoder, the Medical Superintendent, and Dr. Richard B. Hicks arranged for members of the staff to do interviews with patients which I could then comment on, leading a discussion concerning some of the social-psychological factors which might be involved. I explained to my hosts that my concern had primarily been with research or survey interviews, done on a mass basis, but that my colleagues and I were interested in seeing what, if anything, could be transferred from such material to the quite different problems faced by therapists and administrators in interviewing patients.[1, 2]

Four members of the hospital staff—a trained nurse, a social worker, a clinical psychologist, and a resident in psychiatry—volunteered to conduct interviews with patients. Microphones were hung around the necks of interviewer and patient in order that the audience could hear the dialogue; and the patients were told that there would be visitors.

I made notes at the time of each interview as a basis for my discussion and later on I made further notes of recollections of what had transpired, mixed with my own reflections and free associations. The idea of publishing these informal and, of course, confidential notes was stimulated much later by the growing interest of psychiatrists in sociological factors in communication. Accordingly, I have edited my notes and, where necessary, concealed identities.

The Nurse's Interview

A crisp and capable young nurse interviewed an older patient diagnosed as a paranoid schizophrenic, who wanted to move from a closed to an open ward. The nurse had been influenced by the new, progressive

*A report from a research project on The Interview, directed by Mark Benney and David Riesman at the University of Chicago under grants from The Foundations' Fund for Research in Psychiatry and from the New World Foundation.

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administration, and signaled this by not wearing a uniform which, she told me, she regarded as a stiff and starchy barrier against patients. (The older and more hierarchically-oriented staff felt nurses would not be "comfortable" out of uniform—thus employing one of the new "plus" words to retain an older tradition and boundary.) The paradox of the interview was that the nurse, understanding and empathic, eager to probe feelings rather than facts, was confronted by a man frozen in hierarchy and rigidity.

We learned that he had been a sergeant in the Army for two decades and that, while in Korea, he became convinced that the Communists were out to get him (since he was a Negro, it occurred to me that this fear was an index of the effectiveness of Communist propaganda beamed at the Negro troops). After years of model conduct, he had attacked his officers and been hospitalized. He still carried himself like a soldier, dignified and erect. The patient's image of himself as thoroughly controlled was not threatened by the nurse, but neither could he permit it to be questioned: a prideful man, oriented to authority, he seemed to be able to cope with the hospital only by responding to it as a "closed" rather than "open" institution. The gaps of status, experience, and intraceptiveness between him and the nurse were perhaps too great to be bridged, and his own stiffness tended to evoke in the nurse, in spite of herself, the starch that had gone out of her dress. To be unbuttoned was not "comfortable" for him.

In general, however, the strategy of permissiveness and comfortableness seems to work best with the most deprived and underprivileged cadres in our society. For the many displaced persons of our cultural and industrial life, it is an event when one is listened to, especially by a person "outside." Many such people as children were treated as respondents ("Where did you go?" "What did you do?"); thereafter, they never achieved the Oedipal jump to independence—either the independence typical in the working class or even the stolen and early independence typical in the working class or even the stolen and covert independence of the seemingly acquiescent subordinate or "Uncle Tom" Negro. For therapists to get across to such people that educated men, even doctors in white coats, really are listening, really care about what *they* think and feel, requires heroic patience—or Rosen-like shocks of recognition.[3] Such people have never been in a nondirective situation; they have always managed to be told what to do, and when they get into a mental hospital they are often as "cooperative" with the old-line administrative staff (forcing this staff to recreate itself if need be) as they are pliantly resistant to any intensive psychotherapy which is given on the assumption that they are, want to be, or should become individuated and self-directed.

The Social Worker's Interview

This was an extraordinary matching, in which a thoroughly anti-intraceptive elderly white man from the Kentucky backwoods—a migrant to a large urban center in the North—was interviewed by a warmly passive Negro social worker. The latter, a Canadian, had some of the *sang-froid* of the Negro from the British Dominions in dealing with Southern whites, but he was still (as he told me later) "uncomfortable" in his eagerness to justify the faith in him of the new administration in the hospital and well aware of the explosive possibilities in the encounter.

The patient had been a craftsman in a large plant; he drank excessively and, when he attacked his wife, she had him committed. (The wife was a successful real estate agent who had had her husband recommitted when he had made an attempt to live "outside.") He had been hospitalized for eight years, and doubted whether, at 61, he could get back his job; in fact, as the social worker explained, without his wife to fall back upon, he feared he could not get along. And, within the hospital hierarchy, he had reached the highest ranks (analogous to a trusty in prison): a messenger with a key to all the closed wards.

In the interview he presented himself as a solid Southern citizen down on his luck and away from his relatives, whom he had left in Kentucky and lost track of. He seemed to feel that whatever skill of hand and eye he once possessed had disintegrated. He wanted to get a job and be independent of his wife's home and earnings, but he announced this with so little conviction as to imply the opposite. When the social worker asked whether he really desired to leave the comfort of the hospital, he replied pathetically, "I'm no good to the state, to my wife, to myself." Responsive to the interviewer, he talked about his failure; he was somewhat evasive in discussing his drinking and his wife, but this seemed to be a defense rather than conscious prevarication.

In this confrontation, I was particularly struck by two things. An uneducated Kentuckian was opening as much of himself as he could to a Negro; and he was talking freely, if not always truly, before strangers and before a Negro, of his most intimate concerns. The hospital had taught him that it was not unmanly or unseemly to "socialize" his illness, and in so topsy-turvy a world, it did not appear strange to be interviewed by a Negro—and to respond to him not merely as a man who held, along with other officials, the dangerous key to freedom, but also as a human being who might help him locate himself, if not in the complex city beyond the walls, at least in the now-familiar world within. (One could argue that a person who felt himself useless to the state, family, and self could not afford to look down on a Negro; we know, however, that it is just such people who do look down.) Furthermore, the very fact that the Southerner was anti-intraceptive, and hence presumably inclined to racial intolerance, made the patient also polite and submissive to what he interpreted as the authoritarian hierarchy of the hospital. As a messenger, the patient had risen in a world where the simplest skills (to dress oneself, to light one's own cigarette, to find one's way about the extended premises) are rare, and where in consequence, as in an army at war, skills discriminate and order people even more vividly than accent or skin-color. Thus, the hospital climate, though it had not "cured" the patient, had caught him up at that point in his life-cycle where the props of job, home, and money had been removed, and with them some of the cultural defenses of his class and region.

I do not know to what extent the patient was aware that he was being interviewed, not by a high-status physician, but by a middle-status social worker. Very likely, he was not keenly aware of the anomaly of the social worker being a male—but the latter must himself have been keenly aware of this.[4] Americans assume that a social worker, like a nurse, will ordinarily be a woman—so much so, that we have to say "male nurse" or "male social worker" just as conversely we must say "woman doctor." Beyond such occupational stereotypes, Richard E. Farson[5] has pointed out that the listening, nondirective role is in our culture a feminine one; and many observers have emphasized the division of labor both within the family and in the larger society by which men become taskleaders, initiators, "idea-men," whereas women become mood-leaders, responders, specialists in affect.[6]

In the social worker's interview, however, there were many "masculine" notes. The patient was asked his age, how long he had been in the hospital, when he had last been outside, how long he had been married, how long on the convalescent ward. Likewise, there were questions and comments about money: how much the patient had saved, whether he was drawing social security, how much money his wife had. The patient undoubtedly felt "comfortable" with these questions for he, too, as a man, structured his world in such terms. In discussing this theme afterward, the anthropologist Dorothy D. Lee observed that women tell time from "inside": when Johnny was born, or when Mary had measles (the way she herself "dated" Pearl Harbor), whereas men's chronology is external—whether the fifty-minute or the sixty-minute hour. (Similar considerations about the tendency to over-structure interviews turn up in some of the recent literature aiming to teach therapists and others more nondirective modes of interviewing.[7, 8])

The use of humor, of joking, would also seem in our culture to be something of a male prerogative—perhaps in part because its use by women would seem too barbed or "castrating." (A recent study of behavior in Great Books discussion groups reveals that the men are much more likely than the women to make use of jokes and humor,[9] while a study of law students' luncheon conversation indicates the extent to which even professional men make use of joking and teasing.[10]) The psychoanalytic tradition in therapy has a kind of wry, Chaplinesque streak running through it, of sardonic and self-deprecatory humor. It may, therefore, reflect the somewhat anomalous position of the male social worker as a Negro who, facing a white Southerner, carried on the interview on a level of dead seriousness, without resort to the potential camaraderie or release to be found in humor. To be sure, this pattern may also reflect the staged quality of the encounter. (I have been struck, in going over tape-recorded psychiatric interviews, with the relative absence of jokes: no doubt observation—like supervision—makes therapists even more self-conscious and "serious" than usual.) And, of course, in discussing all these interviews I am abstracting from the concrete and idiosyncratic case to the more general social-psychological elements that appeared also to be present.

The Psychologist's Interview

A note of humor did enter an interview between a clinical psychologist and an adolescent boy who had been committed because the reformatory where he had been sent for stealing cars could not handle him. The psychologist was to give the boy the Bender Gestalt Test and try to establish rapport with him. The boy was surly: he carried himself with the chip-on-shoulder air of the delinquent. Again, the interview opened with typically "male" queries concerning space and time: "When did you come to the hospital?" "Where did you come from?" "What reformatory were you in?" "What were you put there for?" "How many cars did you steal?" Except for this last—to which the youngster could proudly answer "twenty"—none of these questions seemed likely to put the boy at ease; and the one that followed—"Did you have any assistance?"—struck me as egregiously tactless: one could see the boy stiffen as he answered with a clipped "Yep."

Yet as the questioning continued, I felt that the psychologist was revealing himself as a hot-rodder *manqué,* vicariously pleased at the boy's prowess: the twenty cars struck him as a joke, as did the boy's reply "I like to ride around" to the question as to why he stole them. To get back into his superordinate role, the psychologist then asked: "Are you sorry you did it?"—to which again he got a curt "Yep." Then, after a few questions (which also struck me as tactless) about the boy's family, the psychologist asked about games and baseball, compared the test he was to administer to a game, and readily secured the boy's minimal cooperation, while not penetrating the latter's protective coat of defiance. (The test showed him to be "normal.")

In this interview, the psychologist was in the difficult position of confronting a hostile stranger, not "sick," but with a reputation for toughness. In trying to "socialize" this encounter, he oscillated between acting like a school principal keeping the score and a nondirective counselor being permissive—a permissiveness which might well have enhanced the boy's sense that his crimes were vicariously pleasing or at least impressing the adults.

In our discussion later, the psychologist was candid in admitting his fears in the situation—and perhaps less aware of the degree of his identifications. A woman interviewer would probably have been still less successful—indeed, the woman psychiatrist, also an interviewer, commented that she would have been putty in the hands of such a boy, and that the boy would have known it. A woman could not have talked so readily about baseball and cars, and any effort to do so would probably have been misunderstood.

I am indebted to Dr. Sara Polka of Michael Reese Hospital for an interesting illustration of this theme, obtained when she was working a few years ago as a psychology intern at a Veterans Administration Hospital. She and Dr. Lawrence Schwartz were working together on a ward of regressed chronic schizophrenics and they alternated leading the discussion in group therapy sessions with twenty-six patients. After a few months of work with the group, the therapists noticed a consistent difference in the topics discussed depending on which of the pair was taking the main role: when the woman therapist was the active leader, the patients discussed topics usually considered to be feminine ones, such as arranging for a picnic, or planting a flower garden, or planning trips to the park or the arboretum, whereas when Dr. Schwartz was in charge, the patients tended to talk about their fears and anger, their resentment at being locked up, and their attitudes toward authority figures. Each therapist preferred to deal with the materials brought up in the presence of the other, and they agreed that each would attempt to facilitate discussion of the area of his preference. Doctor Polka wrote to me, "The patients, however, would not respond, and it became amusingly frustrating to us to find ourselves forced into an ego-alien role because of what appeared to be the intensity of the stereotype the schizophrenics were responding to. I was treating at the same time a couple of these patients individually and under these conditions of one-to-one therapy, the stereotype did not seem to hold."

Such experiences would seem to me to indicate the value of "tandem" interviewing and therapy in which a therapist, seen as one kind of person, helps acculturate the patient or respondent to the appropriate norms of discourse, thus permitting the patient or respondent to proceed further with another person. Of course, such linkages frequently occur in the course of an individual's career of therapy, but they are seldom planned—nor, indeed, do we yet know enough about human communication to go very far beyond guesswork in such planning.

The Psychiatrist's Interview

The fourth of this series of interviews was the only one conducted by an M.D., a former general practitioner who, concluding that more and more of her patients seemed to have psychological or psychosomatic complaints, decided to come for a few weeks to the state hospital to learn some psychiatry and was now in her second year there. A woman of extraordinary gentleness and sensitivity, she conducted group therapy sessions where she managed to make contact both with deeply regressed patients and with aggressive delinquent girls.

In the particular interview under scrutiny, the patient was "Mary," an elderly schizophrenic who suffered from hallucinations and voices; she had been long on the back wards; and the aim of the interview was to see if she might be ready for "promotion" to an open ward. When the microphone was hung around her neck and she fully realized that there were observers, Mary was frightened—plainly, she took fright easily. But the therapist managed simultaneously to call the observers to Mary's attention and to blot them out by relating herself to Mary with passionate intensity and immediacy: there are people who are charismatic speakers but the therapist was a charismatic listener.

With an upper-class person, one often begins by asking (with more or less tact) "Whom do you know?" whereas with a lower-class person one may begin by asking "Where are you from?"—or by talking about the weather. So the therapist reminded Mary of who she was (while at the same time informing us): she carried her through her birth in County Kerry, her coming as a teenager to the United States, first to Boston and then to the Midwest, her marriage, the birth of her daughter, and her husband's death, and then her admission to the hospital. (It struck me that here we were once more in the presence of a displaced person, uprooted both from Ireland and from the "New Ireland" of Boston—one of those semiliterates who lack the facility for keeping in touch with distant relatives over long periods of time; perhaps, too, she was out of touch with any priest from the old country who might have assuaged her terrors, by relating them to a traditional ritual and, in Fromm's terms, to a "frame of orientation and devotion.")

The therapist managed to turn an administrative interview into a quasi-therapeutic one by assuring Mary that her answers on this semi-public occasion would not prejudice her chances for increased privileges. The references to place—to Ireland, Boston, and so on—were not topographic, let alone chronological: they had a reassuring redundancy and did not disturb the affective quality of the encounter. The psychiatrist said afterward that she had thought Mary might start hallucinating, but to the outsider it looked as if the therapist's reassurance became for Mary, as for a frightened child, an almost physical thing, holding irrationalities in check, while not blocking the affective flow. The uprooting of the immigrant that Handlin[11] describes, and of the impoverished elderly people others have described, was made pathetically evident when Mary, after speaking of the rooming house where she had lived alone before coming to the hospital, declared: "I like it here, it's a wonderful hospital"—an effort to show gratitude and response, and an index of previous isolation. Undoubtedly, a traditional culture "carries" many Marys extramurally, while ours, with its heavy demand for rationality and, for many, its lack of kin ties, can only institutionalize them. Even so, Mary did not want to stay: the approach of Christmas affected her and made her eager to go "home," if she could but find one. And the therapist, more by her adept vicariousness, her silent resonance, than by anything specific she said, seemed to hold out to Mary the hope that there might be, even for her, a life beyond the safe underprivilege of the closed wards.

Could any *man,* even were he as effective as Harry Stack Sullivan, have supported Mary? It would be interesting if one could experiment with this. One may only speculate that Mary, her Irish Jansenism perhaps intensified by marriage, was deeply awed and frightened by men, and would be too bewildered to respond, at least at the outset, to a man of education seeking to be gentle and evocative with her, and to talk with her about her "domestic" troubles. But, a woman physician, despite the great disparity in status and education, could have access to that woman's world of succor and sorrow in which Mary lived. Through that access, Mary could be nudged, temporarily at least, into the world where "everyone" lives: the world of place on earth and movement through it, the world of work and family.

The interview may be thought of as a tool which lies on the border between the psycho-dramatic world of role-taking and make-believe and the world of "actual" human relations. As Kai Erikson has observed, there is a stage world analogous to the make-believe of the interview in which patients can sometimes live and move more readily than in the "real" world—so successfully, in fact, as sometimes to

threaten their clarity of alienation from the latter world of responsibility and self-reliance.[12] Correspondingly, I may, in my original notes, have over-emphasized the importance of the qualities of Mary's therapist and of the latter's being a woman and under-emphasized Mary's institutional training, her no doubt considerable experience in the hospital with question-asking professionals, and hence the marginal naturalness for her of being interviewed.

New Directions in the Interview

In the discussion that followed the series of interviews, people sought to describe what it meant to be "natural" in the role of interviewer. Several psychiatrists argued that recording an interview unavoidably introduces strain and artificiality—not on the side of the patient (for whom the whole procedure is "given"), but on the side of the therapist. Others agreed with my suggestion that the interview is both an invention and a convention, like the stage; that there were perhaps "naturals" in interviewing, but that they were people whose skill in learning social interaction included skill in appearing not to learn; and that one had to go through and beyond self-consciousness. I recalled Theodore Reik's saying that an actor has to forget his training when he goes on the stage—the social worker added that if interviewers became too self-conscious they could no longer "fly blind" and concentrate on the task in hand. From the discussion, it seemed to me that the physicians were perhaps especially unaccustomed to interviewing where a record was being made for a potential audience of colleagues—as compared with the audience of the patient himself (who may, in a state hospital, know more than a neophyte resident about the jargon of his own ailments) or of attendants or students—let alone the somewhat protective, if occasionally threatening, audience of his analytic supervisor.[7]

As used in therapy or in the administration of a large state hospital, the interview is neither an informal chat nor a formal probing: it oscillates precariously between intimacy and reserve, nearness and distance.[13] Adding an outsider introduces some further "noise" and indeterminacy into the channels of communication, but transference and counter-transference clog those channels at best, as every therapist knows, and observers may or may not heighten the parataxic processes involved in any dyad.

I have found it a widespread belief that that mythical creature, the "well-analyzed therapist," can, in principle, interview anybody under almost any circumstances, although there may be limits which need to be respected when patients are of the same or opposite sex, depending on the patients' own Oedipal problems and like matters. One psychiatrist, for instance, told me only half jokingly that he would send *any* patient to *any* member of one of the leading psychoanalytic institutes for psychoanalysis (though not for psychotherapy), on the assumption that over the long pull of analysis, mis-matchings based on ethnic or class or temperamental differences of therapist and patient could be handled like any other resistances.

Such clinicians do not take seriously those barriers to communication which are cultural rather than idiosyncratic. If, for example, a psychoanalyst of Italian origin finds himself put off by the crudities of a lower-class Italian (as he would not be put off by the less threatening and less familiar crudities of some other ethnic group), this is only because something is lacking in his own analysis and can be handled if he is still under supervision. But, of course, even psychoanalysts are not in training forever—only almost so!—and there comes a time when it would seem the part of wisdom to decide with whom one can work most productively. I believe most therapists do decide this, but by rule of thumb and by more or less taken-for-granted sorting processes;[14] likewise, various therapists come to be known as having an interest or a special competence with one or another class of patients and then one such patient will lead to another and establish a clientele.

Whether simple liking of the therapist for the patient should play a role in all this remains highly controversial. Some analysts feel they cannot help those they do not like, and recognize that being "well-analyzed" is not a formula for liking everybody. Other analysts feel that they cannot help those they like "too much" for they will become too affectively involved. At the opposite pole from Ferenczi's thinking, they feel that they are applying a technique like any other doctor. (In addition, they belong to that growing cadre of professional workers who regard it as ethnocentric or bigoted to have prejudices against particular sorts of people and seek to live, at least during office hours, by a code of affective neutrality and generalized acceptance of people.)

Nevertheless, if one talks long enough with therapists about these matters, especially with those whose training is still incomplete in the formal as well as the life-long sense, the problem of matching is apt to creep back in terms of discussion as to who is "comfortable" with what sort of patient. To the neophyte visitor to this and other mental hospitals the emphasis on being "comfortable" is striking. Patients are constantly referred to as being made more or less comfortable by the therapeutic procedures. But the concept filters up from below, and in the more progressive institutions the staff is concerned about being comfortable with itself as well as with the patients.

The doctor who had interviewed Mary asked in the discussion how one might train interviewers in empathy and resonance.[15] I think recordings may help, in calling the attention of the interviewer to interruptions, insensitivities, and anxious structurings of which he may have been unaware; but undoubtedly, since one interviews with one's full self, the analysts are right in asking for a personal analysis (or, I would add, its rare moral equivalent in self-achieved self-understanding) as the basis for further and profounder use of the self as an instrument in therapy. Empathy is always desirable, but the permissiveness so notable in Mary's interviewer may not always be its desirable outcome—though in practice the two are often equated (as they are in the common belief that if nations understand each other, they will not quarrel).

Permissiveness is required when one deals with the underprivileged, the displaced persons, whose complaint is that no one ever listens to them. But in private practice and occasionally even in a state hospital, one finds people who have been permissively brought up and for whom the attentive third ear of a therapist is no novelty, but a repetition under new auspices of the indulgence of parents or teachers. Such patients (or respondents of like background in survey interviewing) may profit from sharper, more dialectical, more challenging interviews. The ideal of "comfortableness" may not then suffice.[16]

Let me put this another way. The spread of vulgar versions of Freud among the middle classes has helped to alter the affective bonds which once bound families and friends to each other in rather rigid molds of conduct: permissiveness turns all relations into voluntary ones and makes all conduct, in principle, subject to insight. Under these conditions, indifference, both moral and personal, can easily masquerade as friendly permissiveness, and many people might prefer to be less readily forgiven and less well understood as the price of knowing that their behavior really mattered to their friends and relatives, and hence that they themselves mattered also. Thus, permissiveness, while tempting for the mobile and experimental middle class, is also anxiety-producing. Though the therapist, of course, thinks of his own permissiveness as a one-way street, for he does not allow himself to get furious with the patient, let alone drop him whimsically, nevertheless his permissive ethos and manner may reinstate precisely the climate of anxiety and lack of knowing where he stands with people which helped bring the patient to the doctor in the first place.

I was asked in response to these suggestions whether Americans would accept an interviewer or therapist who seemed to them aggressive —whether questions and comments swathed neither in humor nor in obvious warmth would not be felt as hostile? My reply was that Americans certainly do find it difficult to feel a basic friendliness which does not parade itself under chronic smiling; the kind of give-and-take characteristic of British or French intellectual life would be regarded in this country as too fierce and unsympathetic. Nevertheless, it had been my observation that people—even quite sick ones—could distinguish between "authoritarian" and "humanistic" interviewing, between challenge to irrational preconceptions and their vindictive overriding.[17]

A perhaps more fundamental question about my position was raised by those who insisted that nondirective therapy and interviewing were still imperative in America because, despite the growth of permissiveness, people still were afraid to show their true feelings. I admitted that people often did not themselves take advantage of the permissiveness they granted others, and interpreted the human environment as more severe than in fact it was. But the problem of people surrounded by permissiveness is less often to express than to discover and clarify their feelings: indeed, endless talk and easy discourse about feelings may hamper their discovery. Conceivably, one might arrange for two stages of therapy, either with the same or with different therapists: one in which hitherto repressed feelings were encouraged to come to expression and a second in which the feelings would be subject to judgment and reality-testing. (*Pari passu,* similar steps might occur in interviewing.)

Some psychiatrists appeared to feel that one would lose touch with the patient if one sought to convince him of unpleasant truths or even truths which required reorganization of his previous, desperately-held map of reality. One had to continue supportive, rapport-filled response while allowing the patient to convince himself.[18] But other psychiatrists felt that communication between so-called normal people and so-called neurotics was not so difficult that a more stressful therapy (and interviewing) procedure might work provided the therapist himself were reasonably confident that his own dialectic sharpness did not mask hostility (for which some therapists, like many other people, compensate by over-friendliness). The belief Freud held to, in the face of his great pessimism, that what men do not know does hurt them, and what they do know may help them—this belief in the therapeutic power of truth—remains our best protection against the one-sided and manipulative or merely bland and talky interview or therapeutic session.

At any rate, it was this belief which motivated people at the Ypsilanti State Hospital to question and explore their own procedures, and encouraged members of the staff to face in the same encounter both the unforeseeable reactions of patients and the perhaps not fully understanding criticisms of students of the interview such as myself.

BIBLIOGRAPHY

1. RIESMAN, DAVID: The Sociology of the Interview. *Midwest Sociologist* 18:3-15, 1956.
2. ________ and BENNEY, MARK: Asking and Answering. *J. Business* 29:225-236, 1956.
3. ________: A Career Drama in a Middle-Aged Farmer. *Bull. Menninger Clin.* 19:1-8, 1954.
4. HUGHES, EVERETT C.: Dilemmas and Contradictions of Status. *Am. J. Sociol.* 50:353-359, 1945.
5. FARSON, RICHARD E.: The Counselor Is a Woman. *J. Counsel. Psychol.* 1:221-223, 1954.
6. PARSONS, TALCOTT and BALES, R. F.: *Family, Socialization and Interaction Process.* Glencoe, Ill., Free Press, 1955.
7. GILL, MERTON and others: *The Initial Interview in Psychiatric Practice.* New York, International Universities, 1954.
8. KAHN, ROBERT and CANNELL, CHARLES: *The Dynamics of Interviewing.* New York, Wiley, 1957.
9. DAVIS, JAMES A.: *The Road to Milton.* Chicago, National Opinion Research Center, 1958.
10. FEIGENBAUM, KENNETH D.: The Limited Hour: A Situational Study of Sociable Interaction. Unpublished Master's thesis, Committee on Human Development, University of Chicago, 1958.
11. HANDLIN, OSCAR: *The Uprooted.* Boston, Little, Brown, 1951.
12. ERIKSON, KAI: Patient Role and Uncertainty—A Dilemma of the Mentally Ill. *Psychiatry* 20:263-274, 1957.
13. RUESCH, JURGEN and BATESON, GREGORY: *Communication: The Social Matrix of Psychiatry.* New York, Norton, 1951.
14. HOLLINGSHEAD, AUGUST B. and REDLICH, FREDERICK: *Social Class and Mental Illness.* New York, Wiley, 1958.
15. GREENSON, RALPH: Unpublished lecture at Michael Reese Hospital, April, 1957.
16. WHEELIS, ALLEN: *The Quest for Identity.* New York, Norton, 1958.
17. FROMM, ERICH: *Psychoanalysis and Religion.* New Haven, Yale University, 1950.
18. ROSENTHAL, DAVID and FRANK, JEROME D.: The Fate of Psychiatric Clinic Outpatients Assigned to Psychotherapy. *J. Nerv. Ment. Dis.* 127: 330-343, 1958.

A SUNDAY WITH MESCALINE

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Introduction

The subject of an experiment has no right to pre-empt the data which the designers of the experiment sought and obtained. This material was not sought and this account not solicited by the researchers doing the work out of which it is born. The experiences I have recorded were not of those measurable qualities which the scientific philosophy of experimental design demanded.

Subjective, phenomenological accounts of mescaline intoxication are scarce in medical literature. They are often short and frequently limited to a single perceptual modality, vision. This account deals with several modalities of perception and presents personal material in a fashion which was more in vogue fifty years ago than now.

Originally I did not plan to record these experiences and made no immediate preparations for writing them. It was only after informal discussions with my colleague, Jay T. Shurley, M.D. and considerable encouragement from him that I was persuaded that a description of my own experiences might have some merit as a phenomenological account.

This account is autobiographical. It is heir to the strengths and subject to the flaws of autobiography. I hope that it might engender a willingness in others to contribute to the still small number of phenomenological accounts concerning substances which alter the patterns of mental activity. It is presented as an invitation to others to subject a fallow area to thorough research.

Recording: Oklahoma City, Oklahoma, Spring 1958
Experience: Topeka, Kansas, Fall 1956

I took 200 milligrams of mescaline sulphate as a part of an experiment in which objective measurement of effects of the drug on normal human subjects was attempted. Mescaline is the most active component of peyote and in recent times has been called a psychotomimetic or hallucinogenic drug. The dose was administered about noon on a Sunday by two professional associates, who stayed with me during the afternoon. (It is my opinion that psychiatrists are no braver than others when it comes to tampering with their minds. Some of my fellows had expressed fears of "not coming out of it" about taking such a drug as mescaline.) I had a brief, somewhat embarrassing fantasy about Socrates'

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heroism upon swallowing the poison, but sat back and talked while awaiting whatever might happen. I was hungry, not having had any lunch, but was in no way feeling less than tip-top physically.

About 45 minutes after ingesting the drug, at the suggestion of Dr. M., I lay down on a cot and closed my eyes and consciously set my fancy free. I now felt that something about me was different, different without changing, and in no way foreign to nor dystonic with the usual concept I hold of myself. An example of the quality or quantity of feeling might be such as I feel when I notice that my hair or nails have grown out—I change, but my basic image of myself does not. Soon the subjective effects of the drug were becoming of such magnitude as to be undeniable, but the quality of the change was not at all startling. Without any explaining I told Drs. M. and S. repeatedly that I was the same old me. I could not elucidate at that time, and for a while they listened to my declarations with a gentle but querying smile. Then Dr. S. challenged, " 'Methinks (he) doth protest too much.' Maybe you *are* changing."

I felt at first indignant. Then, in surprise, I realized he really did not know that what I was saying was that I was experiencing myself with greater intensity but not with strangeness. It was as if the whole of my exo-and endo-perceptions had become more easily available and (even though I neither needed nor used them) they were as comfortable as a rediscovered last season's well-worn, well-fitted shoe. The whole feeling was one of comfort if not delight, the opposite of nostalgia.

Upon closing my eyes I could visualize upon a background of pure, lightless, but palpable space, a strange new flower, similar to, if anything, a cactus bloom. The stem was thick and marble-smooth, a soft, radiant blue like that of a well-adjusted gas flame. The bloom was a self-luminous magenta, a little softer hue than strontium salts produce when placed in a flame. The substance of the flower was as ethereal as flame itself, but yet not dynamic like fire. It was, instead, cool and vapid, static and concrete. It disappeared if I chose not to conjure it. It was gone and like a memory if I opened my eyes. It reappeared like a tiresome tune when I closed my eyes. I spent little time looking at this flower of fancy as there was work to be done. I was a test subject and obliged to perform for the experimenters. I felt, however, that this flower was but the first picture in an encyclopedia of all experience. I turned my back on a road which might have led to enchantment.

As a part of the experiment, I was to follow some stereotyped instructions, at one time from verbal direction and at another time from written direction. I had done this type of thing before in a control phase of this experiment and had felt that it was indeed difficult. I had felt that I had exposed flaws of intellect which I had as lief kept hidden even from myself.

I was now certain that I would appear stupid. I could make nothing out of the written word without exercising an extreme intensity of effort at concentration. I remained interested in the project, but the amount of effort necessary to perform these simple tasks (read and listen to the directions) was really heroic. Hearing and seeing required effort. If I failed to exercise the effort, I tended to fall easily back toward fantasy. It took a greater effort to make use of hearing and seeing as the basic techniques necessary for communicative listening and reading. The process of organizing the printed symbol into words and ultimately into thought was step by step a conscious task, requiring painfully difficult, constant, exhausting work.

Old habits seemed to fail to want to function. I had to decide anew, for instance, where to begin when I attempted to read. I knew accurately that one begins on the left, reads left to right and top line to bottom, yet it seemed as if this were not yet decided definitively. I toyed for moments with attempting to read in some different pattern. Nothing sprang from memory to inhibit this ignorant idea, nor to remind me of my well-learned habitual pattern of reading. I thought I would read backward just to see if the sentence still made sense. (I knew it would not.) I thought of reading every other letter, of choosing letters at random, of not attempting to read, of spelling the words "out loud," even of pressing the card with my hand to see if some message would "soak" into my hand without further effort. Judgment considered this folly, but judgment had no muscles. It seemed as if all this dalliance were taking a long time; yet at the same time I also felt, objectively, it had not taken long. It seemed senseless to think of time as passing at all. Time itself was a senseless concept—all that existed in time's stead was the sequentiality of events. Old mental patterns were not reliable until the habit was broken down into something resembling its original components and put together again. That action be logical or pragmatic was not necessary; instead action was satisfying if it attained any sort of goal whatsoever, even the rejection of the problem at hand.

This same type of thinking pervaded other tasks I had to perform: an immediate memory problem, a remote memory problem, solving mazes, and doing some calculations in block design. The testing situation lasted about two hours.

I changed motorically. During the experiment I felt the urge to move and did not move. I sat aware without real pain that I urgently needed to micturate. The whole complex act of excusing myself and acting to fulfill my needs required more effort than I could muster. I

knew that I was functioning at a profoundly different rate and intensity and that I was not communicating this well to my observers, but I did not care.

I recall a delighting urgency to tell and not to tell them of a wonderful and awe-provoking feeling I was having concerning my foot. I thought about the feeling for a while and could not decide to tell them about it. I felt that they would not understand what I was talking about. I doubted I could communicate precisely what I felt. I felt ashamed at the absurdity of it. Finally I told Dr. M. that I would tell him if he would not laugh. Upon his kindly reassurance, I told him that my left foot was about to vomit. I was aware that my foot had no gastrointestinal tract, that feet do not vomit, that they have their own peculiar but other functions; yet, the distillate truth of my perception was that the foot was nauseated and about to vomit.

In this state I felt greatly comforted that I had other people with me and that they could and would make decisions if I failed completely. The feelings of warm friendliness rose easily; but I felt I could with equal ease lash out and assault. I could decry the whole world's stupidity and pointlessness.

In retrospect, I can give some explanation of what had happened to my thinking during this phase of the intoxication. I have been latently aware of the mechanics of decision (which I shall describe) for most of my life. I have regarded the process of decision-making as starting when I become aware that a discomfiture or urgency exists within me. In order to change or ameliorate the discomfiture, I must will to act and then act continuously to the completion of the purpose of the decision. The tension of decision rises until action for change begins and then is reduced as action becomes extant and is at maximum relief when action is completed. This is true for the smallest or largest decisions or acts.

Essentially, there are two positions of the subject in a decision. One may decide to act or one may elect to weather the stress of not acting. Yes and No are the possibilities of response to a linear problem. For example: I am thirsty. Relieving thirst requires that I arise from my chair, go to the hydrant and get a drink. If I do not move, thirst remains and discomfort increases. I withstand the thirst until I finish the paragraph I am reading. The total tension of the situation is reduced a little when I begin to move from my chair and relieved when I complete my action of drinking water. My decision and action relieved my tension (and thirst).

Under the influence of mescaline, decision had another alternative: to *not decide.* (This is in contradistinction to indecision in that it is an election to reject the making of a decision.) The relief of the tension of decision-making was completely accomplished if I would assume the position of *nondecision.* It had become easy to invoke this mechanism. It did not involve postponement nor tension producing indecision. It was satisfying in itself to *not decide.* The effect was as relieving as if I had made a decision and completed a fulfilling action. It could even be invoked at any point in the action once begun, which tried to fulfill a decision, *e.g.:* I had a pencil in hand and was about to write with it. I repeated my understanding of pencil (wood, graphite, used for writing, writing words, words for communication) and started to apply the pencil to the paper. Decision was being made. I stopped with the pencil about an inch off the paper—I *nondecided.* The pencil and my hand remained softly poised in the air in complete comfort. I contemplated the pencil almost as an art object. To not-move was satisfying. No stress of indecision was present. Time's passing engendered no urgency. *Nondecision* gave me complete peace and comfort even with my hand standing useless in mid-air. I sat and savored the timeless moment. Then normalcy waxed a little and I got the pencil to writing position. The whole business of *nondecision* was not completely pervasive. It came and went irregularly but was becoming more continuously present and available.

During my intoxication, to make a decision was extremely arduous and taxed my patience. Since I was making all decisions at a conscious level, and unable to depend on habit, anything that relieved me of making a decision was welcome. Thus, when I finally decided to urinate I was limp with gratitude when one of the observers took me to a rest room and I could have wrung his hand when I did not have to choose which (Men, Women) of the rest rooms to use. I felt grateful that there was a sign "Please Flush" above the urinal since it automatically made a decision for me.

My next move was to return to the testing room. Instead, I *nondecided.* It stopped me stationary and I lay down on the floor of the rest room in a patch of sunlight. I knew this might look foolish, but it was quite satisfying for the moment. I knew I could not explain it to others, but I could not care. It fulfilled me! I felt, toward that sunlighted floor, compassion and tenderness! I felt a bittersweet compassion for the existence of any object. I was glad it existed and loved it for existing! The feeling was much like the warmth one feels for a beloved pet or the fulfillment one gets in comforting a tired child. I patted the floor and said, "Bless your little heart." This struck me as humorous, but it was so purely intellectually funny and so insipid, compared to the feeling I had for the floor's very existence, that it was worthy of something better than laughter.

Purposefulness was a useless concept. All acts were of equal value in that they were equally satisfying. A step backward was as good as a step forward. Silence was no worse than speech. I could direct myself to perform but the action did not have to fulfill any purpose. Inaction would serve as well, and sometimes even better.

I was able to extricate myself from the rest room upon reminding myself that the others expected me to be cooperative in their scientific venture—not just wallow in my own feelings.

Through much of the time of the experiment's formal span, I had been having a change of motion-sense and proprioception. Upon moving, instead of feeling a sense of muscular activity and a resulting changed position, I felt a localized and positional nausea. To move was to experience nausea. The feeling of the nausea of the foot was now generalized and getting quite tiresome. I felt disgusted and angry when my observers, upon my mention of nausea, would look furtively about for a wastebasket. I felt hampered verbally in that I could not communicate the idea that *I* was not nauseated, but that my various bodily *parts* were.

To shift my legs was an experience I would rather not have had. My limbs might tell me a lie in informing me that they were nauseated, but I did not hear the message wrongly. They were not even lying, they were just not using good judgment, or else they were borrowing feelings and sensations not rightly theirs. (During the experience, there was no autonomy of my limbs and I do not imply that there was any un-me-ness as my use of the word *they* might indicate.)

After about four hours of the mescaline world, I was ready to abandon it. I told my observers that I was tired. I was weary in a sense and degree I had never known before. I was not in pain, not nauseated, not fatigued, but simply and magnificently weary. I would have liked a further change in perception, but none was forthcoming. I was given a tablet of Dexamyl—not as an antidote for mescaline, but as a general stimulant. Dr. S. was to drive me home in his car.

In walking to the car, I had the feeling of not having coordinated my movements for a long time, and felt a prideful pleasure at just being able to walk. I was aware that my walking was well-coordinated, yet walking was like discovering that it is still possible to play a scale on the clarinet which has not been touched in ten years.

During the short drive to my home, I felt toward Dr. S. a great sense of friendliness and brotherliness which (unpredictably) has persisted.

Drs. S. and M. and I were never close socially, but even now, whenever I recall either of these two men, the memory is accompanied by a feeling of warmth and goodness—as though we had long shared interpersonal bonds.

Dr. S. told my wife that I was having some thinking difficulty, and her comment during supper was that she could not detect any particular difference from my usual behavior. She acted a little bewildered if not overtly skeptical about the awe I was profusely professing. Seeing my house and family was a warm, good experience. I had not been lonesome for them, but I enjoyed seeing home—I wanted to see each room, touch the furniture, touch the family, to smile and be welcomed. I had no great hunger for this but a greater capacity for enjoying it. I was being plagued with little episodes of sensing difficulty in deciding to perform the simplest of acts—such as picking up my napkin. Dr. S. left us shortly and I retired to bed.

I usually fall asleep easily after a short period of lightly controlled fantasy. My fantasies are mostly visual and commonly contain a short review of some experience of the day just ended. Not so on this night! The fantasy was persistent; it would not wane and yield to sleep. It was uncontrolled. It was uninteresting, even boring, plotless and full of strangers. If I tried to stop the fantasy by supplanting it with another, both would persist simultaneously. It was like watching two movies projected on the same screen at the same time. It was quiet and meaningless. At times I saw characters (people) who, like paper dolls, had only two dimensions—no thickness—and sometimes were covered with patterns like flowered wallpaper. If they moved and turned, they had no substance. I opened my eyes and momentarily the visions disappeared, but in the dark of the bedroom the visions reappeared, seeming to occupy about a cubic foot of darkened space, about four feet in front of me. There was a gradual transformation of this peopled vision into a continuous vista of a field of small yellow flowers over which a wind blew gently. It seemed I spent the whole of the night viewing this monotonous field of flowers. I am not sure whether I slept or not—and this is not a defect of memory. I just am not sure whether what occurred was sleep or some other state.

I went to work the next day and was able to perform my routine duties without much difficulty. I had, however, short periods of indecisiveness each time I used the telephone. Several times, when it rang, I reached for it with both hands and the two hands reaching confused me for a moment. Then I "relaxed" and let habit serve and the left hand perform its usual task comfortably and alone. I had moments of doubting whether I remembered any commonly used telephone number and would think of looking for the number in the directory before I could convince myself that, if I would "relax," the number would be remembered effortlessly. (I am one of those people who chronically doubt the accuracy of memory about such things and I am chronically wrong about telephone numbers which I think I remember accurately.) I found, on this D-day-plus-one, that memory was excellent if only I did not inhibit it, but I never discovered how I went about inhibiting (or facilitating) it.

Sleep the second night was not disturbed but I did not feel fully rested after a full night's sleep. The third day was normal except for perhaps two or three moments of indecision which came to full awareness.

All days since then, I have felt that this experience with mescaline was a sort of milestone. During the first six months following the experiment, I would have been loathe to repeat it. Somehow in the past year, this loathing has passed and I feel I could weather and even enjoy repeating the experience. The whole experience is (and is as) a profound piece of knowledge. It is an indelible experience; it is forever known. I have known myself in a way I doubt would have ever occurred except as it did.

ACTIVITIES OF THE MENNINGER FOUNDATION

The 17th annual meeting of the Board of Governors of The Menninger Foundation, held in Topeka, October 10-12, 1958, was attended by 45 Governors and 231 special guests. Plans for a new Children's Hospital were unanimously approved, and construction is scheduled to begin early this year. The hospital will consist of a 30-bed unit, a 20-bed unit, and a school-activities building. Plans for a proposed research building were revised to include space for the Education Department, Clinical Services, and the Medical Library. The Board also approved our entering into a cooperative research program in biochemistry with the Midwest Research Institute of Kansas City, Mo.

All Foundation officers were re-elected. They are: Dr. Karl Menninger, chairman, Board of Trustees; Mr. David Neiswanger, vice-chairman, Board of Trustees, and chairman, Executive Committee; Dr. William C. Menninger, president; Mr. Laird Dean, vice-president and treasurer; Mr. Eliot G. Fitch, vice-president and chairman, Board of Governors; Mr. Willard L. King, Mr. Arthur Mag, and Miss Mildred Law, vice-presidents; Mr. L. T. Roach, secretary; Mr. R. M. Bunten, assistant treasurer; Miss Lillabelle Stahl, assistant secretary; and Mr. Irving Sheffel, assistant treasurer.

Mr. Lyle Spencer, Chicago, Ill., and Dr. Charles N. Kimball, Kansas City, Mo., were elected to the Board of Trustees. New members elected to the Board of Governors were: Mrs. A. H. Gottesman, Pacific Palisades, Calif.; Mrs. Edwin L. Griffin, Tacoma, Wash.; Mr. Roger M. Kyes, Bloomfield Hills, Mich.; and Mr. Martin Trued, Topeka.

Among the highlights in the annual report of the many activities and developments at the Foundation during the fiscal year of 1957-58 were the following:

The Menninger Clinic: The Hospital continued its high occupancy rate of more than 96 per cent, the same as last year. However, the average daily census rose from 109 to 112 as a result of new beds available upon the closing of the insulin unit in the Hospital. The median length of stay of patients discharged was nearly cut in half. A year ago the figure was 142 days. This year it fell to 77 days. The average daily census in the Day Hospital reached an all-time high of 58 patients, an increase of 70 per cent over the year before and 102 per cent since 1956. The increasing importance of the Day Hospital as a treatment resource is demonstrated by the fact that 46 per cent of the patients discharged from the Hospital continued treatment in the Day Hospital. More hours of psychotherapy—24,576—were provided adult patients during

the year than in any year since 1950. There were more outpatient hours and fewer evaluation hours with adults, although the total number of hours with patients was the same. There was continued growth in the neurology and neurosurgery case load. A total of 1,460 patients were seen, of whom 221 received neurosurgical operations.

The number of children enrolled in residential treatment at the Children's Service (Southard School) increased from 21 to 26 (21 were in residency, two were day patients, and three were in boarding homes). Perhaps the most notable statistic, however, concerns the time our staff spent with children in psychotherapy, casework, evaluations, and consultations—7,832 hours this year compared to 6,030 hours a year ago.

Below cost services to psychiatric patients amounted to $96,069. A total of 458 adults and children, 65 more than in the previous year, were charged less for psychiatric services than it cost the Foundation to provide them.

Professional Training: Forty doctors completed their three-year residency in the Menninger School of Psychiatry—our second largest graduating class and the largest in number of those who had received all three years of training in the School. The class dispersed to 14 states, Canada, France, and Austria. At the beginning of the new School year on July 1, 1958, 33 new Fellows entered the School to begin their residency training in the Topeka psychiatric institutions, bringing total enrollment to 115. In the expanded child psychiatry training program, we have assigned three Fellows to the Foundation's Child Psychiatry Service, two to Topeka State Hospital, and three to the Kansas Treatment Center for Children. Our first four graduates from the coordinated program completed their training this year.

This was the first full year of the program for visiting professors made possible by the Alfred P. Sloan Foundation. Five distinguished men held appointments as Sloan Professors: Seward Hiltner, Ph.D., professor of pastoral theology, University of Chicago; Richard M. Hewitt, M.D., senior publications consultant, Mayo Clinic; Norman Reider, M.D., chief, psychiatric service, Mt. Zion Hospital, San Francisco, Calif.; Hans Hoff, M.D., director of neurology and psychiatry, University of Vienna; and Derek Richter, M.D., director, Regional Neuropsychiatric Research Centre, Whitchurch Hospital, Cardiff, Wales.

Research: The psychotherapy project continues to be the major research effort at the Foundation. Initial studies were completed on 42 patients who are to be subject to intensive research in the project.

Manuals for the gathering of essential data were completed and put into clinical operation. An expanded program, including radiological surveys, is under way in the study of clinical problems of thyroid gland dysfunction. At the annual meeting of the American Psychiatric Association in May 1958, a report was given by Dr. Herbert Modlin on the education research project. The purpose of that work was to evaluate the training and professional development of physicians in training. Books resulting from investigations in two projects—the diagnostic appraisal and treatment planning for disturbed children and how children cope with their problems—are nearing completion.

READING NOTES

The magnificent record of the crowning years of a great life, *The Life and Work of Sigmund Freud, Vol. III, The Last Phase 1919-1939* (Basic Books, 1957), adds new luster to the names of both Freud and Jones. Few have known, and few can realize even now that they know, what courage and self-mastery accompanied the continued productiveness of this giant among men during 16 years of agony. Himself living in the shadow of death, Ernest Jones dedicated his last years to recording the life of the man he loved and by whom he was inspired. This volume records not only the events of Freud's latter years, but the detailed medical records of the surgeons. Increased tolerance of personal discomfort is often listed among the evidences of maturity and mental healthiness; on the basis of this criterion, surely Freud was almost the healthiest-minded man that ever lived. In spite of his incessant and ominous pain, Freud worked on, with unflagging dedication. This final volume is the greatest of the three, and completes what will surely long remain one of the most important biographies ever written, and certainly the pivotal biography for the education of every psychiatrist.

* * * *

"Imagine all the men and women of the United States on a downward sloping line, with the most normal at the top and the least normal at the bottom," says Dr. Earl Bond in *One Mind, Common to All* (Macmillan, 1958). He then proceeds to illustrate these varying degrees of normality, from Albert Schweitzer as (a questionable) 100 per cent to certain brain-damaged patients who are "sans everything" at zero per cent. But, he says, "the differences are less than the likenesses," and quotes Emerson: "There is one mind common to all individual men."

This is a book of personal histories, and they are fascinating reading. Dr. Bond takes his material from clinical records, from the press, from fairy tales and folklore, from the pages of history and from literature, relating them all to his sloping line of the "elusive normal." Any technical terms are carefully explained, so this is a book for lay readers; but as Dr. Bond explains, "This is not a self-help book . . . but an invitation to the intelligent reader to take a look just beneath the surface at himself and the people about him."

* * * *

". . . in the woods near Dansville, New York, a youngster was sitting on a stump with his new birthday gun, waiting for a chance at a deer. A Rochester physician saw a movement in the bushes and shot without having any idea at what he was shooting. The boy died instantly, his red hat intact, his new gun never fired. A mother hanging clothes in her own backyard in a Buffalo suburb was killed by a hunter who was prowling too close to a building. A bridegroom of one week was driving along a country road when a deer leaped across the road in front of his car. Immediately a battalion of hunters opened up on the deer. A fatal bullet penetrated the windshield.

"In Maroa, Illinois, a farmer conducted an experiment with a stuffed pheasant. He posted the bird on a fence in his bean field about a hundred yards from the road. Soon he heard the screeching of brakes and the roar of gunfire. Some two hundred hunters attacked the battered bird during the day, most of them violating three state laws: they shot from the highway, carried loaded guns in their cars and failed to request permission to hunt on private property. . . ." (From *Think*, November, 1954, "Murder in the Woods," by Raymond Schuessler.)

* * * *

For many years Dr. Percival Symonds has stood for a dynamic, systematic presentation of the principles, process and procedures of psychotherapy. *Dynamics of Psychotherapy* (Grune & Stratton, 1958) is the third of three volumes in which he has explicitly defined and discussed transference, resistance, abreaction, insight, interpretation, suggestion, reassurance, persuasion and other terms commonly used. Even though one may differ with some of the definitions, one must acknowledge that Professor Symonds has rendered a service to all those of us who are groping for light on how best to teach psychotherapy.

* * * *

Some time ago my sister Cay gave me a little book which she had found appealing. *Heaven in My Hand* by Alice Lee Humphreys (Presbyterian Committee of Publications, 1950) is a collection of vignettes written in Quaker or Biblical language. Of all the things I have seen about teaching, it is the most effective, because it is so simple and so beautiful. Wise, too. It's about the child who brought the teacher an icicle for a present, unidentified until it melted, and the little boy who delighted in blowing air up her sleeve, and about the little girl who fell asleep and laid her head on her desk, and the little boy who finally provoked the teacher into giving him two spanks after which he sidled up to her and said irresistibly, "You are still my sweetheart," and the mother who came to thank her for teaching her boy to spell "ice," a word which seemed to comfort him in his deathbed fever. If I were a millionaire I would buy 1000 copies of this book and give one to every teacher in town and in some other towns; not being a millionaire, I am only going to get a dozen and send them to some of the teachers

I know who are like this teacher and will read this little volume like a prayer book.

* * * *

Our colleagues in Sheffield, England, E. Stengel and Nancy G. Cook, have collected in a book, *Attempted Suicide: It's Social Significance and Effects* (Chapman & Hall, 1958), researches in regard to suicide, some of which have appeared in journals. After a review of a present state of research on suicide, the authors submit and discuss their material. They conclude that attempted suicide is far more frequent than actual suicide and depends heavily upon its real or anticipated social effects. The rarity of attempted suicide in a hostile community lends weight to the importance of the appeal function.

* * * *

In a recent article on "The Unconscious Before Freud" Henri Ellenberger quotes from Carl Gustav Carus' *Psyche* (1846) the first attempt to construct a really complete and objective theory of unconscious psychological life. (This fact should be more widely known.) The book begins with the following words:

> "The key to the knowledge of the nature of conscious life of the soul lies in the realm of the unconscious. This explains the difficulty, if not the impossibility, of getting a real comprehension of the secret of the soul. If it were an absolute impossibility to find the unconscious in the conscious, then man should despair of ever getting a knowledge of his soul, that is, a knowledge of himself. But if this impossibility is only apparent, then the first task of a science of the soul is to state how the spirit of man is able to descend into these depths."

* * * *

The appellation "psychoanalytic movement," that described the development of psychoanalytic theory and the applications of that theory by a group of men and women absorbed in these undertakings, has been considered a self-evident reproach by some who consider that scientific developments should not be in the form of "movement." The fact remains, however, that both an esoteric experience plus the mastery of a large body of abstruse knowledge are necessary for consistent, significant participation in psychoanalytic discussion. Psychoanalytic training implies something like ten years of postgraduate study, and certainly psychoanalytic teaching is a lifetime dedication. We may, therefore, attach a special value to the labor of love represented by *The Annual Survey of Psychoanalysis* (International Universities, 1958). It strives for an objectivity and impartiality which it doesn't entirely achieve; it is over three years behind; it is too big. But it expresses an effort toward critical compilation which can only be rewarded by the gratitude of all psychological scientists.

* * * *

Many have wondered and phantasied, no doubt, regarding the nature of the psychic and social conflicts which lead to the election of prostitution as a mode of life. Harold Greenwald did the logical thing; he attempted to help some victims of the "racket" with psychological study and treatment. The treatment "worked" and the study provided the information presented in a book *The Call Girl* (Ballantine Books, 1958).

* * * *

Dr. James Clark Moloney's experience with the Okinawans stimulated his thinking in regard to other minority groups and the effects upon them of trends and surges of our so-called civilization. He recorded his thoughts in the book *Fear: Contagion and Conquest* (Philosophical Library, 1957). In all of this he is constantly reminded of the stabilizing, character forming influences of the early months of "properly measured" mothering. There are no dull pages.

* * * *

Probably no one less ingenious, indefatigable and widely acquainted than Eileen Garrett could have persuaded theologians of six different faiths, philosophers, psychologists, physicists, and even a psychoanalyst to discuss the question of personal survival after death—the meaning of the concept and its possibility *(Does Man Survive Death?,* Helix Press, 1957). The Editor herself maintains a scientific attitude: "I do not have the answer to these questions. (But) it is my eternal quest. . . ."

* * * *

A beautiful book, *Schizophrenia 1677: A Psychiatric Study of an Illustrated Autobiographical Record of Demoniacal Possession* (Dawson & Sons, 1956) is the second in a series by Ida Macalpine and Richard A. Hunter. It contains colored plates taken from photographs in the original manuscript of the Christoph Haizmann case. Haizmann was a 17th century Bavarian painter who had repeated attacks of "convulsions, absences, and demoniacal apparitions" which he ascribed to a bargain entered into by him with the devil and from which he was finally "cured" by the "intervention" of the Virgin Mary. The manuscript, partly in Latin and partly in German, contains autobiographical data, copies of his pacts with the devil, accounts of the miracles written by the abbot of the monastery and various letters together with these amazing illustrations of the devil in various "horrifying," "disgusting," "dreadful," "abominable," "loathsome" guises.

Freud examined this material and commented upon it at length in confirmation of his views regarding the relationship of unconscious homosexuality to paranoid symptom formation. (Haizmann contracted

to be the "bodily son" of the Devil.) Freud published this comment 12 years after his analysis of the Schreber case, partly, I believe, in reaction to some criticisms from Adler. Macalpine and Hunter do not mention Adler, but they make a number of sharp criticisms of their own relating to Freud's analysis of this and the Schreber case. They particularly object to Freud's interpretation of the dominant role of repressed homosexuality in paranoid projection, with which others of us have also taken issue.

The authors review psychoanalytic theory as it relates to psychiatry, and make the excellent point that an artificial line continues to separate the neuroses from the psychoses, and psychoanalysts from psychiatrists. They feel, too, that "circular thinking" of a kind derives from what they call psychoanalytic ritual, so that the duration of psychoanalytic treatment tends to become longer rather than shorter—as it perhaps should—with our increasing knowledge and experience. These thought-provoking strictures add to the interest of this valuable book.

* * * *

Allen Wheelis, our alumnus, had already distinguished himself while in the Menninger School of Psychiatry, in Topeka, by creative writing. He left us for Riggs in Stockbridge and thence moved to California. His book, *The Quest for Identity* (W. W. Norton, 1958), is the annotated case history of a man who gives up writing for the study of medicine and the practice of psychoanalysis. It is perceptive and thoughtful, but at times the assertions and inferences seem a little too sweeping.

* * * *

Melanie Klein employs the word "envy" to describe the emotions accompanying the aggressive destructive upsurge—resentment, bitterness, longing, and the like—aroused in the baby by feeding (and other) deprivation *(Envy and Gratitude,* Basic Books, 1957). She sees many anti-social attitudes, including greed, destructiveness, and homosexuality as reflecting the development of these feelings. Her theories in this respect correspond to those offered in *Love Against Hate.* "Gratitude" describes the baby's reaction to the termination of deprivation, and its appreciation of the mother's approval; from this gratitude develop such later traits as generosity, altruism and creativeness. It is a tribute to the importance of these ideas that they come through in spite of difficulties in presentation. Though opposed by many Freudians, Klein consistently endeavors to be faithful to her interpretation of Freud's meaning.

K.A.M.

BOOK REVIEW

Human Potentialities. By GARDNER MURPHY. $6. Pp. 340. New York, Basic Books, 1958.

The humanity of Gardner Murphy is everywhere a part of this book; it holds his thoughts on life and on the "something" that brings order to it. He foresees the future environment of man and its guessable repercussions upon human nature. He believes that in this century and the next, there is a possibility that thoughtful men and women may define the various kinds of societies and of individual lives that will be possible in the future and about which they will make conscious and voluntary choices. He further believes we can learn to live, to study the latent potentialities of mankind, to discover which ones are feasible and satisfying and to utilize science, education, and government to achieve them.

In a progression of carefully developed thoughts, Murphy shows what kinds of things we shall need to know if we are to realize our potentialities as human beings. We shall need to know, in his words:

> . . . that man achieves some measure of understanding himself only in facing crisis.
> . . . that only by meeting challenges can man raise himself to a new level of creativeness.
> . . . that basic human nature can begin to change if one makes a fundamental search of the sources available within human nature for new varieties of thought, value, and aspiration.
> . . . that information about man has become available from the sciences which indicates the sort of thing man is, the directions *current* biological and social evolution may give to his life in the years ahead, and the areas of freedom in which he may actually discern possibilities and intelligently select among them.
> . . . that man's newly acquired skills are changing not only the environment in which he must live but the very structure of his being. Potentialities are not just incompletenesses but radically new kinds of human nature.
> . . . that the realization of human potentialities involves a much deeper understanding than we now possess of the relation between man and his environment. It involves the awareness that nothing is inherited; nothing acquired, but *everything* springs from the interaction in life-space. Human nature itself is the *reciprocity* of what is inside the skin and what is outside. A field principle is involved in trying to define genuine satisfactions and opportunities for the release of potentials for men as they will be in another era. Instead of extrapolating man—as he now exists—to be acted upon by new cultural forces, one has to imagine a continuous succession of forces (social and biological) acting upon new men.
> . . . that in this field-science one becomes aware of changes in human potentialities that are quantitative (as new alertness, or new sensitivity); that are qualitative (as new depth of perception); that are new elements of experience (as new knowledge, or new drugs); and that are configurational (as reorganization of the familiar into new forms).

> . . . that human potentialities are also given by *action* and functioning. It is distinctively human to *use* what one has as a person for the processes of integrated organic creativeness through the reciprocity of inner and outer potentials, which then transforms both the man and his world, giving rise to new and finer biosocial interactions.

Murphy also develops his conception of the three kinds of human nature and the kinds of *interaction* that are most frequent between them and characteristic of them. This leads him, first, to detail the nature of knowledge which comes from the study of the instinctual life; second, to describe the cultural systems of man which bring about an investment in a certain *way* of looking at life and which build a world of values that becomes stable; and finally, to show that by understanding the nature of the creative process, the self-emancipation of man can be achieved.

J. Cotter Hirschberg, M.D.

BOOK NOTICES

The Impact of the Antibiotics on Medicine and Society. IAGO GALDSTON, ed. $5. Pp. 222. New York, International Universities, 1958.

We expect nothing less than excellence from the New York Academy of Medicine and we get it. Among the best of its recent publications is this monograph, the second of the Academy's Institute of Social and Historical Medicine, comprised of 14 essays describing the influence of antibiotics on medicine and society. The contributions, all by men eminent in their specialties, deal with such aspects as historical perspectives, microbiological research in the modern era, mass production of antibiotics, and the effects of these new "miracle" drugs on clinical practice, animal husbandry, the livestock industry, on public health and on the community. The story of the antibiotics makes one of the most fascinating chapters in the entire history of medicine. (Nathaniel Uhr, M.D.)

New Primer on Alcoholism. By MARTY MANN. $2.95. Pp. 238. New York, Rinehart, 1958.

Marty Mann presents an excellent statement written for and about individuals who have difficulty with alcohol. There are 238 pages of helpful information, explaining alcoholism, and giving practical, helpful suggestions to the alcoholic and to his relatives. (W.C.M.)

Current Concepts of Positive Mental Health. By MARIE JAHODA. $2.75. Pp. 136. New York, Basic Books, 1958.

This is a compact little monograph written in a direct, vigorous, concise style. The author's goal is "the development of a rational approach to the problem of defining mental health" and to this end she considers various definitions which, as she points out, mingle values and facts. The absence of mental disease, and the concept of normality are rejected as unsuitable. Surveying current literature (most of it since 1950) she sorts out the criteria of growth, integration, autonomy, perception of reality, environmental mastery, *etc.* which recur in discussions by different individuals and groups. Each of these is discussed critically. The book is a good short cut to an acquaintance with contemporary thinking in

The Psychology of Religion. By WALTER HOUSTON CLARK. $5.95. Pp. 485. New York, Macmillan, 1958.

Good up-to-date textbooks in the psychology of religion are badly needed. Despite its usefulness as an introductory text, this specimen is not up-to-date and does not represent the whole scope of the field. Significant omissions are: Flournoy, Bovet, Jones, Mueller-Freienfels. Freud and Jung are dealt with cavalierly. The pastor-psychoanalyst Pfister is not even mentioned. (Paul W. Pruyser, Ph.D.)

Psychosomatic Medicine: A Clinical Study of Psychophysiologic Reactions. By EDWARD WEISS and O. SPURGEON ENGLISH. $10.50. Pp. 557. Philadelphia, W. B. Saunders, 1957.

Since the appearance of the first edition in 1943, this has been a standard introductory text into the increasingly cultivated field designated as "psychosomatic medicine." Like its predecessors, the current edition's virtues as a basic text are likewise its limitations. The complexity of the field, both conceptually and in its variety of actual clinical and experimental observation, is reduced to a deceptive simplicity. Many stimulating, provocative and significant contributions are not represented. The book is, nonetheless, an excellent first text for the practitioner of psychiatry or general medicine interested in this field. (Robert S. Wallerstein, M.D.)

Mental Health Consultant and Educational Services of New York. Community Council of Greater New York. Research Department. Pp. 181. New York, Community Council of Greater New York, 1957.

Conducted under the general direction of Dr. Blanche Bernstein, this survey was an attempt to determine the extent of the mental health consultant and education services in New York. Questionnaires were sent to all public and voluntary organizations listed in the *Directory of Social and Health Agencies of New York City for 1956-57.* Although lack of uniformity of records and differences of terminology presented problems in collecting and recording the information, the report should be of interest to all city, state and voluntary agencies concerned with mental health services. (Vesta Walker)

Epilepsy. By LETITIA FAIRFIELD. $4.75. Pp. 159. New York, Philosophical Library, 1957.

This small monograph on an important subject is written by an English physician presenting no new data in the conventional perspective of the general problem of seizures. Much of the treatise has to do with the socio-economic aspects of the convulsive patient and is pertinent to and most understandable in terms of British medicine. Its usefulness, therefore, in the management of patients in this country is limited. It, however, makes extremely interesting reading. (John A. Segerson, M.D.)

The Hangover. By BENJAMIN KARPMAN. $9.50. Pp. 256. Springfield, Ill. Charles C Thomas, 1957.

The author calls the hangover the *via regia* into the emotional life of the alcoholic and finds all the psychological problems of the patient reflected in magnified fashion in his verbal productions of the hangover state. Fourteen case histories, each a revealing glimpse into the mental life of the particular individual as seen through the mirror of the hangover, are given. Vivid drawings

which accompany the text attempt to capture the specific flavor of each individual's emotional dilemma. Few would go so far as the author, however, in asserting that the study of the hangover is *the* key to insight into the psychodynamics of alcoholism. (Robert S. Wallerstein, M.D.)

Social Class and Mental Illness. By AUGUST B. HOLLINGSHEAD and FREDERICK C. REDLICH. $7.50. Pp. 442. New York, John Wiley, 1958.

Ten years of work by a group of social scientists and clinicians at Yale, reviewed here in full for the first time, have focused upon two questions often raised but too little studied in depth: (1) What are the relationships between diagnosed mental illness and social class? (2) How do the social characteristics of patient and therapist affect treatment? The authors contend that their findings demonstrate the need for radical changes in current psychiatric training and practice, both to utilize new knowledge and to cope with increasing public demand for professional mental health resources. Their recommendations have drawn wide attention and provoked considerable controversy, but one suspects that the debate has just begun. (Charlton R. Price)

Peptic Ulcer and Psychoanalysis. By ANGEL GARMA. $6. Pp. 143. Baltimore, Williams & Wilkins, 1958.

The author propounds in expanded book form his now familiar views on the psychodynamics of the peptic ulcer patient. From the Kleinian position he states in his thesis that the ulcer process represents the bad internalized mother acting aggressively (biting, devouring) upon a person in a state of "oral-digestive regression." He documents his position with much analytic case material and seeks to establish that thorough psychoanalysis is the only truly etiologic therapy for the ulcer patient. As always, his views should command respectful attention. (Robert S. Wallerstein, M.D.)

Psicotherapie del Grupo. By LEON GRINBERG and others. Pp. 242. Buenos Aires, Editorial Paidos, 1957.

This first book published in Spanish on the theory and practice of group psychotherapy reflects well the enthusiasm and dedication of a small group of pioneers in Argentina. The clinical approach is based upon psychoanalytic principles and is well qualified and up-to-date. Chapters dealing with practical problems are especially interesting. A summary of the book in English is included, together with the bibliography. (Kenneth Munden, M.D.)

The Brain and Human Behavior. HARRY C. SOLOMON and others, eds. $15. Pp. 564. Baltimore, Williams & Wilkins, 1958.

It is stimulating to read this volume which contains the papers presented at the 1956 meeting of The Association for Research in Nervous and Mental Disease. Included are data from many different modes of investigations of the relationships of the brain and behavior—some of the problems and points of view in this area are presented by Dr. Karl Lashley. The disciplines of psychology, neurophysiology, neurosurgery and neuropharmacology are all well represented. A considerable section is devoted to problems of the temporal lobe disorder and studies of lobotomy, of experimental parietal lobe lesions and of the corpus callosum are included. This volume presents an opportunity to learn or to review many facets of the enormous amount of present investigative work. (Joseph M. Stein, M.D.)

The Psychiatric Hospital as a Small Society. By WILLIAM CAUDILL. $6.50. Pp. 406. Cambridge, Mass., Harvard University, 1958.

The thesis of this incisive and imaginative study is that "the hospital is a small society, and that the ongoing functioning of such a society affects the behavior of the people who make it up in many ways of which they are unaware." The author, an anthropologist, uses concepts from psychodynamic, small group and formal organization theory to depict the hospital organization as a network of interlocking (and to some degree predictable) events. The last chapter suggests specific functions which social scientists can usefully perform in clinical settings. (Charlton R. Price)

Marriage Counseling: A Casebook. EMILY H. MUDD, ed. $6.50. Pp. 488. New York, Association Press, 1958.

Edited by a committee of The American Association of Marriage Counselors, this book has thirty-eight reports from counselors about their experiences in dealing with forty-one marriage counseling cases. Techniques and methods used vary considerably from counselor to counselor, partly because some of the counselors are physicians, some psychologists, some sociologists. Moreover, not many of the counselors had received specific training in marriage counseling as such. Consequently, the reader may be somewhat confused as to just what constitutes marriage counseling. However, the editors have provided a brief, general explanation that should be helpful in this regard. (Dean Johnson)

Psychotherapy of Chronic Schizophrenic Patients. CARL A. WHITAKER, ed. $5. Pp. 219. Boston, Little, Brown, 1958.

This is a verbatim report of eight sessions in a meeting at Sea Island, Georgia in 1955 of seven psychiatrists and an anthropologist. Participants were: Malcolm Hayward, M.D.; Gregory Bateson, the anthropologist; Carl Whitaker, M.D.; John Workentin, M.D.; Donald Jackson, M.D.; Thomas Malone, M.D.; John Rosen, M.D.; Edward Taylor, M.D. They had met together with the exception of Bateson as a "peer" group to exchange ideas on schizophrenia each year for eight or nine years prior to this meeting. All were primarily interested in the psychotic patient and all used psychotherapy exclusively. A significant aspect of the diagnosis and treatment of the schizophrenic patient was considered at each session. The material for the 1955 meeting, which appears in this book, was edited, but not rewritten. (Dorothy Danna, M.D.)

Medical Sociology. By NORMAN G. HAWKINS. $6.75. Pp. 290. Springfield, Ill., Charles C Thomas, 1958.

In an unusual approach to the nascent field of his book's title, Professor Hawkins, one of the growing number of social scientists on medical school faculties, discusses such varied topics as the cultural context of illness, research methods, age and chronicity and the use of research findings in the interest of prevention. Footnotes, bibliography and index are extensive. (Charlton R. Price)

Correction

In the article "Projective Tests in the Evaluation of the Tranquilizing Drugs" by Dr. Herbert J. Schlesinger in the November 1958 issue of the *Bulletin* on page 226, line 17 is wrong. This was a printer's error. The line "tests have little to contribute to the evaluation of drugs as criterian" should have read "drugs on patients seem hardly relevant to the problem of drug