Psychotherapy

Lewellys F. Barker

PSYCHOTHERAPY

By LEWELLYS F. BARKER

PSYCHOTHERAPY
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PSYCHOTHERAPY

Treatment that attempts to improve the condition of a human being by means of influences that are brought to bear upon his mind

BY

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whose foresight in introducing
work in mental hygiene among college students
should always be remembered

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CHAPTER I

DEFINITION OF PSYCHOTHERAPY

THE writing of a small volume on psychotherapy, the contents of which will be understandable by general practitioners of medicine and by intelligent laymen, is no easy task. Though psychotherapy, in one form or another, has been applied by both physicians and laymen since the very earliest times, the more scientific methods of utilizing it are comparatively recent and, during the present century especially, have undergone a prodigious development. I have myself systematically made use of it in hospital and private practice for more than thirty years.

The number of books and articles published on psychotherapy is enormous; no single person could hope to read everything that has been written on the subject. Moreover, in recent years, not only have the simpler methods undergone marked amplification, but more recondite measures have been introduced and extensively employed. In connection with the latter, a large new vocabulary of terms has been devised; some of these terms are difficult to explain in simple words to the ordinary reader. Indeed, many physicians are so markedly repelled by the language and the ideas of some of the writers on psychotherapy (especially on psychoanalysis), that they feel that a

subject so apparently recondite can be of but little value in ordinary medical practice and can be safely ignored.

Unfortunate as this attitude is, it undoubtedly exists, and there is danger that even the simpler and more easily applied methods of psychotherapy may be thrown overboard along with the recondite by some physicians, to the great detriment of patients who need psychotherapy in addition to other forms of treatment. Indeed, a leading American internist has made the statement that many physicians unfortunately identify the special aims and methods of psychoanalysis with the general aims and methods of psychiatry and tend to think of the whole field of psychiatry as ridiculous and contemptible (L. Hamman, 1939).

If the word "therapy" is simply another word for "treatment," what do we mean by "psychotherapy"? As simple a definition as I can give is: "Treatment that attempts to improve the condition of a human being by means of influences that are brought to bear upon his mind (psyche)."

In thus defining psychotherapy, I think of the human being as a body-mind (somatopsychic) unit, and of the therapy as being directed especially toward the psychic aspects of that unit. As Menninger has said, in treatment by psychotherapy we utilize "the psychological machinery, rather than the physical or chemical machinery of the personality." It is necessary to transform the energies of the patient from harmful into useful forms. As a matter of fact,

"psychobiological therapy" or "personality therapy" would be better names than "psychotherapy," but the latter term has become "naturalized" and will doubtless continue to be used.

Much confusion has arisen from philosophic considerations that promulgate monistic, dualistic, or psychophysical parallelistic conceptions of man. We do not need to think of man as body alone, as mind alone, as body and mind independent of one another, or as a being in which for every physical change there is a parallel psychic change. We do far better to accept the idea of Adolf Meyer, who thinks of the individual as a whole, as a psychobiological unit, as a personality, recognizing that the physical body and all its functions, including those called "mental," belong inseparably together.

Man, as a whole, is a highly complicated integrated unit. In our practical work we may analyze this unit into its component parts and may consider the properties and functions peculiar to each of these parts as though they were separate, but we must always remember that each of the parts is never really entirely separated from the others but is interrelated with all other parts and is integrated in the personality as a whole.

As Diethelm has put it, the qualities and functions of the component parts "can be treated as though they represent a hierarchy of specific levels or groupings (orders) of integration." This should always be borne in mind when one speaks of an anatomical, a physiological, a neurological, or a psychobiological level of

integration. Though the mentally integrated functions form the psychobiological unit, it must not be thought of as existing separately, since it includes all the lower levels. * In other words, it is methodologically wrong to think of dealing with a mind (or psyche) alone; we must, at the same time, give due consideration to the facts that bear upon the physical, chemical, physiological, and neurological levels. Plato long ago said that "the great error of his time in the treatment of the human body was that physicians separated the soul from the body."

Psychotherapy, accordingly, is not confined to the treatment of nervous and mental disorders; it is also of value in the amelioration of physical disorders. The clinical problems with which the psychotherapist has to deal have been well outlined in C. Macfie Campbell's article in *The Problem of Mental Disorder* (National Research Council, 1934).

The psychotherapist is interested in the adaptation of patients to their total situations; he attempts to influence the attitudes of patients favorably in many different ways: (1) toward themselves as a whole, their behavior, and their beliefs, (2) toward their various bodily and mental processes, and (3) toward their physical and social environments. To succeed in these attempts, a thorough knowledge of the patients and of their situations is essential; in other words, treatment should be preceded by thorough

* An interesting attempt to relate the functions of the autonomic nervous system to personality makeup will be found in E. J. Kempf's *Psychopathology* (1920).

diagnostic studies. Account must be taken of the various "drives" that influence human beings, especially the drive for security, the drive for sexual gratification, and the drive for power and achievement.

A person manifesting disturbances in one domain may, on examination, be found to have disturbances in several domains. Treatment directed toward improving one domain only might be wholly insufficient. The psychotherapist should never allow himself to be hampered by stereotyped classifications or to be limited to stereotyped therapeutic methods; as D. K. Henderson has emphasized, he must be "elastic-minded enough to use any method that seems most applicable." All the needs (physical, chemical, mental, situational) of a patient should be determined, and the several best methods of meeting those needs should be applied.

This task is not one for a tyro but belongs to the well-trained medical practitioner, who in some cases may require the aid of consulting specialists. Moreover, the psychotherapist should, to some extent at least, fulfil, as A. Gallinek has said, the requirements expressed by Nietzsche in these words: "He must possess the persuasiveness that adjusts itself to every individual, a diplomat's suave way of negotiating, and the adroitness of a detective in understanding the secrets of a soul without betraying it."

CHAPTER II

The Making of Comprehensive Diagnostic Studies

In my clinical teaching of medical students, I have always laid emphasis upon the desirability of thorough general diagnostic studies in every case, no matter what the patient's complaint may be or how obviously it may point to any one particular bodily system (circulatory, respiratory, digestive, excretory, endocrine, or nervous). The only exceptions are certain cases of immediate urgency; for example, sudden surgical emergencies (such as fractured bones, dislocated joints, hemorrhages, acute appendicitis, or acute intestinal obstruction) or medical emergencies (such as acute poisonings and certain acute infections) in which quick action must be taken to lessen the threat to life. And even in these more exceptional cases, after the emergencies have been satisfactorily met, a more complete study should follow whenever it is feasible. For, once a patient has consulted a physician, it is the latter's duty to try to direct him so that he can make the best possible adaptations to the life situations in which he finds himself. In order to succeed in this, the physician needs fully to appraise the patient's assets and liabilities, on the one hand, and carefully to analyze the situations to which the

patient has to make adjustments, on the other. The astute physician thinks not merely of diseases and of symptoms but also of the various maladjustments of the human organism as a whole.

There has been in the past far too much one-sided study of patients, with resulting failure of detection of co-existing organic and functional disorders and much lack of success in therapy because of failure to include all the remedial agencies indicated by the total situations of patients.

In the making of a thorough diagnostic study, the physician takes a full history of the patient (*anamnesis*), makes a general *physical examination,* provides for such *X-ray examinations* and *clinical laboratory tests* as seem to be indicated, and asks for *examinations by specialists* in various domains when these appear to be desirable as a result of the statements in the history and the findings on physical examination. An up-to-date internist is much more likely to make a comprehensive study than is a specialist, who is too prone to devote his whole attention to the recognition and treatment of disorders pertaining to one particular domain.

The Clinical History (*Anamnesis*).—After recording his name, age, state, home address, occupation, and names and addresses of relatives, it is well to ask the patient why he desires help and to put down his *chief complaints* (verbatim), for the exact terms he uses may later prove to be very helpful to the examiner.

One then inquires into the *history of the present*

illness, its date and mode of onset, its course from its beginning to the time of consultation, and the treatment, if any, that has been followed. Possible causes (intoxications; infections; physical or psychical injuries; deleterious occupational influences; dietetic errors; exposure to cold or wet; exposure to contagion; personal, familial, or social conflicts or maladjustments) should be recorded.

Next, one asks specifically about symptoms or signs referable to the various bodily systems that may have been noticed (e.g., headaches, pains, dizziness; disturbances of cutaneous sensation, smell, taste, sight, or hearing; cough, expectoration, shortness of breath, palpitation; disturbances of appetite, nausea, or vomiting; flatulence or gaseous eructations, constipation, diarrhea, piles; frequency of urination, especially at night; disorders of sex functions; sweating or dryness of the skin; changes in body-weight; sleep, general behavior, orientation; stream of talk and activity, power of concentrated attention, power of retention and recall; fatigability, predominant mood, special interests, memory for recent and remote events; and various nervous and mental symptoms, including fears, anxiety, day-dreams, temper outbursts, obsessions, compulsions, feelings of unreality, indecision, and various pathological ideas. Answers to the three questions, (1) "Are you sick?" (2) "Have you been sad, blue, or gloomy?" and (3) "Have others treated you well?" are often revelatory.

The *previous history of the patient* is then recorded. Diseases the patient has had earlier (either

in childhood or in adult life), any surgical operations that have been performed, and the state of the general bodily functions (respiratory, circulatory, digestive, urogenital, locomotor, endocrine, and nervous) in earlier life are noted.

In addition, data are accumulated upon the patient's habits and previous experiences. We ask about the character and the hours of the patient's work; the amount of exercise, rest, and recreation provided for; the content and variety of his diet; the time meals are taken, and the thoroughness of mastication. The patient's habits regarding the use of tea, coffee, alcohol (beer, wine, whisky, cocktails, etc.), tobacco (cigars, cigarettes, pipe-smoking, chewing, snuff), and drugs (sedatives, hypnotics, cocaine, morphine, heroin, and certain drinks containing bromides and acetanilide, sold at drug-stores and soda-fountains for the relief of headaches, etc.) are ascertained. The amount and character of the education received and any history of difficulties at school or college should be inquired into. Points of interest regarding the patient's general life experiences, including interests, ambitions, occupation, hobbies, public life, religious activity, satisfactions and dissatisfactions, travel, and social relations are next recorded.

Finally, the anamnesis should include data regarding the *family history*. The age, if living (or at time of death), of parents, sisters, brothers, and children and the states of health of each, are recorded. Especial inquiries are made regarding instances among near or distant relatives of diseases in which either heredity

or contact may play a rôle (tuberculosis, syphilis, nervous and mental diseases, alcoholism, diabetes, gout, obesity, disorders of the glands of internal secretion, and tumors like cancer or sarcoma).

Physical Examination.—The patient is asked to undress completely, in order that a thorough general physical examination may be made. The physician then dictates to his secretary his findings (1) upon certain general points (gait, attitude, posture, height, weight, form of bodily build or habitus; the state of nutrition of the musculature; the bones and joints, the lymph glands and the skin; the body temperature, the radial pulse-rate at both wrists, and the blood pressure, both systolic and diastolic); and (2) upon the findings in the head, neck, thorax, abdomen, and pelvis (including the results of rectal examination and, in females, of a vaginal examination); and (3) upon the nervous system (including a quick orientative examination of the mental functions—intellect [cognitive functions], emotions [affective functions], and will [conative functions]).

X-ray Examinations.—After the study has progressed thus far, the experienced physician will know what X-ray examinations are indicated. In some patients few, if any, may be required; in others, many may be necessary (fluoroscopy or X-ray plates).

Thus, if the paranasal sinuses are suspect, they should be X-rayed; if lesions in the lungs or heart are found, or if a cervical rib be suspected to exist, a chest plate or a teleroentgenogram may be ordered. If the teeth are suspect, periapical infections will be

sought in dental X-rays. If there are marked digestive disturbances, X-rays of the gastro-intestinal tract and of the gallbladder may be required; if there is a history of renal colic, X-rays of the kidneys and urinary tract will be made. If the joints are involved, X-rays will often determine the nature of the involvement. If brain tumor be suspected, stereoscopic X-rays of the skull are indicated; or, if a tumor or other lesion within the vertebral canal be possible, X-rays of the spine before and after injection of lipiodol may be required.

Laboratory Tests.—The examiner next decides upon the clinical laboratory tests that should be made. Here good clinical judgment, based upon experience, is very important. Unnecessary tests should not be ordered, but tests that are indicated by the history and the physical examination should not be neglected.

In most patients, a blood examination (including counts of the red and white cells and platelets, hemoglobin determination, and Wassermann or Kahn reaction for syphilis, even in the absence of any history of infection) should be made. Studies of the blood chemistry (content in uric acid, non-protein nitrogen, sugar, calcium, phosphorus, vitamin C, bloodbromides), and of the blood sedimentation rate may occasionally be necessary. If gout, Bright's disease, diabetes, rickets, latent scurvy, or bromidism be suspected, certain of these chemical tests of the blood should be carried out to corroborate or refute the suspicion entertained.

In all patients, examinations of the urine (morning and evening specimens) should be made, and if albumen and casts be present, tests of renal function with phenolsulphonephthalein may be carried out. If the urine contains pus, bacteriological examinations should be made to determine the nature of the infectious agent.

In a general diagnostic study, it is well also to make an examination of the feces for occult blood and for parasites (or their eggs), for otherwise a small gastric or intestinal ulcer or a parasitic infestation may easily be overlooked.

Laboratory examinations of sputum, stomach juice, basal metabolic rate, and cerebrospinal fluid, as well as tuberculin tests, allergy tests, electrocardiograms and electro-encephalograms are ordered only when need for them is indicated.

Reports from Specialists.—When the conductor of the diagnostic study feels that examinations in certain special domains are necessary, he will ask for them. Thus, in some cases, he may desire a report from an ear, nose, and throat specialist, an ophthalmologist, an orthopedist, a gynecologist, a urogenital specialist, an allergist, a neurologist, a psychiatrist, or some other specialist.

Here again, no special examination should be requested without sufficient reason. The cost of a thorough diagnostic study of a patient should never be lost sight of. In an obscure case the cost involved will often be considerable, but, in any case, physicians must see to it that no financial hardship upon the

patient is entailed. Well-to-do patients will have no difficulty in meeting the costs. Impecunious patients may secure a thorough study in the dispensary, or in the public ward of a hospital that provides for such examinations free of cost, or at special "pay clinics" at which only a very small nominal charge is made. When patients are neither well-to-do nor very poor, and these represent the majority of those who consult doctors, special arrangements have to be made. Group clinics should make it a rule to reduce the cost of the study to an amount that is no hardship to the patient. Moreover, the general practitioner or the internist can usually arrange with specialists and laboratories so that, for people of moderate means, a so-called "blanket fee" to cover the whole cost will be collected from the patient, all those participating in the study receiving corresponding percentages of their regular charges.

Summary of the Findings.—After the study has been made, the physician conducting it will do well to summarize all the positive and negative findings upon a special summary sheet something like the following:

SUMMARY SHEET

Name: *Age:* *Occupation:* *Body Temperature:*

Habits: (tea, coffee, tobacco, alcohol, work, rest, exercise, diversion).

Infections and Intoxications: (dates and severity of these; immunological tests; allergy).

Operations: *Traumata:*

Respiratory System: (including sputum, nose, throat, sinuses, lungs, pleuræ).

Circulatory System: (including pulse-rate, blood pressure, vessel walls, heart).

Blood and Blood-Building Organs: (including blood counts, hemoglobin, Kahn or Wassermann reaction, stained smears, sedimentation time, blood chemistry, blood cultures, spleen, and lymph glands).

Digestive System: (including stomach juice, stool, abdominal and rectal examinations, X-rays, liver-function tests).

Urogenital System: (including urine, sex organs and functions, sex adjustment, kidneys, ureters, bladder).

Locomotor System: (including gait, posture, bones, joints, muscles).

Nervous System and Sense Organs: (including smell, taste, hearing, sight, bodily sensation, motility, reflexes, intelligence, emotion, will, behavior, cerebrospinal fluid, X-rays of skull, ventriculograms, etc.).

Metabolism and Endocrine System: (including height, weight, habitus, basal metabolic rate, pituitary, thyroid, parathyroids, islands of Langerhans, adrenals, and sex glands).

Remarks: (including salient points from family history, hereditary influences, environmental influences, economic status, disease-insight, and occupational, social, political, and religious influences).

Having an epitome of all these findings upon a single sheet, the diagnostician glances over it as a whole and can quickly recognize the more important and less important deviations from the normal. He is then prepared to make a comprehensive, multidimensional diagnosis.

Thus, in one case recently studied by the group in which I work, the diagnostic findings were as follows:

1. Idiopathic epilepsy with history of grand mal seizures and of ambulatory automatism.
2. Dysplastic habitus with epileptiform type of temperament and tendency to aggressiveness, fault-finding, and social maladaptation.
3. Chronic laryngitis (following gassing in the World War).
4. Chronic bilateral otitis media, with partial deafness.
5. Oral sepsis (one periapically infected tooth).
6. Chronic renal disease with albumen and casts in the urine, low phenolsulphonephthalein output and increased non-protein nitrogen content of the blood, but without increase of blood pressure.
7. Mild hypopituitarism (dystrophia adiposogenitalis) with obesity (thirty pounds above normal weight for height), large breasts, and small testes.
8. Faulty habits (excessive use of coffee and of cigarettes).

In a second case, the results of the diagnostic study were as follows:

1. Angina pectoris, with history of pain in the chest radiating into left arm and fingers, slight dyspnea, palpi-

tation on exertion, and suggestive changes in the electrocardiogram.

2. Gastric hyperacidity, with spastic colon, gaseous indigestion, and constipation.

3. Slight hyperthyroidism; basal metabolic rate plus 11, and slight tachycardia.

4. Anxiety neurosis, with history of marital infelicity and of worry over anginal attacks.

5. Faulty habits (cigarettes, 20-30; coffee, 3-4 cups daily; excessive use of alcohol).

CHAPTER III

Planning Adequate Treatment After Thorough Diagnosis

Much of the lack of success in the treatment of patients lies in (1) failure to make a sufficiently thorough diagnostic study, or (2) failure, after comprehensive diagnostic study, to plan the therapy so as to include all the remedial agencies that are indicated by the whole situation of the patient.

Take, for example, the first patient whose diagnostic findings have been summarized in the preceding chapter. On account of his recurring epileptiform convulsions, he would be most likely to consult either his family doctor or a specialist in neurology. But if either of these practitioners had been content with the obvious diagnosis of epilepsy alone and failed to make studies that would rule out a symptomatic epilepsy (due to brain tumor or other recognizable cause) or to make the examinations necessary to reveal the other positive findings in the case, the patient would not have received the comprehensive treatment to which he was entitled. The administration of phenobarbital or of dilantin would, it is true, have markedly lessened the frequency and severity of the epileptiform attacks, but the patient obviously needed much more treatment than merely the administration of an anticonvulsant drug.

He should be asked to reduce the amount of coffee used and the number of cigarettes smoked. The infected tooth should be extracted and its socket should be curetted. The diet should be low in caloric value because of the obesity and, moreover, should be planned so as to contain an adequate amount of proteins, fats, mineral salts, and vitamins, while avoiding the throwing of too much work upon the already damaged kidneys. Because of the endocrine deficiency, a series of injections of a pituitary gland substance (antuitrin S) would seem to be worthy of trial.

Though probably relatively little can be done to overcome the chronic laryngitis or the chronic inflammation of the middle ear, the larynx should be protected as much as possible, and if the deafness should become too troublesome, an apparatus could be worn to aid the hearing.

Another feature of this patient's case is interesting from the standpoint of treatment, and that is the epileptiform temperament with associated abnormal tendencies (over-aggressiveness, fault-finding, and social maladaptation). Here a difficult task confronts the practitioner, but he should do as much as he can by psychotherapy to make the patient conscious of his mental and emotional difficulties and to teach him to overcome his faults. If the family doctor has not the time, or is not qualified by his experience, to cope with this side of the case, he might do well to ask a sensible psychiatrist to assume that responsibility for him.

In the treatment of the second case mentioned in

Chapter II, the anginal attacks, of course, demand attention, and the patient should be advised to avoid over-exertion and the emotional stresses and strains that are likely to precipitate attacks. He should carry a vial of nitroglycerine tablets (1/100 gr.) in his waistcoat pocket and, in case of an attack, rest immediately and swallow one of the tablets.

In addition, he should overcome the constipation by taking mineral oil, should take one methatropin tablet (1/25 gr.) thrice daily for the spasticity of the colon, and should use a mixture of sodium bicarbonate and magnesium hydroxide for the gastric hyperacidity.

The faulty habits should be corrected at once. Tobacco should be stopped entirely. The patient had been using too much alcohol and would do best to become a total abstainer. The amount of coffee should also be reduced to one cup a day.

The hyperthyroidism is not marked enough to demand treatment, but the pulse-rate should be watched and, later on, another measurement of the basal metabolic rate should be made.

The anxiety neurosis, related in part to the marital infelicity and in part to the worry over the anginal attacks, calls for skilful psychotherapy. The patient and his wife were both emotional people and both sensitive to criticism. They quarreled frequently and neither had learned how to cut a quarrel short. Fortunately, they had a child, of whom both were very fond and appeals should be made to each of the marital partners to make a better adaptation for the sake

of this child. Part of the husband's alcoholism had been the result of an attempt to "drown his sorrows" in the inebriating cup. The patient's wife had a schizophrenic brother and her own mental state required further investigation.

It would be easy to give hundreds of similar examples, from personal experience, of patients who, because of multiple diagnostic findings, require various medical and surgical measures of intervention in addition to psychotherapy. But the two instances above recorded are, I think, sufficiently striking to illustrate the principles involved and to make the citation of other cases to prove the point superfluous.

CHAPTER IV

The Importance of Understanding the Heredity and Environment of a Patient

Every human being starts as a fertilized egg-cell—the union of the paternal spermatozoon with the maternal ovum. The inheritance of the resulting individual depends upon the chromosomes (containing sets of genes) within the nuclei of these parental germ cells. Students of genetics have shown that all characteristics and properties of a living organism are products of the interaction of the genes received from the parents with the conditions (before and after birth) under which the individual organism develops. It can not be too strongly emphasized that all characteristics are influenced both by the genes that an individual bears and by influences of the environment; no characteristic is dependent either upon heredity alone or upon environment alone.

It is true that different types of characteristics differ greatly in their susceptibility to change through alteration of genes or environment. Thus, as Jennings points out, differences between individuals in respect to color of eyes, form of features, and the like are almost entirely due to diversities in the genes borne by the different individuals, whereas diversities in mentality and behavior may depend upon differences

in the genes borne, upon differences in conditions under which the individuals develop and live (their life experiences), or upon both. Every student of psychotherapy must, therefore, give due attention to both classes of factors (hereditary and environmental) if he is to make an adequate appraisal of any single person. Characteristics that depend mainly on differences between the genes of different individuals follow, in inheritance, unmistakable methods of distribution of the genes from parents to offspring; the distribution follows either the rules of Mendelian inheritance or of sex-linked inheritance.

But, as I have said, the kind of individual that a given set of genes will produce will be profoundly influenced by the environmental conditions to which the individual is subjected during development. For this reason, in studying a given person, one must be very careful not to lay false emphasis upon the separation of heredity and environment, though he may try to disentangle their respective contributions to the fully developed individual. Undoubtedly, our knowledge of the genetic system of man is as yet far from being adequate for safe predictability regarding the inheritance of defective conditions, especially since any given set of genes may be so influenced by the environment during development as to change greatly the expected results of a defective genotype.

For these reasons, the psychotherapist has learned to be cautious in his evaluation of a family history, lest he be unwittingly led into errors of judgment. But the recording of family histories is of real im-

portance; it is to be regretted that interest in such studies has so greatly waned. Family studies should be revived, but on a sounder and more critical basis than before. The Eugenics Record Office at Cold Spring Harbor, Long Island, N. Y., is encouraging such studies. Whenever possible, the history of at least three generations should be recorded, since such a history may be necessary for the determination of certain types of inheritance. For this determination, one must be familiar with the course of the two main types of inheritance (Mendelian or sex-linked) as manifested in either a dominant or a recessive defect, and also with the course of the rare type through the *y* chromosome (in the male line only). For the prevention of mental diseases in the future, psychiatrists must find out which of them require mainly genetic and which of them mainly environmental control.

Closely connected with genetic considerations are the studies of different types of constitution and their relation to predisposition to physical diseases (G. Draper) on the one hand and to types of temperament, character, and mental disorders (E. Kretschmer) on the other.

Thus, Draper, trying to correlate certain physical types with bodily diseases, suggests that it may be possible to recognize a "peptic-ulcer type," a "gall-bladder type," and a "pernicious-anemia type," through facial characteristics and certain special measurements.

More important have been the attempts at correlation of physique and character. Thus, the relation-

ships of (1) the *asthenic* (tall, thin) type of physical habitus to the *schizoid* (offish or seclusive) type of temperament, and (2) the *pyknic* (short, thick, round-faced) type of physical habitus to the *syntome,* or cyclothymic (hail-fellow-well-met, good mixer) types of temperament have been very definitely established. Schizophrenias (dementia praecox), as well as tuberculous infections, occur predominantly in persons of asthenic habitus, and the manic-depressive psychoses (elations and melancholias), obesities, and high blood pressure conditions are met with predominantly in persons of pyknic habitus.

Two other types of habitus have been described by Kretschmer: (1) the "athletic" type, in which cancer on the physical side and paranoid states on the mental side are particularly common, and (2) the "dysplastic" type, in which epilepsy is common.

In his studies of constitution, C. G. Jung lays great stress upon two types of temperament: (1) the predominantly "extrovert," and (2) the predominantly "introvert." Jaensch, a student of eidetics, distinguishes several "integration types," especially J_1, J_2, S_1, and S_2. It is interesting that the J_1 type of Jaensch resembles closely the cyclothymic type of Kretschmer and the extrovert type of Jung.

Obviously, therefore, the astute physician, familiar with these several types of habitus and of temperament and with the abnormal states with which they tend predominantly to be associated, may at first sight of a patient gain clues to the possible existence of various abnormal tendencies. Indeed, a knowledge of

these types of constitution is very helpful in the differential diagnosis of both bodily and mental disorders.

Here again, however, one must be cautious in applying these doctrines bearing upon constitution ("physique") and temperament ("psychique") too rigorously. Undoubtedly, we meet with many mixed types, as might be expected; for example, in the offspring of an asthenic type of man married to a pyknic type of woman. Moreover, no two human individuals (even identical twins) are just alike; we must be satisfied with deciding that a given person is a close approximation to one or another of the types that have been described.

Though "typical pyknics" and "typical asthenics" usually remain so throughout life, many persons are probably pluripotential, at least in some degree (W. Freeman). Indeed, it would seem that, in certain instances, one type may change so as to resemble another during later development; thus, the distinguished American neuropsychiatrist, S. E. Jelliffe, asserts that as a youth he was an "introverted asthenic," in college he became "athletic," and in maturity he was a "pyknic extrovert!"

Eugenics and race-hygiene are subjects of vast importance for human welfare, and legal limitation of reproduction of persons of definitely bad heredity is desirable for the sake of the welfare of the race; but it would be a prostitution of the eugenic movement to go as far as Hitler has gone in Germany in an effort to improve the race by exclusion of all Jews, even

though it be admitted that many members of the Nordic race have been "superior people."

Here in the United States all races are welcome, though we should do what we can to elevate the eugenic standards of each of them. We do discourage marriage between whites and blacks, but, in general, colored people enjoy great liberties here. In America, we do not persecute the Jews, expel them from the country, or confiscate their property. Princeton has given a welcome to the great Jewish physicist, Einstein. One member of the Supreme Court of the United States is a Jew. At the end of 1939, President Roosevelt nominated a Jew to participate in the movement to bring a satisfactory peace to war-torn Europe. It is to be hoped that America will continue to frown upon racial intolerance.

CHAPTER V

METHODS OF PSYCHOTHERAPY

A GREAT many varieties of treating patients by influencing their minds have been practised, some of them upon an empirical basis as a result of experience, others of them upon a more rational basis following exact scientific studies. In a small volume, such as this, an extensive discussion of all these methods is precluded, but a brief summary of them will suffice for general orientation.

SUGGESTION AND HYPNOTISM

In treatment by suggestion, consciously used by physicians, ideas are given to patients in the expectation that they will be received more or less uncritically and will be acted upon as though they were true, with resulting disappearance or amelioration of certain symptoms. Doctors, through their suggestions, lead their patients to believe that certain results will follow treatment and they often actually do. This form of psychotherapy makes use of what has been called "the patient's automatism."

But many beneficial effects of treatment consist of suggestions given to the patients unconsciously by their physicians. Patients who go to physicians for relief are in a state of expectancy, of somewhat nar-

rowed attention, of uncritical credence often, and of willingness to submit to medical influence. The degree in which such states exist in patients, in which they have a tendency to accept and to submit to suggestions, may be regarded as a measure of their "suggestibility."

All of us are, to a greater or less extent, susceptible to suggestions; some have strong impulses to follow suggestions ("positive suggestibility"), whereas others have strong impulses to resist suggestions and to do the opposite of what is suggested ("negative suggestibility"). It is probable that every person is more or less both positively and negatively suggestible.

It would be interesting to know how much of the benefit received by patients from drugs prescribed, from surgical operations performed, from electrotherapy, and from massage and various other forms of physical therapy has been due to the physician's belief, or to the patients' belief, in the efficacy of the treatments and to the suggestive influences exerted, rather than to direct physical or chemical effects upon the bodies of the patients. I suspect that the rôle of suggestive influences is often greatly underestimated, by both doctors and patients.

In modern psychotherapy, the use of indirect suggestions in a purposely hidden form (for example, placebos given for functional disturbances with the assurance that they will give relief) is avoided. The psychotherapist of to-day prefers to be frank with his patients, telling them of his diagnostic findings and discussing with them not only their general medical

problems but also their personality problems, fully and honestly. Though undoubtedly indirect suggestions play a part in the treatment, they are not employed in a purposely misleading form. The hospital environment, the physician's personality, and the friendly influence of social workers, of members of the patients' families, of employers and others with whom the physician may have consulted regarding adaptations, all may exert helpful suggestive influences without intent to deceive.

The method of so-called "autosuggestion" advocated by Coué is really a special type of suggestion emanating from the practitioner, since it is through his authority that a patient makes use of it. The patient is told to repeat to himself mechanically, over and over again, "Every day in every way I am getting better and better," or some similar formula. Such a method of suggestion is too general to be effective; any influence it may have must be attributed to the patient's faith in the method.

Our ideas of the power of suggestion and of the nature of suggestibility were for a long time vague and but poorly formulated. It was only after the phenomena of sleep-walking (somnambulism), both spontaneous and induced, began to be more thoroughly investigated that better understanding came. Studies of the phenomena of induced somnambulism represent the beginnings of experimental psychology. The observation of the changes in behavior that can be easily brought about during somnambulism through the influence of the spoken word excited close atten-

tion. Especially striking were the suggestions that were not acted upon until after the subject had been reawakened.

Bertrand plainly stated over one hundred years ago that artificial somnambulism is explicable as being due solely to the working of the subject's imagination. The patient goes to sleep because he thinks he will, and he re-awakes for a similar reason. These observations upon somnambulism (trance, hypnotic state) began to be applied in the treatment of certain disorders, especially hysterical contractures, paralyses, and anesthesias.

Before the discovery of ether and chloroform anesthesia (1846-47), hypnotic sleep was used to induce anesthesia for minor and even major surgical operations, but afterward, for twenty years, hypnotism fell into disuse by physicians and was left to charlatans, many of whom practised frauds upon the public. Indeed, for a time, it was scarcely reputable for scientific men to make further studies of hypnotism. Charles Richet (1875-83) had the courage to revive studies of induced somnambulism, despite the prejudice that prevailed, and tried to analyze the state from the standpoint of psychology.

Next came the studies of hypnotism by the two rival schools of Paris (Charcot) and Nancy (Liébault; Bernheim). Researches at both places were valuable, but those made at Nancy were the more serviceable, both from the standpoint of explanation of the phenomena and from that of practical application in treatment. Though Bernheim admitted that in hys-

terical persons somnambulism could be induced with great ease, he also maintained (and brought statistics to prove) that the vast majority of normal persons can be hypnotized by the technic developed by Liébault and himself. Thereafter, suggestion and hypnotism attained to considerable vogue as successful methods of psychotherapy, not only in the treatment of nervous disorders but also of general medical and surgical diseases.

Later on, however, the limitations and the dangers of hypnotism as a therapeutic method began to be emphasized. It was urged that hypnotism "lowered the moral dignity of the patient," and that "suggestion appeals only to automatic tendencies, not to the higher elements of the personality (reason, will)." Moreover, some practitioners were accused of immorality in connection with hypnotism, but ethical doctors have insisted, when hypnotizing a woman, upon having another woman present as chaperon.

On the whole, the use of hypnosis for treatment has undergone a marked decline, though it still has a place, especially when a psychotherapist desires to make use of so-called post-hypnotic suggestion (suggestion given during the hypnosis that will lead the patient to act in some desirable manner when later awake and also to have the feeling that such action is desirable and the result of personal impulse).

Treatment by suggestion, aside from hypnosis, is still and will continue to be, an important practical method of psychotherapy.

PERSUASION; MEDICAL MORALIZATION

A psychotherapeutic method that, in theory, opposed the use of suggestion and relied wholly upon encouraging conversations with the patient, upon reasoning with him, and upon moral suasion, attained to popularity early in the present century through the writings and practice of the Swiss physician, Paul Dubois.

Dubois did not regard his method as a cure-all, for he attempted to restrict its application to so-called "functional" diseases, to patients who were psychoneurotic or had merely mild mental disorders, short of "insanity." He took his patients into a sanatorium, isolated them from their families, kept them in bed and on a milk diet for a time, eschewed the use of drugs, massage, and hydrotherapy, and then depended upon intimate daily moralizing conversations, in which confidence of cure was instilled and enlightenment as to the true nature and origin of the symptoms was attempted.

The patient was told that his malady was functional (not organic) and was curable and that symptoms like fatigability, lack of endurance, difficulty in concentration, insomnia, anxiety, fears, palpitation of the heart, headaches, pains, and other distressing sensations were to be ignored, since they depended upon false ideas and upon bad mental habits.

It was important, he further told them, not to think about their troubles and to behave as though they did not exist, accepting the symptoms, if possi-

ble, with a smile. To get well, he said, the patient must be convinced that he will be cured. The idea of health must be made to enter the mind to dispel the illusion of disease. Absurd notions of disease must be replaced by "sublime philosophical thoughts," with insistence upon the power of mind over the body and upon the complete freedom of the will!

Instead of thinking of themselves, the patients should give more thought to the welfare and happiness of others. Instead of ruminating pessimistically over their own discomforts, they should educate themselves to be optimistic, to be tolerant of others, and to exhibit affection, sympathy, and kindness to those about them. They would thus learn to discover their own best qualities. Both reason and emotion were obviously appealed to in this way by the therapeutic moralizer.

This treatment by the method of persuasion (or moralization) was utilized by many in Switzerland, France, and the United States, though most physicians who tried it modified Dubois' methods to a greater or less degree. In the so-called "Emmanuel Movement" that began in Boston, physicians and clergymen became associated in the practice of psychotherapy by persuasion. No patient was received for treatment without medical examination and medical approval, but much, if not all, of the task of "persuasion" was delegated by the physician to the clergyman, and religious exercises (church attendance, prayers, hymn-singing) were considered to be a valuable part of the treatment.

There have been many criticisms of this method of treatment by moralization on the grounds (1) that the diagnostic studies made were too superficial, (2) that the belief that the treatment owes its successes entirely to appeals to reason is a false idea, since not only the intelligence but also the automatism, the sentiments, and the emotions of the patient are influenced, (3) that even Dubois could not be sure why he succeeded in some cases and failed in others, and (4) that the method can not really be taught to pupils, probably because many of the factors of success are unknown, some of them being purely personal and others wholly unrelated to the theory of moralization. It must not be forgotten that isolation, bed rest, milk diet, regulation of habits, orderly surroundings, examples set by physicians and nurses, and the authority of a therapist of repute may, taken together, be of real importance as influences favorable to cure.

It should not be forgotten, either, that in Dubois's method there is not only emphasis upon the superiority of the physician and the relative inferiority of the patient, but a relationship like that of parent to child is developed, and the patient is perhaps less affected by "reasoning" than by faith in a "father" who, he believes, is endowed with unusual powers.

That many patients have recovered from nervous illnesses by the method of Dubois just described is certain. It is the explanation of the reasons for recovery in different cases that must still remain somewhat in doubt.

REST AND ISOLATION

Since a large proportion of nervous patients complain of fatigue or of exhaustion, it is not surprising that methods of treatment in which enforced *rest* is a prominent feature came into vogue.

In this country, the Weir Mitchell "rest-cure," from 1875 on, became very popular. The Philadelphia physician placed his patients in sanitaria; cut them off from visits and letters from family and friends; kept them at complete rest in bed in a darkened room, under the care of trained nurses; encouraged complete muscular and mental relaxation; prescribed daily massage for them, and made them gain weight as rapidly as possible by insisting upon the ingestion of large quantities of milk and other foods.

Through this enforced repose of body and mind, nervous energy was economized, power often returned, and the feelings of fatigue and exhaustion gradually disappeared. Later, through occupational therapy and mild forms of exercise, the patients became stronger and were returned to ordinary life. For Weir Mitchell's success, his own personality and the wisdom of the counsel he gave to his patients were undoubtedly important factors, in addition to the measures of rest, isolation, massage, and superalimentation. The rest-cure soon became fashionable, especially for the treatment of psychoneurotic states and of states of exhaustion following prolonged overexertion or physical illnesses of various sorts. Large

numbers of patients certainly received great benefit from them.

The method, which was based upon the assumption that the nervous system had become exhausted because of excessive expenditure of energy and therefore needed rest, was, however, sometimes used when other modes of treatment would have been better. Too many rich and idle women resorted to rest-cures when they would have done better to seek "work-cures." Moreover, some patients were compelled to eat too much for too long a time and became obese, for in the early days of rest-cures too little attention was paid to the matter of the ideal weight for a patient of given height. In many cases rest-cures were too prolonged, the patients being kept in bed for many months or even for a year or longer.

Over-attention to fatigability as a real and essential symptom is a criticism often directed against conductors of rest-cures. Some confused true fatigue with the obsession of fatigue; they failed to look beyond the superficial complaints to the more fundamental disorders underlying them. Dubois had a disdain for fatigue, which he thought to be merely an insignificant illusion of the invalid that should be ignored; Déjerine referred to the "terrible sensation of fatigue" complained of by the psychoneurotic as a psychic phenomenon due to autosuggestion, the memory of fatigue being called up over and over again. R. C. Cabot regarded the symptom of fatigability as being due, not to overwork, but to excess of emotion.

Some went so far as to say that rest-cures frequently did not alleviate the symptoms of neuropaths but, instead, tended to foster their neuroses. Economies realized in nervous energy by discontinuance of all disbursements of energy will not in themselves suffice; the patients must learn to become competent later on in the regulation of their capacities in order to live a normal life. Some persons are so constituted that, on recovery from a neurosis, their only safety lies in the simplification of a life that was formerly too complex.

The importance of temporary *isolation* from family and from business and social life generally is a factor in treatment that is often underestimated. Familial relations and social activities are often more exhausting than other forms of activity. This fact must have been recognized by many of those who, through the ages, voluntarily separated themselves from the ordinary social environment and led their lives as hermits, recluses, anchorites, monks, or nuns.

Weir Mitchell in America, Playfair in England, Charcot and later Déjerine in France, and Dubois in Switzerland all made temporary isolation a component of their rest-cures and their persuasion cures. That there are advantages and disadvantages associated with such isolation, every physician of experience must admit. But, undoubtedly, for the majority of psychoneurotics, temporary isolation is a boon. It removes for a time the strains associated with family or community life, facilitates improvement in behavior, helps to break up bad habits, makes enforce-

ment of rest and suitable dietetic measures easier, and in general accentuates the psychotherapeutic efforts of the physician.

After the patient's confidence has been gained, the physician can often, through repeated conversations with his patient, find clues to familial or social conflicts that must be resolved before the patient can live happily in ordinary surroundings. Not infrequently a neurotic woman may have a husband, a child, or other relative whose behavior has been abnormal and must in turn be modified for the benefit of the patient. Some of my own successes in psychotherapy have depended in large part upon ability to discover and tactfully to correct such abnormalities of behavior in persons with whom the patient was compelled to associate in ordinary life.

I recall especially one patient whose nervous breakdown was strongly contributed to by her husband who, though he was greatly liked by most people, tortured her repeatedly over a long period by threats that he would commit suicide, behavior on his part that was unsuspected by her physician or her friends. In this case, the husband needed treatment fully as much as did the patient herself. R. C. Cabot, in his article on "Analysis and Modification of Environment" in Parker's *Psychotherapy,* has given many interesting examples of maladjustments in family life that must not be allowed to go uncorrected if success in treatment is to be achieved.

Unfortunately, the patient's associates do not as a rule regard themselves as invalids or their behavior

as in any way responsible for the patient's illness. As Pierre Janet has said, "It is far easier to write a prescription for a soothing syrup than to contend with the authoritarian manias of some of the patient's associates and with the self-sacrificing manias of others; but this regulation of the invalid's domesticities is an essential and fruitful part of psychotherapeutics."

PSYCHOANALYSIS; MENTAL LIQUIDATION; MENTAL CATHARSIS OF FREUD

Another method of treatment by the utilization of psychological economy is that known as "psychoanalysis," one form of "treatment by mental liquidation" or "mental catharsis." It grew out of the earlier experiences of many neurologists and psychologists bearing upon the relation of indelible and distressing memories (following upon certain events in earlier life) to functional nervous disturbances.

Between fifty and sixty years ago, Charcot, in Paris, brought definite proof of the relation of emotion following accidents in earlier life to hysterical manifestations in later life. At about the same time, Janet expressed the view that hysterical paralysis or contracture could be due to the persistent memory of some earlier accident, and also suggested that the memory of some event (not a physical accident) associated with moral perturbation might also be the cause of nervous symptoms. In other words, "traumatic memories" (either physical or emotional) could be important factors in the origin of neuroses and either directly or indirectly cause the symptoms.

These investigators also showed that, by reviving the memory and then modifying the patient's ideas, the nervous symptoms could often be relieved or even abolished. They soon found, however, that important traumatic memories might be imperfectly known by the patient, being, as it were, subconscious, though these "hidden memories" could sometimes be revived by getting clues from a study of their dreams or of statements made by them in induced somnambulistic states. Janet thought of these hidden memories as "subconscious fixed ideas" that could be dangerous for the patient because they were no longer under the control of the conscious will. In nervous patients in whom he suspected hidden memories as a cause, he attempted to help them by what he called "mental disinfection by the dissociation of traumatic memories"; he spoke of this as a form of "mental liquidation." It is surprising how far these studies of the French neurologists went in anticipating some of the main features of the theory and practice of what is now called "psychoanalysis."

J. Breuer, studying hysteria in Vienna (1880-82), had found that, under hypnosis, hysterical patients could often recall experiences of which they had no memory when in a normal waking state. Sigmund Freud, after working with Charcot in Paris and visiting Bernheim in Nancy, returned to Vienna and collaborated with Breuer in similar studies. In 1893, these two investigators published an account of their observations and formulated the "traumatic theory of hysteria," according to which a hysterical symptom

is the result of a traumatic psychological event that a patient was incapable of consciously recollecting—an emotional impulse thus becoming transformed into an abnormal physiological function which they spoke of as a process of "conversion." When the recollection of the traumatic experience under hypnosis is accompanied by a strong reproduction of the original emotion, it ceases to exert its unconscious causal effect and the symptom disappears. They called this therapeutic effect an "abreaction," and the method used was spoken of as "emotional catharsis." Freud, however, soon turned away from this hypnotic method (partly because of a feud with Breuer concerning the explanation of the hypnoid state) and adopted, instead of it, the procedure of "free association" in the awake state, for arriving at the underlying forgotten experiences. Like many other psychotherapists, he was convinced that the symptoms of psychoneurotic patients were dependent upon mental conflicts that they could not solve by themselves; sometimes conflicts existed that the patients were not aware of, in which cases they must be uncovered so that the patients could really understand what they were and learn how they might be solved.

Realizing that ideas are associated with one another in the mind in two different ways: (1) rational or logical relationship, and (2) emotional relationship, it was to this second type of association that Freud paid most attention when subjecting a patient to the "free-association method." As a matter of fact, though Freud spoke of "free association," the process

is not wholly "free" but must really be directed by the analyst if it is to be fruitful, and much of the direction depends upon the human relation that develops between the analyst and the patient.

Freud asked the patient, lying on a sofa with her back to her physician, to say whatever came into her mind, no matter what it was—sense or nonsense, conventional or objectionable. By listening carefully to what the patient said and by watching intonation, gestures, and any emotion evinced, Freud collected the data for subsequent appraisal. Relieved of the necessity of logical thinking, the patient under analysis will necessarily, Freud believed, under the pressure of emotions tending to express themselves, say things that will give the analyst clues to the content of the deeper layers of the patient's psychic life.

Through this association method, Freud gradually brought into the consciousness of the patient "repressed material" that had been held back in the unconscious because of "resistances." Often the repressed material itself did not come directly into the mind of the patient but instead approximated it in an allusive way, and Freud asserted that the experienced psychoanalyst could, from the allusions, draw inferences regarding the unconscious material itself (wishes or memories), or even recognize its character and explain it to the patient.

Through uncovering resistances and through the art of interpretation, the healer tried to cure the neurosis. Through discovery of the hidden conflicts and by emotional re-enactments of the situations from

which they arose, the patient was given the insight that would make it possible for him to control his conflicts and thus get rid of his neurotic symptoms.

Freud soon came to the conclusion that the adult traumata that he and Breuer had studied in the hypnotic state were not the primary but only the precipitating cause of the neurotic symptoms. The original psychic factors that predisposed to the neurosis, he declared, were to be found in events of the earliest years of life, often in infantile emotional experiences, and here he laid emphasis especially upon the sexual impulses and experiences of infancy, or fantasies of such experiences, and upon hostile and anxious reactions of the child to discipline.

During the free-association interviews, dreams often were talked about by the patient, and Freud entered upon an intensive study of such dreams. He soon became convinced that dreams are "wish-fulfilments," that they have a definite meaning, though this is usually disguised. A dream, like a nervous symptom, is, he concluded, the conscious expression of an unconscious fantasy or wish that can not be thought of in waking life (owing to "censorship" by the "unconscious") until it has been elicited by the skilful use of the technic of free association.

Freud divided dream-materials into their "manifest" and their "latent" content. The manifest content was, for Freud, of but little import; it was the latent content, he believed, that was significant. The latter, he said, is "representative" of the repressed material that is to be sought through free association.

Dreams have, according to Freud, a preventive function, in that they shove disturbing ideas aside, while at the same time they attempt to gratify underlying strivings of the personality. Certain desires and strivings, because of their ethical, esthetic, or social significance, are "censored" and can not be accepted openly, even in a dream.

Dream-experiences are, therefore, always distorted; they are, according to Freud, "symbols" of unconscious dream-thoughts. To interpret dreams, the analyst must, therefore, utilize the "manifest" content to get at the "latent" content. Among common symbols in dreams reported by psychoanalysts are: anything that protrudes like sticks, snakes, squirrels, swords, umbrellas, pencils, guns, knives, arrows, or trees (representative of male genitals), anything like a box that has an opening, doughnuts, bags, windows, figs, spiders, or ravines (representative of female genitals), and keys and locks (representative of sexual wishes).

Though such interpretation of dream language may sound as absurd to the ordinary man "as Chinese to an Englishman," Freudian psychoanalysts maintain that, to the really informed, it is justifiable. Stekel and his pupils believe that by skilful dream interpretation, the duration of treatment by analysis can be greatly shortened, since there will be less need of toilsome and lengthy free associations. For many examples of dream interpretation by psychoanalysts, the reader is referred to E. A. Gutheil's *The Language of the Dream* (1939).

In addition to hereditary predisposition, the main

causal factors in the origin of the psychoneuroses are, according to Freud: (1) adult emotional traumata, (2) infantile traumatic memories, and (3) certain infantile fantasies.

The term *sexuality,* as used by psychoanalysts, includes, in addition to impulses to sexual intercourse, all aspects of life to which the term "love" is ordinarily applied. In this wide sense it is made to include friendship, parent-child affection, love of self, ideals, and indeed anything that yields pleasure or is essential to pleasure.

Psychoanalysts lay stress upon forms of "unconscious sexuality" that are met with in both normal and abnormal persons. In the first place, they assert that all human beings have impulses of *bisexuality.* Each male has some feminine tendencies, each female some tendencies that are masculine; in other words, there are latent homosexual inclinations in every one, even though they may be entirely repudiated by consciousness.

In the second place, Freudians assert that impulses of love and hate for the same person often co-exist, a condition that has been designated by Bleuler as *ambivalence.*

In the third place, they maintain that drives to accomplish, to create, and to enjoy various kinds of experiences (artistic, athletic, practical) are often to be regarded as transformations of erotic impulses, or what they call *sublimation* of sexual impulses.

In the fourth place, they accord importance to what they call *displacement*—"the representation in

consciousness of a part or whole of the original unconscious fantasy by some associated substitute." The repression of the original idea is thus preserved, though the unconscious wish has its symbol in the substitute.

One example of such displacement is to be seen, they think, in the phenomenon of "transference," when a patient develops an affection for her physician, clergyman, employer, or teacher, the latter thus becoming an unconscious surrogate for some one who had shown affection for the patient, perhaps in her childhood.

Finally, psychoanalysts lay emphasis upon *infantile sexuality,* the sexual impulses of the first five years of life, as factors in causing neuroses. They regard infantile sexuality as the outstanding formative factor of human personality and the analysis of it as of the greatest importance for the treatment of nervous disorders. The infant's sexual instincts, they say, turn to itself as object first, to outside objects later.

Freud stated that, during the first three years of life, the infant's sensual pleasure is experienced in parts of its own body other than the sex organs (and independent of the love of another person); this he called "pre-genital psychosexuality." He divided this into two chief phases: (1) an "oral phase," in which the mouth is the source of the sensory pleasure ("erotogenic zone"), as in sucking, and (2) an "anal-urethral phase," in which bodily orifices other than the mouth are the erotogenic zones. During the pre-genital

phases, the self is the object of the libidinous desires (narcissistic tendency).

From the third to the sixth year, sex impulses in the child become united and centered in the genitals (as erotogenic zones) and interest in sexual objects outside of self appears, especially love for the parent of the opposite sex (along with hatred for the parent of the same sex)—an emotional situation that Freud called the "Œdipus complex." Whereas most people think of childhood as the "age of innocence," especially with regard to sex affairs, some Freudians maintain that the child, during its first five years of life, has "experienced all the passions of which adults deny he is capable." They maintain that certain "sexual fantasies" about birth, procreation, assaults by adults, and the sexual intercourse of man and animals are present in every child, and these fantasies, they assert, can, through psychoanalysis, be correlated with many details of later adult life.

After the sixth year, the sex impulses of the child tend, according to Freud, to become "latent" and to remain so until the age of puberty, when they again become prominent and masturbation becomes common. During the period of latency (in which the infantile sexuality is repressed), the child uses its energy for the development of its personality and gives evidence of a desire to be as the parent of the same sex seems to it to be. After puberty, when the sex organs have become fully developed and capacity for complete sexual intercourse has been attained, sex becomes a dominating, driving force; it becomes associated with

love, a craving for reciprocal sexual pleasure, and a desire for children by one particular sex-partner.

Psychoanalysts maintain that they feel sure of what they call the "facts of infantile sexuality" because of their studies of the "unconscious memories" of adults. They assert that the observations of mothers (infantile masturbation, curiosity of the infant regarding its excrement, and pleasure in touching feces, pride in the urinary stream) confirm their views.

Moreover, the non-genital love-life of adults is, they say, replete with survivals of infantile sexual needs (the kiss as oral pleasure, obscene jokes and smutty stories referring to excretion, as anal eroticism, etc.). They regard adult sexual perversions (such as Lesbianism) as survivals of infantile sex pleasures.

Infantile sexual fantasies have been reported as recurring in the dreams of adults and in the ideas and behavior of neurotic and psychotic people. The fact that normal adults have no memory of events during a certain period in the fifth or sixth year is explained as due to repression of vivid emotional experiences of that time. Even the criticisms of scientists of Freud's doctrine of infantile sexuality are regarded as convincing confirmations of its reality, since the critics, they say, are subject to recognized taboos, just like the general run of mankind.

In his consideration of human instincts, Freud developed certain ideas regarding the "pleasure principle," the "reality principle," and so-called "repetition-compulsion." He believed that psychological (and social) activities are determined by a feeling of need

to reduce emotional tension. Tensions result from instincts and give rise to painful or disagreeable feelings. Action is therefore taken to reduce the tension and this results in a feeling of pleasure. Hence, he called this law of instinct the "pleasure principle."

A psychoneurotic person represses a wish for pleasure that is denied direct gratification, owing to unconscious punishment fantasies, a conflict thus arising between two opposed instinct-systems. He therefore manifests a neurotic symptom, which is a surrogate gratification of sexual fantasies, that lessens tension and produces pleasure, while at the same time it reduces the tension of the guilt system (punishment fantasies). Thus, the neurotic symptoms are a compromise through which the most pleasurable, or the least painful, adjustment of the conflict of instinct-systems is made possible for the patient's personality.

In his further discussion of instincts, Freud modified the "pleasure principle" by adding the idea of the "reality principle." By this he meant the ability of a person to forego immediate pleasure for the sake of pleasure (or avoidance of pain) in the future. Infantile behavior conforms to the "pleasure principle," whereas adult behavior may, as the result of experience, be modified by the "reality principle."

Again, Freud found that, as a part of instinct, there is an innate tendency to reproduce emotional events; this he called "repetition-compulsion." Thus, shell-shocked soldiers tend to repeat the traumatic event in their dreams. And in many psychoneurotic patients, the capacity to make use of the "reality prin-

ciple" is greatly limited, because they are repeating over and over again some earlier emotional infantile experience.

In considering the human personality as a whole, Freud divided it into three parts: the *Id,* the *Ego,* and the *Super-ego.* These are succinctly defined by Ives Hendrick as the "It wants," "I will (not)," and "You mustn't" departments of the personality.

The Id is the core of the personality, is entirely unconscious, is the source of the several unorganized instinctive drives (analogous to animal impulses), and is subordinate to the pleasure principle. The child soon learns that some of his impulses can be indulged and not be followed by pain, though others are. It begins to differentiate self (Ego or "I") from the rest of the world; the Ego is split off from the Id by contact with reality through the sensory-motor apparatus, the function of which is to maintain harmony between the Id and external reality. This Ego, which is largely conscious, includes the knowing and willing parts of the personality; these tend to repress and to inhibit the instinctive drives that do not give pleasure.

The Super-ego, also largely conscious, is defined as the part of the personality that fears remorse or the threats imposed by the "fantasies of punishment"; its mandates include not only those of one's ideals and one's conscious morality but also many that are "unconscious." The function of the Super-ego is to keep the Id under cover. Feelings of moral guilt are said to be due to conflicts between the Ego and the Super-ego.

In their analyses of patients, Freudians endeavor to find out in how far each of these subdivisions of the personality is involved in a neurosis. Thus, the symptoms of anxiety may, in one case, they say, be a reaction to a disturbance in the instinctive life (the Id), in another to dangers recognized in the outer world by the Ego, and in a third to threats from conscience (the Super-ego).

Freud was especially interested in "psychoneurotic anxiety" (anxiety without adequate external causes); he divided the anxiety neuroses (see Chapter VII) into (1) the "actual neuroses" (including neurasthenia), in which the anxiety is not referred to a specific external stimulus, and (2) "anxiety hysteria," in which the anxiety felt by the patient is ascribed to some specific thing or situation.

From what has been said, it is obvious that psychoanalysts make use of "psychic determination" as a working hypothesis. Some adopt "psychic determinism" as a cause of all neurotic symptoms as a dogma, but the more cautious psychoanalysts will, to-day, admit that when they encounter matters that can not thus be explained, they are willing to abandon the hypothesis and seek explanation "in biological factors that are drawn from a simpler level of integration."

Psychoanalysis as a therapeutic method has been used in the treatment of all sorts of diseases, both functional and organic. Too often it has been used by persons inadequately trained in either general medicine or psychiatry. It is a time-robbing procedure requiring months or years for application. It is finan-

cially very expensive for the patients and hence is not available for the indigent or for people of moderate means, though Freud, in 1918, said that there should be some kind of organization for treating large masses of people analytically, since "the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving life." And Coriat, in 1938, said that "another development of the future will have to be the founding of psychoanalytic clinics for the therapy of those handicapped neurotics who are unable to avail themselves of private treatment," hinting, however, that the process of psychoanalysis will have to be modified in such cases.

Most psychoanalysts agree that their method is unsuitable for the treatment of elderly people. Successful application has most often been reported in the treatment of psychoneuratic states and of sexual perversions occurring in adolescents and in adults before the age of sixty.

In psychoanalysis, as in all methods of psychotherapy, much stress is laid upon the establishment of a satisfactory *rapport* between practitioner and patient. Unless the patient likes the doctor, it may be difficult to be of help to him. The emotional attitude may range all the way from friendliness to love and is spoken of by analysts as "positive transfer." When, however, the patient dislikes the doctor, the state is referred to as "negative transfer" or "resistance," and then the underlying (perhaps unconscious) implications of this feeling of hostility must be sought and

interpreted, in order that the negative attitude may be changed to positive.

METHODS OF ANALYSIS DIFFERING FROM FREUDIANISM

Orthodox Freudian psychoanalysts object to the use of the designation "psychoanalyst" for any person who does not adhere strictly to Freud's technic. Though many practitioners have made use of parts of this technic and have resorted to the theories and even the phraseology of Freud, the orthodox maintain that other therapists omit essential parts of both theory and method. A few of these deviations from what Freudians think is the only true path are deserving of mention.

Janet's Methods of "Psychological Analysis."—I have already pointed out how important the studies of "hidden memories" by the Paris school of neuropsychologists (Charcot, Janet) were and that they antedated the studies of Freud. Janet, over a long series of years, made important contributions to the study of hysteria and of psychasthenia (with its phobias and obsessions). In both his study and his treatment of patients, he made use of "psychological analysis" and "mental liquidation"; the therapeutic results he achieved compared favorably with those of any other physician of his time.

In his treatise, entitled *Psychological Healing* (1925), he reviewed what had been published upon psychotherapy up to that time and gave a full account of his own methods and experiences. The Paris school had found that sexuality may play an important part

in the origin of a neurosis. Freud adopted this notion but transformed it into what Ladame has called the "dogma of pansexualism," which Janet criticized severely.

For Freud, sexual troubles and infantile sex memories were not merely the essential, but the only cause of neuroses, just as syphilis is the specific cause of locomotor ataxia and general paresis. Anxiety, according to Freud, is due to repressed sexual desire or to incomplete sexual acts (because of moral restraint, celibacy, coitus interruptus, etc.). Frigidity in a woman was due to a guilty passion for her father in childhood (Œdipus complex) with excessive repression of these incestuous longings and resulting lifelong inability to obtain pleasure from sexual intercourse. Homosexuality in a man was due either to excessive ambivalence or to undue fondness in his childhood for his mother, followed by undue repression that made him (1) incapable (when adult) of loving a woman, and (2) through "excess of virtue" become a sexual pervert. According to Freud (1905), it is a fundamental principle that "in a normal sexual life a neurosis is impossible."

Many have tried to explain why it was that "Freud saw sex wherever he looked." Some thought that Freud must have questioned his patients regarding their sexual life in a peculiarly impressive way, influenced them by suggestion to secure the kind of answers he wanted, and attributed too great importance to their most trivial words concerning sex matters. Others suggested that there must have been a pecul-

iar kind of sexual atmosphere in Vienna where Freud worked, and that this environment foredoomed him to over-estimate sexual influences. Janet, admitting such possible influences, believed that, in addition, Freud's doctrines regarding sex were a logical outcome of his earlier studies of traumatic memories and subconscious fixed ideas, for they led him to exaggerate the importance of sexual experiences referred to by the patients "allusively"; his ingenious interpretations and bold generalizations seem to have been characteristic of his mental tendencies.

Janet admitted that distressing memories with a sexual content can be detected in many neuropaths, but had doubts regarding their degree of importance as causes of the neuroses, and he was sure that they were neither a constant nor a necessary factor. American neurologists had laid stress upon fear, disgust, and other non-sexual memories as determinants of neurotic behavior, and Janet made it a point to study various disquieting tendencies in addition to sex memories by his method of psychological analysis. To him, the method of the Freudian psychoanalyst was one of symbolical and arbitrary construction that tried to show how the facts "might be" explained if the sexual causation of the neuroses were definitely accepted; but he maintained that "there is no proof which justifies any such generalization of the causative significance of sexual phenomena. Moreover, there is much evidence that nervous diseases are in themselves often the causes of disordered sexual behavior, the latter being secondary not primary."

But, in turn, the psychoanalysts criticized Janet's views by implying that they were due to his never having practised psychoanalysis in the Freudian sense. This Janet admitted, but retorted that he did not believe in dogma, his only aim being to establish the truth; he did not have the kind of "faith" that permitted him to accept in full the symbolical interpretations of the psychoanalysts.

Janet's writings contain reports of the successful treatment of hysteria and of other neuroses (especially psychasthenic states, with their phobias and obsessions) by means of his own methods of "psychological analysis."

Adler's Method of "Individual Psychology."—Alfred Adler, though at first greatly influenced by Freud, later developed a theory and a form of practice along the lines of what he called "individual psychology." He laid stress upon strivings for self-assertion and for superiority, the "will-to-power," and looked upon many neurotic symptoms as evidences of the so-called "masculine protest" animated by the desire to deny weakness or inferiority. A child that has feelings of inferiority will, he maintains, try to compensate for them by behavior that will prove that these feelings are not justified. In so doing, he will often overcompensate and manifest neurotic symptoms. Every person wants to be appreciated, to heighten the importance of his own personality, and to satisfy his feeling of need for security. His ambition may become so great that he can not succeed in the conflict with reality. Though discouraged, he is then unwill-

ing to admit defeat and tries to save his self-esteem by living as though he were really sick, having rights still, but no obligations. In other words, he attempts to escape from his dilemma by means of neurotic symptoms, thus, in a way, satisfying his desire for power.

In his treatment of such cases, Adler tried to convince the patient that his satisfactions obtained through symptoms were fictitious, and then by "re-education" taught him how to make necessary readjustments. He thus played the rôle of a "wiser older brother" to the patient. He attained much success by his methods in the management of many childhood disorders such as bed-wetting, nail-biting, nervous tics, temper tantrums, and abnormal shyness.

Freudians admit that the will-to-power is an important motive factor, but regard it merely as a part of the self-preserving Ego-functions that are often agents in the development of repressions. They regard the so-called "inferiority complex" as one of the ways in which unconscious guilt produces conscious suffering and assert that the only way to get true relief from it is through dynamic psychoanalysis of its unconscious sources.

Struggle for recognition, approbation, and popularity is often very evident among young people, especially among those who suffer from feelings of physical, intellectual, or social inferiority. Fortunately, in many schools and colleges, counsellors and instructors in mental hygiene have become available since Princeton University set the example by appointing Dr.

Stewart Paton in charge of a department of mental hygiene and Yale University followed with annual appropriations for similar work. The National Committee for Mental Hygiene, founded by Clifford W. Beers, and its journal, *Mental Hygiene,* have done a vast deal of good in promoting understanding of mental needs and provision for suitable psychotherapy. The contributions of Alfred Adler to studies of individual psychology have undoubtedly greatly helped workers in mental hygiene.

Jung's Method of "Analytical Psychology."—Carl Jung, a leading follower of Freud for several years, made careful psychological studies of the dreams of neuropaths and of the symptoms of schizophrenic patients. But in 1910 he withdrew from the Freudian camp because he could no longer agree with Freud on the differentiation of sexual desire (libido) from other forms of mental energy.

Jung became interested in the broad cultural and racially-deep motivations of human beings and emphasized especially what he called the "collective unconscious"—the symbols and fantasies common to all racial groups—whereas Freud stressed rather the personal experiences that determine particular unconscious trends in each individual.

By means of his analytical psychology, Jung treated his patients in four successive stages: (1) "confession," through which he tried to release repressed emotions, (2) "explanation," through which he gained insight into the factors of unconscious fixation, (3) "education" along the lines of Adler's individual psychology,

and (4) "transformation" of the personality as a whole, so as to make it possible for the patient to educate himself.

Jung's division of people into two fundamental types (see Chapter IV), *introverts* and *extroverts,* has served a useful purpose in psychotherapy. By an "introvert," he meant one who is subjective in his thinking, feeling, and acting, relating everything to himself; by an "extrovert," he meant one who is objective and tends to relate everything to the world outside himself. A knowledge of these tendencies was utilized by Jung in his practical psychotherapy.

Jung's patients were guided especially in the development of activities other than those of their ordinary employment; attention was called to the resemblances of symbolic elements of their fantasies to those to be found in art, religions, and mythology.

Much of Jung's success has been due to his notable intellect and to his knowledge of general culture; he has been called "the psychagog to the collective and creative unconscious." Orthodox Freudians say that Jung does not get at the deeper causes of neuroses, which, they believe, lie in unconscious personal conflicts from the bondage of which patients must be released if their personalities are to undergo the dynamic change that will make them capable of more mature development.

Rank's Analytic Method.—Otto Rank, another of Freud's pupils and an early contributor to the nonmedical aspects of psychoanalysis, about 1926 decided to abbreviate the process of analysis and to try to

achieve cures in the course of two or three months, rather than to subject his patients to the protracted course of treatment deemed necessary by Freud and his orthodox followers. For Rank, the main problem in treatment was to be solved by the analysis of will-power. He used methods that attempted to strengthen the patient's will and to develop the personality so that it could accept itself as it was. Acknowledging the importance of resistance to recollections of earlier emotional events as causes of neuroses, in his guidance of patients he directed the treatment largely toward the overcoming of resistances to existing emotional relationships.

Rank's conception of what he called "birth-trauma" seems to have been the basis of his theory of the origin of neuroses. Birth, besides being a "biological separation," had for Rank also a psychological meaning. A patient's neurosis was due, he thought, to separation (1) from the mother, biologically, (2) from moral factors represented by the parents, and (3) from the self of the past. Through such separation, feelings of guilt and anxiety arise because of the realization of self as an individual. Rank, therefore, tried to make the patient through his will accept the separation as something in reality wanted by the self, that is, the "will for freedom." This theory of "birth-trauma," like that of Freud's "infantile sexuality," is disdainfully rejected by many psychotherapists as mythical.

Stekel's Analytic Method.—Another advocate of short (as contrasted with long) analytic treatment is W. Stekel, who would restrict it to a few weeks, never

a period longer than four months, since, in his opinion analysis conducted longer than a year leads to a harmful artificial childhood regression. He had studied symbols as elements of dream-images that are derived, not from the experience of the individual, but from a general propensity to represent "unconscious thoughts" and especially sexual thoughts by certain symbols. To get quick results from analysis, he depended largely upon intuition for the discovery of the important problems. Many attribute Stekel's successes to his uncanny flair for correct intuitional interpretation. His studies of various pathological impulses (like dipsomania and kleptomania) and of sadistic and masochistic tendencies have been noteworthy.

Meyer's Method of Distributive Analysis and Synthesis.—Adolf Meyer believes that the best way to correct personality difficulties on a psychobiological basis is (1) to analyze all the factors and situations that can be concerned in the origin of the patient's symptoms, and (2) to synthesize the several factors and strivings that can contribute to the patient's security, thus achieving a satisfactory integration of his whole personality, as well as of his various functions.

In the analysis, he distributes the studies according to the indications given by the complaints, the problems the analyzer recognizes himself, the patient's imaginations concerning the present and the past, the actual situation of the patient, the attitude of the patient towards his future, and the outstanding features of his personality. All abnormal factors are

studied with a view to desirable modifiability. Meyer's form of psychotherapy, applicable to psychotic as well as to psychoneurotic and minor personality disorders, has been ably described in textbooks written by three of his ablest pupils (L. Kanner, 1935; Oskar Diethelm, 1936; Wendell Muncie, 1939).

As will be seen, this method of study and treatment comes close to satisfying the requirements postulated in Chapters II and III of this book. It makes use of methods necessary for the comprehensive study of the patient as a whole and all of his parts, as well as of the various forms of treatment for which the multidimensional diagnosis arrived at gives the indications. The goal of the treatment is the restoration, as far as is possible, of both physical and mental health. Bodily infirmities are corrected, and the attempt is made to restore a feeling of security based upon self-dependence, combined with "the ability and willingness to be an integrated part of the group in which he lives and of society in its broadest sense."

This comprehensive plan permits of the utilization of all of the resources of modern diagnosis and treatment required for any given patient. It is eclectic in the sense that the therapist may, when necessary, call to his aid internists, surgeons, or any medical or surgical specialists who, he thinks, can be of help either in diagnosis or in treatment. In the use of psychotherapy there is no sole dependence upon the technic of any single therapeutic school; one-sidedness, dogmatism, and mystical speculation are avoided; there is refusal to participate in the internecine strife

among the "isms," and all the methods of psychological healing that may with advantage be applied are resorted to. It would, therefore, seem to be worthy of hearty recommendation. In general it is in accord with the kind of practice for which I have appealed during the past forty years, for, comprehensive in both diagnosis and treatment, it stays close to the facts of observation. Moreover, the methods may be used by any intelligent general practitioner who will call upon specialists for aid in case of need.

Schilder (1938) praises some features of Meyer's methods but on the whole is critical of Meyer, Diethelm, and Kanner. He thinks that they use sexual interpretations "with all too great precaution" and that their therapeutic approach may be summarized by saying that "it puts the patient into a simplified situation of which the physician, slightly soothing and slightly helping to understand, is a part." He goes on to say that the adaptation reached by psychobiology is of a more or less superficial character, though he admits that it may be invaluable for psychotics from whom we do not demand a full adaptation.

From my observation of the work of Adolf Meyer and his associates, I can testify that their methods and results are far from being of the wishy-washy character that Schilder's criticism would intimate. Nor need the Meyerian school of psychiatry be disturbed by the opinion of G. E. Daniels who, in discussing Diethelm's book, which attempts to bring about a solution of psychobiology and psychoanalysis, says that the result is "more in the nature of an emulsion." Meyer

and his pupils make use of all the methods of psychotherapy that are available, and are free to employ deep psychoanalysis in cases in which it seems to them to be indicated. Not only in the psychiatric clinic but also in the medical wards (public and private) of the Johns Hopkins Hospital, too, many psychoneurotic patients have been successfully treated by Meyer's methods during the past thirty-five years.

Orthodox Freudian psychoanalysts give the impression that they practise the only kind of psychotherapy worthy of the name. But there were good psychotherapists long before Freud, men who, thoroughly trained medically, knew the human heart, had strong personalities, and were endowed with wisdom. Though grateful for the contributions that psychoanalytic workers have made, we should not over-estimate them. It would indeed be regrettable if we had no ways of helping nervous patients except the time-robbing and purse-impoverishing method of so-called orthodox psychoanalysis. Methods undergo change with time and with the fashion. We can feel sure that gradually all methods that are of use in curing "sick souls" will find their appropriate place in our therapeutic armamentarium.

METHODS OF PSYCHOTHERAPY DEPENDING UPON EDUCATION, EXCITATION, OR GUIDANCE

Thus far in this chapter the methods of psychotherapy dependent upon suggestion and upon economy of psychic expenditures have been dealt with. But, besides the use of the mental powers possessed and the

restriction of outgo, there are methods available for the making of "psychological acquisitions" and for the recuperation of powers that have been lost.

Education and Re-education.—In our desire to augment the psychic income of our patients through increase of their psychic capital, we may try to educate them to acquire new forms of activity that they have never possessed, or we may try to re-educate them to regain powers that they have lost. When such efforts are successful, the self-confidence of the patients will be increased and their ability to deal with their difficulties will be enhanced.

Theoretically, treatment by education and re-education would seem to be sound, but practically there are great difficulties in the way when we try to apply the methods to neuropaths. For teaching new methods of activity to neurotic and psychotic patients is far different from the teaching of children in school or from the teaching of an apprentice in a shop by his master.

Experiences of psychotherapists with patients manifesting hysterical contractures, tics, writer's cramp, and other disorders of motility have shown that success is rarely achieved by direct attempts at education of the motor functions. The approach must be indirect rather than direct. Fortunately, psychiatrists are gradually gaining fuller information regarding the origin of the tendencies involved in various kinds of abnormal behavior and are learning how to attack the roots of the disorders rather than the branches and leaves (the symptoms). The nervous patient us-

ually has no understanding of his real difficulties; the physician's task is to seek the causes and to apply the appropriate remedies.

The *timing* of the application of educative and re-educative processes in the treatment of the neuroses and psychoses is as important for the success of a psychotherapist as is the timing of purchases and sales of stocks for the success of a Wall Street operator. Thus, attempts to use these educative processes on nervous patients when they are very fatigued, extremely anxious, deeply depressed, decidedly abulic, or incapable of attention or effort would be ill-timed and would almost certainly do more harm than good. In my own practice, when such conditions exist I precede the educative process by a period of complete rest and isolation. The energies are first economized in order to restore some of the psychic capital before resort is made to measures that require the expenditure of energy.

After such a preliminary rest-cure, a campaign of education and training can often be most helpful for the development of the total personality and for making adequate use of the assets that the patient possesses. And, as Kronfeld has emphasized in his "psychagogy," the patient must learn not to be too individualistic; he should be taught to develop a feeling of responsibility to the group in which he lives and, without loss of his individuality, become willing to make suitable adjustments to members of that group. Though educative methods of psychotherapy are not all-sufficing, they clearly have a place in the treatment

as a whole, after it has been planned by the method of distributive analysis and synthesis.

Stimulation to Activity; Psychological Excitation; Work-Cures.—These methods, too, applicable to the treatment of certain neuropaths, are gradually finding their proper place as methods of psychotherapy.

Philosophers (especially the Stoics), as well as physicians, long ago recognized the importance of appeals to the courage and the energy of man. In our own time, the pragmatist, William James, has laid stress upon the desirability of effort and upon education of the will, urging action ("even against the grain"), rather than undue contemplation.

Psychiatrists have quoted Sterne, who said: "It is better to do the most useless thing in the world than to remain for a quarter of an hour without doing anything at all. Cultivate rare tulips, become an autograph collector, breed rabbits, be a fisherman, turn egg-cups, cut out silhouettes for your children, hunt butterflies, or collect postage stamps. The one thing that matters is that you should have a passion for something."

The value of gymnastic exercises does not lie solely in the strengthening of the muscles; it improves other physiological functions and exerts a favorable effect upon mental states. Janet lauded muscular exercises (even those accompanied by a certain amount of danger), especially for young people, since it enabled those who made use of them to acquire self-confidence, helped them to be practical persons, and provided an antidote to obsessive scruples and phobias.

Golf, tennis, fishing, hunting, and other forms of outdoor exercise are valuable for people who are predisposed to nervousness. Setting-up exercises before and after the morning bath are generally to be recommended.

In this country, R. C. Cabot has been a leading advocate of the "work-cure," rather than the "rest-cure" for certain neuropaths. Work, when it brings success, is one of the happiest of life's experiences, and it can often restore health to a nervous patient, especially if the physician can find for him some occupation that will bring him pecuniary profit. The social contact involved in the work "promotes comradeship and cheerfulness, and encourages a sense of freedom and responsibility." Putnam, in Boston, tried to establish social relationships among neurotic patients in the hospital, encouraging them to make joint efforts and to communicate enthusiasm to one another.

During the period of convalescence from nervous or other diseases, *occupational therapy* is often most helpful from a psychotherapeutic standpoint. In larger hospitals, instructors in such work are now available, and time that might otherwise be felt as tedious is filled up with basket-making, leather-tooling, wood-carving, and other forms of interesting employment.

Training in concentration of attention, no matter how this is brought about, is often very helpful. Vittoz made his patients concentrate their thoughts persistently upon successive objects. When the patients complained that their thoughts wandered, he urged

them to pull their thoughts together energetically. After the powers of attention have been improved, selected stimulative reading may be prescribed. In the Boston "Thought Control Clinic," Dr. J. H. Pratt has successfully made use of the systematized practice of relaxation as a help to neurotic patients.

Excitation to activity can be useful as a psychotherapeutic method when it leads to physical, social, or psychological successes without producing undue fatigue or exhaustion. The physician, through the study of his patient, may discover deep-seated, highly-charged tendencies that can be aroused to activity in which energies that have been latent come into play. But we must be careful to excite only to activities that will be followed by a feeling of success. Even trifling failures may affect the patient dangerously. Here again, as in educative and re-educative methods, the *timing* of the resort to excitative methods is of paramount importance. And when we do resort to them we must watch their effects with the greatest care, continuing them, increasing them, or diminishing them as seems in our judgment best for the welfare of the patient.

Even in patients suffering from psychoses that require internment in asylums for the insane, work-cures may do much to ameliorate the conditions; the patients often do better than when treated by rest and hydrotherapy. In Germany, Simon has emphasized the value of instituting rational work treatment for the insane, while at the same time maintaining strict medical discipline; he has spoken of his method as

"the best means of humanizing asylums." Some patients do farm work, some work in shops, some are manual laborers, some are cooks, some work in the printing office, and others in brick yards.

Guidance.—Years ago, I pointed out that in the treatment of a psychoneurotic we may sometimes have to begin with a "medical absolutism" that does not leave the patient any freedom and then, by degrees, develop in him the power of self-direction, even though, for many patients, some medical guidance may have to be continued throughout the whole of the patient's life. In many cases, fortunately, a complete cure can be brought about so that the patient becomes permanently self-directing.

Some persons have such a strong feeling of need for being guided or directed by others that it may almost amount to an obsession. This is true of many wives (and husbands!), of many children, of many church members, as well as of many patients who are under medical care. As long as the guidance continues, such persons may get on well, but with the sudden loss of the "director" or "guide," they become greatly disturbed and find it difficult to carry on in the absence of the "guardian angel." Deprived of the "rod and staff" that comforted them, they do not know what to do.

Every family doctor will recall the disabilities displayed by certain women who have suddenly lost their husbands, upon whose guidance they had too greatly relied; by the son or daughter of a parent that had been too greatly adored; by a parishioner, after

the death of a priest; or by a patient whose favorite physician had died or moved to another city. Such people describe themselves as being "at loose ends," for they are left disconnected, undecided, and unguarded; and though other guides or directors would seem to be available, they often prove to be less successful, since the deprived ones feel the loss of an influence that was in some peculiar way *personal.*

To the Freudians, such "personal" influence (e. g. the *rapport* established between physician and devoted patient, known as "transfer") falls in the domain of "sexuality" in the broad sense in which they use this term, so broad that it apparently includes all forms of liking or affection. The personal influence is often so strong that the patients want their director to intervene in all the actions of their lives and, therefore, they tell him everything they do. The director is a father-confessor, a prop, a supporting and guiding hand.

During such "periods of influence" the suggestibility of the patient toward the particular director is greatly increased, though the phenomena of such influence are psychologically too complex to be explained wholly by "suggestion" or by sentiments of "love."

No small part of the "influence" consists in the saving of psychological expenditures through decisions made by the director. Through the advice of the latter, the patient learns to act more practically, to be less disturbed by fears and anxieties, to rest more, and, in general, to behave more thriftily in the use of

psychic energy. An intelligent, energetic, tactful, skilful, sympathetic, and congenial physician can, through his guidance of patients who accept him as their director, be of very great help to them.

But "guidance" must not be used to the exclusion of other needed methods of treatment. The aim should be to cure the malady from which the patient suffers by meeting all the indications of the multidimensional diagnosis that has been made. Moreover, when guidance through personal influence has been utilized as one factor in the treatment, the wise physician will try to discover when and how he is to terminate his specific direction without harm to the patient. Sensibly used, in association with other methods, treatment of neuropathic patients by guidance can often be fruitfully applied.

METHODS OF PSYCHOTHERAPY DEPENDENT UPON MYSTICISM, QUACKERY, PSEUDO-PHILOSOPHICAL IDEAS, OR PARTICIPATION IN LAY PSYCHOTHERAPEUTIC GROUPS

A whole series of psychotherapeutic methods that attempt to produce healing have been introduced by people who were not members of the medical profession and who had not received any sound medical training. Before leaving the subject of methods, some of these must be referred to briefly.

Religious Miracles.—From the earliest days of human history on, there have been evidences of a tendency of the sick to invoke the aid of the gods for relief. At the Temple of Æsculapius, at Epidaurus, at the sacred statues and healing springs to which

votives of the Middle Ages made pilgrimages, and, in our time, at the Shrine of Our Lady of Lourdes, in France, or that of Ste. Anne de Beaupré, in Canada, many "miraculous cures" have been reported. Such "cures" were the result of (1) ardent desire for cure, and (2) religious belief that the cure could thus be obtained.

Cures through Magic.—The attempts at cures through faith in a god, had a counterpart, for a time, in the faith in the magic of the touch of exalted personages, a good example being the belief that a king could cure scrofula ("the King's Evil") by the laying on of hands.

The word *Abracadabra,* in the second century and later, was used as a charm; it was believed that, when written in a triangular arrangement and worn around the neck, it would cure ague.

The words *Max, Pax, et Adimax* were, at one time, believed to be a cure for rabies.

In England, long ago, at the cost of fifty pounds, sterile women were promised a cure by means of a "divine balsam" or through sleep in a "celestial bed" that was allegedly filled with "celestial and electric fire issuing from magnetic vapors."

Mesmerism.—In 1766, Mesmer published a paper on the influence of the planets on the human body, due, he believed, to the instrumentality of a universal fluid, which he called "the fluid of animal magnetism." This fluid could be set to work by the human will. Later on, at a clinic in Paris, he treated a variety of diseases, making use of elaborate apparatus and

ceremonial rites around a large oaken tub, and many cures, especially of hysterical patients, were reported through the production of a salutary convulsive state called "the crisis." A medical commission investigated the matter and decided that Mesmerism was an unwholesome influence and that the phenomena that had been reported were explicable by imitation on the one hand and by imagination on the other. Mesmer left Paris in disrepute.

Later, magnetizers found that, instead of producing a convulsion, the treatment occasionally made a patient go into a sleep from which he could not be awakened by noises or by shaking, though after a time he would rise, walk about and talk, and obey orders given by the physician. To this sleep-walking state that he had induced, Puysegur gave the name *somnambulism,* since a similar sleep-walking state had been known to occur spontaneously ("natural somnambulism"). He and his followers believed that through such induced somnambulism the mode of thought of the patient could be transformed and that it might have a great future.

Magnetizers soon attained to great vogue (1813-50) and some scientists became deeply interested in the study of the phenomena observed. Undoubtedly, some real contributions to knowledge were made and the studies of induced somnambulism were the precursors, as we have seen, of later studies of hypnotism. But the magnetizers, in turn, became extravagant in their claims (some of which were absurd); the French Academy discountenanced their work, and,

despite its modicum of truth, magnetism again fell into such disrepute that any physician who gave evidence of further interest in it jeopardized his career.

Modern Spiritualism.—Since 1848, when the Fox family in New York State began to be disturbed by unexplained knockings and later came to believe that through the raps they could communicate intelligently with the spirit of a peddler who had been murdered, many "spiritualistic mediums" have claimed that they could communicate with the spirits of dead relatives and with deceased men of prominence.

The movement spread like an epidemic, and spiritualistic séances became very popular. The phenomena and modes of communication reported were partly physical (raps, voices, etc.), partly automatic (table-tilting, writing, trans-speaking, etc.), and partly curative (diseases healed by mediums). Much fraud has been discovered, but there are some scientists who do not feel sure that all can be explained either by fraud, hallucinations, or the subconscious personality of the mediums. The Society for Psychical Research has collected a vast amount of data on the subject. In many instances, the phenomena reported have been due to "conjuring" by the medium. Any cures of disease that occur must be regarded as "faith cures." Recently, a spiritualist in New Jersey has been bombarding government officials with letters in which he "predicts" coming events and demands action.

Group Analysis.—An attempt has been made by Trigant Burrow to have psychoanalyst and patient

live in a community and analyze one another. Schilder also has used group psychotherapy in the outpatient department of Bellevue Hospital, New York City, though he avoids mixing sexes in a group, for obvious reasons. He finds that there are some cases in which material comes forward in the group which does not come out in individual psychoanalysis. A rather full account of the questionnaires he has devised for this work concerning (1) relation to other persons, (2) relation to one's own body, (3) relation to the functions of one's own body, (4) the attitude toward one's self as a psychic personality, (5) one's social functions and relations, (6) aggressiveness, and (7) death, will be found in his *Psychotherapy* (1938).

Alcoholics Anonymous.—A lay group, calling themselves "Alcoholics Anonymous," has recently made some headway in the United States. Its members consist of alcoholic addicts who admit their plight to one another, realize their inability to become abstainers by their own free will, and believe that only through some mysterious power outside themselves can they be rescued. This mysterious power apparently becomes effective, in one way or another, through personal associations formed in the group; hope of gaining the esteem of a group may help an addict to make the effort to remain abstinent.

In a recent volume (1939), the story is told of how more than one hundred men have recovered from alcoholism! My own experience in the treatment of addiction to alcohol keeps me in the ranks of the sceptics; but if joining Alcoholics Anonymous should

prove to be an easy, effective, and unobjectionable method for the cure of alcoholic addiction, it will be welcomed by none more cordially than by practitioners of medicine, for whom the cure of the confirmed alcoholic is still a problem that has not yet been satisfactorily solved.

The well-known psychotherapist, Karl Menninger, thinks that alcoholic addiction should be grouped with the psychoses; in his opinion "the prognosis in schizophrenia is better than the prognosis in alcoholism."

A newspaper columnist, Westbrook Pegler, has suggested that the liquor industry might be subjected to a tax, the proceeds of which should be used for the treatment of people who become addicted to the use of alcohol!

CHAPTER VI

PSYCHOTHERAPY OF SO-CALLED "ORGANIC" DISEASES

THE distinction drawn between "organic" and "functional" diseases is a purely arbitrary one. For convenience only we make it and define an "organic" disease as a disorder that depends upon structural lesions in the body (either lesions that are visible to the naked eye at autopsy, or lesions visible under the microscope on histological examination).

We define a "functional" disease as a disorder in which no such lesions are demonstrable by present methods of anatomical-histological examination; but we assume that, in such "functional" disorders (including functional neuroses and psychoses), the structural changes in the body are so slight as to escape our present methods of examination, or the changes may be either physical or chemical, rather than structural in the anatomical-histological sense.

Many assert that structure and function are incomprehensible without each other; as A. Myerson has put it: "They do not exist alone but may be merely two aspects of the Great Unknown."

We know much more than we formerly did about the relations of psychological processes to the physiological processes that go on in the body. The pulse-

rate will often increase under a corresponding suggestion, and the blood pressure is markedly susceptible to psychic influences. The respiratory rate and rhythm undergo changes during emotional stress. Physiological methods are now used as "lie-detectors." The secretion of saliva, of tears, of sweat, and of the digestive juices may be strikingly influenced by mental factors. Even the basal metabolic rate may be psychically influenced. And the chemical changes in the body accompanying fear and rage have been the object of special studies by Cannon and others.

As examples of organic disease, pulmonary tuberculosis, valvular diseases of the heart, gastric or duodenal ulcer, arthritis, prostatic hypertrophy, diabetes mellitus, disseminated sclerosis of the brain and spinal cord, locomotor ataxia, general paresis (dementia paralytica), cerebral apoplexy, advanced dementia praecox, and tumors may be cited. On the other hand, certain irregularities of the heart, certain types of indigestion, the psychoneuroses, and the manic-depressive psychoses will serve as examples of "functional" disorders.

Has psychotherapy any place in the treatment of patients who are suffering from organic diseases? Miracle producers, magicians, Christian Scientists, osteopaths, and chiropractors treat all kinds of patients (those with organic, as well as those with functional maladies), and make extravagant claims of the successes they achieve. As we have seen, all these therapists make use of methods that, wittingly or unwittingly, are mainly psychic in their influence; most,

if not all, of any actual benefits that accrue to patients from their treatment must, therefore, be ascribed to psychotherapy. As might be expected, the majority of those benefited are neuropaths. And undoubtedly, in many instances, organic disease may become a source of neurotic behavior. The sufferings of the patient, due to his organic malady, make him more dependent upon others and entitle him to more consideration and affection. The patient with a "will-to-power" may, through his disease, sometimes gain a superior position in the family without resorting to strife.

But can psychotherapy exert any direct influence upon the organic processes themselves? Can influences exerted through the minds of our patients remove existing organic lesions? The answer is No. This is not, however, tantamount to saying that psychotherapy can be of no help in the treatment of patients suffering from organic disease, for in these cases the practitioner must treat his patients as "wholes," not treating simply the processes that cause organic lesions, nor simply the functional disorders that may accompany such lesions. Remarkable effects have sometimes been observed after psychotherapy in patients harboring severe organic diseases (see Chapter IX).

The behavior of any person represents the totality of his outward reactions as a living being. In studying behavior we must, therefore, always keep in mind the inseparable unity of structures and functions, of physical processes and mental processes. We must, in

every case, not only make decisions regarding the disease or diseases that exist in our patients, but we must also try to understand how the patients (as whole personalities) react to their illnesses, and must leave no stone unturned in seeing to it that no influence that can be of benefit to them is neglected.

The psychiatrist, in the treatment of personality disorders, would be blameworthy if he confined his treatment to psychotherapy, failing to apply also measures that could correct bodily disorders or improve the environment. Similarly, the physician, surgeon, or specialist who limited his treatment to measures directed toward improvement of the physical condition and the environment of his patients only and failed to avail himself of opportunities to influence favorably their personality-reactions by means of psychotherapy, would be equally culpable. In modern therapy, we dare not think of either "soma" (body) alone nor of "psyche" (mind) alone; we must keep ever in mind the fact that in a patient we have to deal with a highly complicated, integrated body-mind unit, and that disturbances on any level of the integration—anatomical, physiological, neurological, or psychobiological—will exert effects upon the whole unit. It is gratifying to know that the publication of a quarterly journal devoted to discussions of "Psychosomatic Medicine" was begun in 1939; there is a wide field for articles upon this subject.

Faith in the physician consulted, belief that help will be secured, and assurance from the physician that after complete diagnostic studies have been made,

everything humanly possible will be done to improve his condition—all these are psychotherapeutic influences that are useful in the treatment of patients suffering from "organic" diseases as well as of those who suffer from disorders of a functional nature.

Organic diseases are often accompanied by functional disorders, and, as I have said, both types of disturbance call for their appropriate treatment. As a result of many organic diseases, maladaptations of various sorts may become evident, and the best solution of the difficulties that arise from these must be worked out by the patients with the help of their physicians.

A few examples may be cited. I remember one patient who suffered from attacks of angina pectoris, an organic disease, in which, however, the attacks of pain may be precipitated by emotional events. After he was induced to marry, through overcoming a state of indecision based upon over-conscientiousness, his anginal attacks became less frequent and less severe.

A patient suffering from pulmonary tuberculosis may, after receiving treatment in a sanatorium, be compelled to readjust his life, the character of his work, and the amount of rest and recreation he takes, in order to prevent a flaring-up of the tuberculous process that has become quiescent. The advantages of psychotherapy in the management of patients suffering from tuberculous processes have been thoroughly ventilated by L. J. Moorman (1939). In his excellent article, he quotes H. F. Amiel upon the neglect of

many doctors to treat the individual as a whole, because they think only of his disease.

Again, a patient who has presented evidences of developing cerebral arteriosclerosis (personality changes, memory defects) may not realize his impending incompetence. His physician, after explaining the situation to the patient and after consultation with his family, may find it necessary to insist upon withdrawal from an occupation involving responsibilities with which the patient dare not longer be entrusted, or upon transfer to an occupation in which responsibility is minimal. He also may help to make arrangements, through the patient's lawyer or a trust company, that will protect (by means of some form of legal guardianship) the patient's financial resources from being dissipated through unwise ventures due to a badly-functioning brain, for the permission of unlimited freedom of action in such a case is all too often followed by disastrous consequences.

When functional neuroses are superimposed upon organic diseases, or when organic diseases develop in neuropaths, the methods of psychotherapy used in the treatment of the psychoneuroses may be applied with modifications made necessary by the co-existent organic malady.

In *delirious states (dysergasias),* the practitioner should be careful to push his diagnostic studies far enough to determine the nature and cause of the delirium, for it would be unfortunate to confuse a drug delirium with a delirium tremens, or a uremic

delirium with the delirium of a Korsakoff's psychosis, or that of an infection like encephalitis.

Delirious states are most often observed (1) as toxic effects after ingestion of alcohol, bromides, cocaine, marihuana, or other poisonous substances, (2) during infectious processes like typhoid fever, pneumonia, influenza, and encephalitis, (3) in the course of various metabolic disturbances like uremia, pellagra, and the toxemia of pregnancy, and (4) after injuries causing concussion of the brain or fracture of the skull.

Recently, I have treated a number of patients in which *bromide delirium,* with disturbances of speech, was due to intoxication, either from excess of bromides prescribed by physicians over a long period, or from self-medication by bromide tablets or solution. The diagnosis of bromide intoxication is easily made by chemical determination of the brom-content of the blood, and treatment through abstention from bromides and administration of common salt will make the blood bromide-free in the course of a few weeks, after which the diagnosis of the malady for which the patient took bromide in the first place may be made and appropriate treatment for it instituted.

Acute alcoholic delirium (delirium tremens) usually develops in chronic alcoholic addicts after a spree lasting several days, during which time but little food has been taken and the patient has been sleepless. It is said that when the amount of alcohol in the blood is as much as 3 mg. per cc., delirium will develop; should the blood-content be as great as 5

mg. or more per cc., there is danger of a fatal outcome. In delirium tremens, the patient is disoriented and generally suffers from visual hallucinations, seeing moving black objects like mice, rats, snakes, or dogs. A peripheral neuritis may develop because of lack of vitamin B_1 (thiamin) in the diet. The patient should be hospitalized, and after the delirium passes off the psychotherapy should be directed toward the cure of the alcoholic addiction.

In *uremic delirium* the diagnosis is made by studies of the urine and determinations of the non-protein nitrogen content of the blood.

CHAPTER VII

Psychotherapy of Functional Disorders

In many patients psychoneurotic reactions and psychotic reactions of the personality are met with in the absence of any evidence of the co-existence of any important organic disease; these are the so-called "functional" disorders, and in the treatment of them psychotherapy has had its greatest triumphs.

No sharp distinction can be drawn between psychoneurotic reactions and psychotic reactions. For the sake of convenience, however, neurasthenia, hypochondriacal states, hysteria, anxiety neurosis, compensation neurosis, and psychasthenic states are usually referred to as "psychoneuroses," whereas manic-depressive insanity, schizophrenic states, and paranoid states are referred to as "psychoses." The abnormal mental states of constitutional psychopathic personalities are sometimes more psychoneurotic, sometimes more psychotic in type.

Here again, precise diagnosis is very important in determining the methods of treatment to be applied. Possible intoxications and the state of the general nutrition (emaciation or obesity) should be given careful consideration. Though psychotherapy may be the most important indication in treatment, other methods of therapy should not be neglected when it is believed that their application will be of benefit.

Neurasthenia.—In neurasthenic states (Beard, 1880) the patients complain of fatigue, exhaustion, difficulty in concentration, disturbances of sleep, irritability, headaches, vague aches and pains and, often, palpitation, constipation, and indigestion. Though these patients need psychotherapeutic treatment, many of them suffer also from physical disorders that need attention. As I emphasized in 1906, "If we want to cure the neuroses, we must especially take into account local processes, diseases of the ears, the eyes, errors of refraction, disorders of the sinuses, genito-urinary diseases, tuberculosis, arteriosclerosis, syphilis, alcoholism, larval forms of Graves' disease, etc."

This statement still holds true. Many neurasthenic patients are markedly undernourished; in such cases, if the emaciation be overcome by rest in bed, forced feeding, and injections of protamine-zinc insulin, a good start toward the cure of the neurasthenia will have been made. Persons whose vital activities are of low grade, owing to prolonged undernutrition, do not have enough energy to adapt themselves properly to difficulties in the environment and are prone to manifest neurotic disorders of behavior.

An emaciated sexual neurasthenic recently under my care did well after I made him gain sixty pounds in weight in the private ward of the hospital, though a psychiatrist who had seen him at first felt doubtful of success in therapy outside of a psychiatric clinic. Improvement of the general health (nutrition, circulation, endocrine functions) with re-establishment of the bodily energy of the patient will make the task

of the psychotherapist in the treatment of neurasthenia much easier. Massage and occupational therapy are valuable adjuvants to rest, isolation, and dietotherapy.

One must not expect, however, to transform the mental state of neurasthenics by the application of physical measures alone. The mind of the patient must be carefully explored for disturbing factors and, based upon the findings, the physician can apply the special kinds of psychotherapy (suggestion, persuasion, mental liquidation, education, excitation, guidance) that seem to him to be indicated. At the proper time the physician will make appeals to the patient's interests and his capacities for effort. Nor will he forget appeals to the emotions, since the cultivation of hope, of cheerfulness, and of joyous emotions generally will potently stimulate both body and mind.

Many of the complaints of neurasthenics are the result of disappointments in life, or of mental conflicts of various sorts. When this is the case, the physician's analysis of the factors concerned will usually suggest appropriate management. Too often, in the old days, general practitioners told their neurasthenic patients that their troubles were "imaginary," that there was nothing wrong with them, and that they should go home and forget their symptoms! More wise was the British practitioner who once, somewhat paradoxically, said: "When a man is so ill as to believe he is ill when he is not ill, he is very ill indeed."

As an illustrative case in which a woman suffered

much because she had been told that her troubles were "imaginary," the following may be cited:

A married woman, aged forty-three, was referred to us for study and treatment. She complained of recurrent diarrhea, gas, and pains in the abdomen, headaches, fear of being treated as a nervous patient, misunderstandings with her husband, and anxiety lest her condition be misinterpreted by physicians.

On careful diagnostic study, it was found that she had visceroptosis and spasticity of the colon with mucous colitis; a mild refraction error in the eyes (myopia and presbyopia); one infected tooth; and impending menopause. The main symptoms were, however, referable to her nervous system and to her personality-reactions.

The family history threw some light upon her case. Her mother had been a nervous invalid but had died when the patient was only nine years old. She became strongly attached to her father, who was congenial in temperament and entered into her enjoyments and satisfactions with keen pleasure. During her childhood she had been more or less shut out from her parents' life and was brought up under the wing of a governess. She therefore looked back upon her childhood with a definite sense of loneliness.

Her husband had not been a very understanding person. His tendency was to express most of his emotions outwardly and to take out on the patient his moods of depression and his worries. The patient herself had always held a particularly high standard of duty as to what a wife and mother should be, but stated that she had the feeling that she had not done as much as she should have done in the way of living up to these stand-

ards. Her husband had failed in business and one of her children had hip disease and she reacted to these situations with diarrhea and gaseous indigestion.

A little over a year before we saw her, she had been treated for colitis in another city, where, though the neurotic element in her case was emphasized, she seems to have been rather poorly handled by a psychoanalytic enthusiast. The husband, sickening of what he was told was the patient's "imagination," carried her to another state, where she was desperately unhappy and was finally obliged to throw herself upon the mercy of physicians who, she felt, did not understand her, since they accused her of being a drug addict.

The friction between husband and wife had by that time become rather intense, and the marriage nearly underwent shipwreck because of lack of confidence on the part of each marital partner. A few months before we saw her, however, the husband had seemed to realize that the patient was really "sick" and had become more considerate and fuller of understanding.

During our first interview with the patient, she laid most emphasis upon physical symptoms—diarrhea, recurrent attacks of gaseous indigestion, and frequent headaches. But when we talked further with her, she complained of her lack of usefulness in life and stated that she felt she had handled her personal problems very poorly. She desired sincerely that she might be guided so that she could direct her activities better in the future. She confessed to be distinctly ashamed over what she called her weaknesses, including her over-emphasis upon physical complaints and her inability to rise above temporary irritations, and she wondered if we could not teach her in some way to control her over-sensitiveness.

Though, she was told, sensitiveness and conscientiousness are in themselves excellent constructive mechanisms in the personality, provided they are used with a proper sense of values, there was danger in letting these two characteristics have too free a rein.

Fortunately, the patient before her marriage had had much esthetic enjoyment; beauty in various forms had appealed to her, especially music and art, which she had enjoyed leisurely in early life on visits to Europe. It was evident that we had to deal largely with a functional nervous disorder and a "chronic invalid reaction," partly constitutional, partly situational in origin.

On my advice her husband consented to place the patient under our care in the hospital, where she would be temporarily isolated from family and friends and would give herself over entirely, for a period, to treatment. We explained that if anything went wrong at home and we were told about it, we would let her know; similarly, regular reports would be sent to her husband regarding her condition. It was pointed out that experience had taught us that, in cases of functional neurosis, more thorough coöperation was obtainable by this method, and the patient was relieved of many minor worries and upsets that might come through the mail or that might be caused by visits from members of the family or friends. A period of complete protection seemed necessary in order to give the nervous system the greatest possible rest.

Though at first the patient was strongly opposed to the idea of being considered "nervous," she soon became thoroughly coöperative and attained a satisfactory insight into the situation. She was kept in bed under the care of a special nurse for the daytime; a novatropine

tablet was given thrice daily because of the spastic colon and mucous colitis. A simple diet was ordered at first, but later she found that she could eat a general and varied diet without discomfort, which soon convinced her that a large part of her abdominal symptoms were due to functional nervous disturbance. She became cheerful, was contented with the methods of treatment applied, showed a gratifying confidence in her physicians, and began to feel sure that there was a possibility of return to health. Though she had periods when she felt nervous and a little depressed, these symptoms gradually became less and less marked. After a complete rest of five weeks in bed, she began to sit up and later to walk. Through occupational therapy her activities were gradually increased.

During the period of transition between complete rest and the assumption again of a more normal life, some dreads, doubts, and fears arose in her. We pointed out, however, that we would "make haste slowly" and not attempt to push her ahead too rapidly. Very little sedative medicine was required, though she had small doses of phenobarbital at the beginning of the treatment. Later on, she slept well without the aid of drugs.

Her various difficulties were thoroughly discussed with her, and it was pointed out to her that, because of her nervous malady, she had a tendency to "make mountains out of mole-hills." It was explained to her that she was over-conscientious and was somewhat too serious-minded. She had worried about her youngest child who, she feared, might be mentally retarded, though we could not obtain any definite evidence that this was true.

After some three months of treatment she had improved so markedly and was doing so much outside that

we thought it feasible to allow her to return to her home for a time. There she was, at first, to keep up "part rest," lying down for an hour or two after the midday meal and retiring early at night. She was to continue regular exercise daily out of doors and was advised to take up golf again, though gradually. She was urged to avoid situations in which friction might develop and was asked to report, first by letter at regular intervals and, later on, by occasional visits. Her husband was interviewed several times and was given advice as to how he could be most helpful in favoring the progress of her cure.

Soon after her return to her home, she wrote us that she had been doing nicely, though she had had some nervous tension and an occasional feeling as though diarrhea might return. She said that she was happy and delighted to be again at home, that she was determined to readjust herself to conditions there, that she would make every effort to keep the right ideas in the foreground, and that she felt sure that she could be successful. She enjoyed the regular exercise out of doors and she spent week-ends in the country.

A little later on she wrote that she could not tell us how grateful she was for the help that had been given her. Life had been anything but easy for her after her return to her home, but she was pleased to report that her husband's attitude had been completely kind. She had had very little digestive trouble, had slept well, and had found that she was getting stronger all the time. Later on, she took up horseback riding, found that she could go to the theater with pleasure, and occasionally had people in for dinner. At the end of a year her husband wrote us that the change that had taken place in her was

remarkable and that both he and his wife felt most grateful for her improvement.

Through letters and occasional visits from her, we have kept in touch with her during the several years that have elapsed since her treatment here. Though she has had, from time to time, slight exacerbations of her condition, she has on the whole made a very good adjustment and now leads a fairly satisfactory life.

The so-called "sexual neurasthenics" often develop their nervous symptoms because of sexual maladjustments. These patients are prone to complain of backache (for which they consult an orthopedist), or of abdominal or genito-urinary symptoms (for which they consult genito-urinary specialists or gynecologists). In young men, excessive masturbation over a prolonged period not infrequently leads to congestion of the deep urethra that can be lessened by local treatment; but, in general, success in the therapy of "sexual neurasthenia" depends upon corrective mental adjustment and dissipation of the undue concern regarding sexual frustration.

Young men often worry greatly for fear that they have done themselves harm by masturbation and in many instances a so-called sexual neurosis develops.

An interesting case in which such sex worries developed may here be cited:

The patient, a college boy of eighteen, was referred to me by a physician with the statement that the young man had been suffering from a sexual psychosis for about a year. The young man told me that he had worried, first about masturbation which he had begun a little after the

fourteenth year, and later about a peculiar practice that he had developed with an electrical apparatus. He had been given a small transformer which generated six volts, two wires were attached to it, one to be placed on his penis and the other upon his scrotum. When he turned on the current it stimulated sex feelings when applied for four or five minutes. He did not think much of this at the time, regarding it more or less as a childish prank, but continued to apply it about once a week for nearly a year.

At the time he did not know that other boys masturbated and until a year before coming to me "did not know the purpose of the testicles." About a year and a half before coming to me, he stopped the use of the electricity but continued ordinary masturbation.

One year before admission he went to a doctor for examination, as he wished to take part in wrestling contests. The doctor found that his pulse was somewhat accelerated, that his blood pressure was 140, and that he had lost twenty pounds in weight during a few months in order to get into better shape for wrestling. He asked the doctor about the influence of masturbation and was told that it was a common practice among boys and that he need not worry about it. He still yielded to the habit about once a month but began to ruminate over the situation and thought that his increased blood pressure and rapid pulse must have developed as the result of the masturbation and that therefore he must have done himself harm by the practice. For a time he worried about his heart but as the pulse-rate grew slower he became reassured as far as his circulation was concerned.

On entering the university, a few months before admission to the hospital, he began to study everything he

could find about sex. Then he began to worry for fear that the use of the electrical apparatus had done him harm, though his doctor tried to reassure him and even showed him his own spermatozoa under the microscope so that he could see that they were actively motile. He found it difficult to concentrate in his studies, and had become convinced that his genitalia had been damaged, or that if he should have children in the future they would not be normal.

Sometimes he realized that his worries were probably unjustified but nevertheless he could not dispose of them. They definitely interfered with his school work; he said that he "simply could not study." At times he became depressed and had "desperate ideas," even thinking of suicide. Before these worries had developed, he had considered himself an "all-around man" but since they had become dominant, he began to doubt this, and to feel that he must have an "inferiority complex." Despite his feeling that he could not study well, he passed his examinations satisfactorily. Aside from his sex habits, his behavior had on the whole been good; he had used no alcohol, though he had smoked rather too many cigarettes. He was interested in athletics, swimming, wrestling, and tennis and other outdoor activities.

Examination of his mental status showed that he talked easily, gave no evidence of retardation, did not look depressed, though he mentioned that he had been depressed and rarely felt optimistic, his pessimism being due to the fact that he could not get his worries off his mind. He did not think that he was more highly sexed than other boys but at every turn he "found sexual issues"—the girls on the street, the stories he read, etc. Memory for recent and remote events was accurate, arith-

metical calculation was normal, and his general information was rather good.

His insight statement was as follows: "The one thing I worry about is this electricity. If I could be perfectly reassured, but they have tried and I can't be. I occasionally worry about masturbation, but not much; it's just the electrical part. In that respect I was different from other boys." Aside from occasional frontal headaches, more marked when the worries were excessive, there were no other nervous symptoms. When asked what would constitute satisfactory reassurance for him, he at first thought that if he could find out that there had been other boys with a similar history who had got along well and later had had healthy children, he would be reassured. But later on, he was not so sure that such a naïve solution would suffice.

The mental content of determined worry of a sexual sort and of a kind that defied naïve reassurance was somewhat disturbing. The patient had had a lot of encouragement from several physicians but without apparent beneficial effects. A psychiatrist who examined him feared that he had all the elements of a serious psychosis in the making and that he should be kept under psychiatric observation.

Our general study showed that the patient was about ten pounds above calculated ideal weight; that he had a posterior urethritis with congestive prostatitis and preputial retention of smegma. It seemed clear to me that we were dealing with a definite psychasthenic state of somewhat unusual character, with especial worries about sex, phobias regarding the future, obsessions, over-conscientiousness, particularity, and difficulty in making decisions.

He was placed in a private room in the hospital with one special nurse in attendance. I arranged for circumcision, for local treatment of the posterior urethra and prostate, and for close supervision by one of my associates, Dr. Ernest S. Cross.

On a reducing diet, the patient lost some eight pounds in weight. His worries were then systematically discussed with him and his abnormal tendencies pointed out to him. The thorough study that had been made gave him great confidence, and he was pleased to meet with understanding rather than with ridicule concerning what had been called "imaginary symptoms." He was kept in the hospital approximately six weeks, during which time psychotherapy was steadily continued. His symptoms rapidly cleared up and during the last two weeks of his stay in the hospital he said he was quite happy and confident about the future. I arranged for him to go on a cruise to South America and later to spend a period on a ranch in Wyoming, after which he was to take up college work again.

Some patients with extreme fatigability, low blood pressure, and with a history of prolonged periods of rest in bed are in reality cases of hypoadrenia. They have been described as "the recumbents" (*les allongés* of Chatagnon and Chatagnon) and can be greatly helped by treatment with suprarenal cortex preparations.

Hysteria.—In hysterical reactions we have to deal with emotional states that are out of proportion to the stimuli that arouse them. Extraordinary disturbances of behavior, sensation, and secretion may be met with

because of the abnormal mental state; in other words, they are psychogenic. Such patients often exhibit a heightened suggestibility; sudden transformations of mood are common; the total behavior may be described as "capricious." Hysteria may affect either sex but is more common in females than in males.

The protean symptoms of the malady are often spoken of as "hysterical stigmata." The *bodily, or somatic,* stigmata include: (1) the *globus hystericus,* the patient complaining of a feeling of constriction in the neck, or of "a lump in the throat that cannot be swallowed"; (2) the *clavus,* a pain in the head described as resembling "a nail being driven in"; (3) *functional paralyses* of half of the body, of one or two extremities, of the speech musculature (hysterical aphonia), of the muscle elevating the eyelid (hysterical ptosis), or of the muscles concerned in standing and walking (hysterical astasia-abasia); (4) *contractures;* (5) *anesthesias* in which the loss of sensation complained of corresponds frequently to areas of the skin covered by certain articles of clothing (e.g., gloves or stockings); (6) concentric contraction of the visual fields ("tubular fields," or "gun-barrel fields"); and (7) the so-called *grand hysterical attacks* in which extraordinary passional attitudes are assumed or wild, rotating movements (clownism) are exhibited.

The *psychic stigmata* include: (1) emotional states disproportionate to the stimuli; (2) abnormal variability of moods; (3) fallacies of memory; and (4) "ideas of reference" in which patients refer to themselves comments or acts not so intended, maintaining

that they have been "insulted," "slighted," or "misunderstood"; (5) lack of due consideration for others and other evidences of diminished capacity for ethical ideas; and (6) in severer cases, hysterical twilight states, somnambulism, and trances.

The existence of hysteria can usually be easily recognized by means of the presence of one or more of the bodily and psychic stigmata above mentioned, by the "theatricality" of the general behavior, and by the capricious oscillatory course of the disease. Hysterical patients are usually very difficult to live with; they have been well described as "explosive mixtures."

In diagnostic studies, the physician should never forget that genuine organic disease may sometimes be present in association with certain hysterical manifestations. I recall one interesting example of a man who had great difficulty in rising from a chair and in walking, and who complained of increasing weakness of the muscles of his trunk and extremities. Because he had transitory "glove anesthesias" that were evidently of hysterical nature, one diagnostic clinic decided that the whole picture, including the muscular disability, was due to conversion-hysteria and that the patient was simulating muscular weakness in order to secure sympathy and financial aid.

On thorough examination of the patient I found that the muscular weakness was genuine and that it had been slowly progressive for at least fifteen years; on attempting to rise from a chair or from the recumbent position, he exhibited the typical behavior of a patient suffering from progressive pseudohyper-

trophic muscular dystrophy, and the calves of his legs were three times the size of those of a healthy man. In other words, this patient was suffering from a most serious progressive incapacitating organic disease of his muscles, which was wholly independent of his slight hysterical stigmata; his muscular symptoms and his behavior were not the result of hysterical "conversion" of imperfectly repressed infantile genital strivings! It would have been most unfortunate for the patient (as well as for his physician) if this mistake in diagnosis had been permitted to go uncorrected.

Psychotherapy is essential for the successful treatment of hysterical reactions. The symptoms are relatively unimportant except as a help to the physician in recognizing the existence of the malady. In milder hysterical reactions, treatment by suggestion (sometimes hypnosis), persuasion, and re-education may suffice. Babinski, one of the first to develop clearly the diagnostic points that differentiate organic from hysterical paralyses, emphasized the importance of suggestion, both as the cause and a method of cure of hysterical manifestations; he also devised for hysteria the term "pithiatism," which signifies "curable by persuasion." But in the severer forms, a search for the cause, for the dynamic factors involved, may have to be made by means of Adolf Meyer's method of distributive analysis and synthesis.

Freud laid great stress upon repression of infantile genital strivings in the parent-child relationship (Œdipus complex) as the cause of hysteria; he believed that unsatisfactory repression gives rise to a

substitute expression in the form of bodily symptoms (hysterical conversion), and thought that the patient in this way evaded a satisfactory settlement of the Œdipus complex, while at the same time avoiding actual difficulties in life. The psychoanalytic aim was to discover first the process that caused the repression (infantile sex strivings), and later to analyze various complexes that exerted a disturbing dynamic influence. The Freudian method demands a great deal of time and the expenditure of large amounts of money. I must agree with Oskar Diethelm when, writing of the treatment of hysterical reactions, he says that in the average case of hysteria in one's daily practice, psychoanalytical treatment is neither desirable nor practicable.

Compensation Neurosis.—In a paper entitled *Resultant and Purposive in Psychiatry*, H. Crichton-Miller uses the term "resultant" to mean any deviation from normal that can reasonably be regarded as the manifestation of inherited characteristics, or as the reaction of the organism to environmental influences, be these reactions somatic or affective (e.g., a toxicosis or a grief or anxiety proportionate to the stimulus). By the term "purposive" he refers to symptoms that subserve an end, be it of exhibitionism, evasion, defence, protest, or punishment (as in hysteria, malingering, etc.).

After an accident in civil life or after injury in war, disability may be claimed and monetary compensation sought. The disability asserted is often in the form of a psychoneurotic or a hypochondriacal reac-

tion, and physicians may have real difficulty in deciding in how far the reaction was resultant, in how far it was purposive; whether the trauma was responsible, or whether the possibility of "financial gain through illness" or even a "desire for retaliation" was the motivating factor.

In every case of this sort, a thorough diagnostic study should first be made. The precise character of the original injury should be ascertained; discoverable actual results of the injury should be recorded, and various possible after-effects should be carefully considered. The attitude of the patient and of those about him must be carefully examined and the general personality make-up of the patient may throw light upon the factors concerned in the origin and maintenance of the neurotic symptoms.

It is wise, whenever possible after such careful study, to arrange for a just, final, and irrevocable settlement of the claim for compensation. Unfortunately, in the Veterans' Administration, such final adjudication seems to be impracticable, if not impossible, so that compensation neuroses among "shell-shocked" veterans tend to be "inveterate" to treatment.

Even when a fair settlement has been made, one should not expect complete recovery at once. Supervision and guidance by a suitable psychotherapist may be necessary for a shorter or longer period.

Hypochondriasis.—A person whose attention is continuously occupied with the condition of his own body or mind is called a hypochondriac. The word

owes its origin to the belief of the ancients that a settled depression of spirits was due to disturbances in the organs of those parts of the abdomen that lie just below the ribs and their cartilages *(hypochondrium);* thus certain abdominal organs, including the liver, gallbladder, stomach, and spleen, were formerly supposed to be the seat of melancholy and "vapors."

Though it is possible that, in many cases, hypochondriacal states have their starting point in abnormal visceral sensations, these states are, in reality, pathological forms of personality-reactions to life-experiences and situations. Due attention to the functioning of one's body and of one's mind is, of course, desirable; it is only when such attention has become continuous and exaggerated and an undue concern about the meaning of various feelings has developed that it becomes pathological. In some persons hypochondriacal ideas become fixed beliefs in which the patients can not be shaken; such persons are said to harbor "true hypochondriacal delusions."

Hypochondriacal complaints are prone to develop in young people whose parents are constantly oversolicitous about them. Children should, of course, be taught to take ordinary precautions against catching cold, against exposure to contagion, and against accidents, and should be expected to report to their parents any symptoms of illness. But a mother who is constantly harping upon dangers to health, or who is forever making inquiries of her children concerning their feelings, and who keeps them observing their

sensations too closely is all too likely to sow the seeds of hypochondriasis.

In a healthy home atmosphere, expressions of sympathy for minor complaints are kept within bounds, and parents see to it that unwholesome over-concern is avoided, teaching their children to meet their smaller difficulties with fortitude and developing in them a more or less stoical attitude of patient indifference toward the little ills of life, though, of course, taking care at the same time not to be too austere. In such a home, the children are less likely to develop anxieties, fears, and hypochondriacal ideas than in homes in which children are spoiled by pampering and coddling.

Physicians, too, are sometimes to blame (though, of course, unintentionally) for the fostering of hypochondriacal ideas through ill-advised medical care. Too many unnecessary and useless operations have been performed upon hypochondriacal patients and excesses of endocrine, vitamin, electrical, and other forms of therapy may deepen a hypochondriac in his conviction that he is seriously ill.

The physician must, of course, differentiate between ordinary primary hypochondriasis and the secondary hypochondriacal reactions that are sometimes met with in psychoses (manic-depressive insanity, chronic paranoia, catatonic forms of schizophrenia, dementia paralytica); but if a careful general diagnostic study be made, there should be but little, if any, difficulty in assigning a given hypochondriacal reaction to its proper place.

The preliminary diagnostic study of a hypochondriac should be sufficiently comprehensive to convince the patient that nothing important in his condition could be overlooked. When the study has made the existence of a hypochondriacal reaction clear, the physician should explain in detail to the patient the differences between symptoms that are due to organic disease and those that are functional in origin and dependent upon his total personality and its reactions to experiences.

The patient must then be taught to disregard disagreeable sensations, to avoid excessive strains and exhausting emotions, and to cultivate a state of greater confidence in his body. Re-education and guidance for some time is necessary.

In severer cases of hypochondriasis, in which a marked "chronic invalid reaction" has developed, success in treatment may require removal from the ordinary environment by placing the patient in a hospital, isolating him from family and friends, providing for rest and later for occupation, while regularity of habits is insisted upon under the supervision of the physician and a well-trained nurse. For an excellent discussion of the chronic invalid reaction, the paper of Esther L. Richards (1919) may be consulted.

Anxiety Neurosis.—In this form of psychoneurosis, we observe recurrent acute attacks of anxiety, in which the patient usually refers the symptoms to the chest, complaining of stoppage of the heart or of rapidly beating heart with palpitation, suffocating

and constrictive feelings in the chest, choking sensations, weakness in the extremities, faintness, dizziness, sweating, and panic. These attacks are much dreaded by the patient who, on account of their occurrence, fears to be left alone. Between the attacks there may be restlessness and irritability (anxiety-equivalents), and the patient remains apprehensive because of the anticipation of further episodes of acute anxiety.

An acute anxiety attack can, as a rule, be quickly relieved by the physician who, after examination of the heart and lungs, assures the patient of the absence of any dangerous condition. A little later a diagnostic study should be made and this should be so comprehensive that, on the recurrence of anxiety, the physician can quietly reassure the patient of the absence of organic disease and can say that no repetition of the examination of the heart is necessary. The physician should explain to the patient that worry and anticipation are likely to precipitate attacks of anxiety, and should urge him to ignore any symptoms referable to his heart. For the restlessness, irritability, and apprehension that tend for a time to persist, the temporary use of bromides, or of barbiturates, and the prohibition of tobacco-smoking may be helpful. As a rule, however, it is best to avoid the use of sedative drugs, since patients may tend to lean too much upon them and to evade facing the realities of the situation. It is better to cultivate the self-confidence and self-reliance of the patient.

The diagnostic study in such a case should include a psychiatric examination that will attempt to get at

the personality difficulties that underlie the anxiety neurosis. The Freudians, as might be expected, refer the origin of the anxiety either to the repression of infantile sexuality, to sexual frustration in adult life, or to coitus interruptus. Experienced and well-trained clinicians are sure that this is too narrow and one-sided a view. Though not denying that sex difficulties may be a causal factor in some cases (and when they are, they should receive due attention), one finds in everyday practice that various forms of mental conflict may be responsible for anxiety neuroses.

Standards and ideals that come into conflict with reality, personal attitudes that cause tension, incapacity to make suitable adjustments to the situations of everyday life, ambition to live upon too high a level, and long continued stresses and strains of various sorts may be responsible for the development of tension states. Fear of impending danger to one's self or to some loved one, and threats to personal or family welfare may be causal factors. I recall, especially, the case of one married woman, the mother of children, whose husband over and over again threatened that he would commit suicide. Though no one outside the family was told by the man of his alleged intention to end his life, he would sometimes say to his young daughter in the mother's hearing: "Daddy is going away and will never come back." In general, the husband was much beloved and highly esteemed by his acquaintances and was very successful in his occupation. But, in time, the wife broke down under the continued strain, and when I saw her for the first

time, she was exhibiting typical anxiety-tension attacks. On getting the complete history, it became obvious to me that both she and her husband were in need of psychotherapy.

Not infrequently, in cases of anxiety neurosis, the diagnosis of "effort-syndrome" or of "neuro-circulatory asthenia" is made, in which case the physician is likely to direct too much of his therapy to the cardiovascular system and to neglect the more important personality disturbance.

In every case of anxiety neurosis it seems to me to be essential to discover the particular personality factors and the special environmental situations that may be playing a part in the origin of the malady. The patient must be brought to a better self-understanding, existing conflicts must be solved, and disturbing environmental situations must be corrected. Afterward, the patient needs to be trained gradually to lead a regular and normal life under the guidance of the physician.

In severe cases, hospitalization for a period, with temporary rest, isolation, and hydrotherapy may be necessary, during and after which, proper psychotherapy may be practised.

Psychasthenia.—Neurologists and psychiatrists owe a great debt of gratitude to Raymond and Janet for their monumental work upon *Obsessions and Psychasthenia* (1903) in which psychasthenic states, with their obsessive ideas, pathological scruples, overpowering impulsions, ruminative states, and phobias were thoroughly analyzed and discussed.

Since their studies, it has been made clear that psychasthenia is not a single disease entity but includes several groups of reactions that differ more or less from one another in clinical picture, etiology, prognosis, and response to different forms of therapy (cf. W. Malamud, 1938). Common to most of these groups is the feeling of the patient that his symptoms are *forced* upon him; he says that he is *compelled* to manifest them, despite every effort of his will (so-called "anankastic symptoms").

Psychasthenic states are characterized by periods in which there is marked tendency to indecision or doubt *(folie du doute)* and in which the patients are plagued by fears of people *(anthropophobia)*, including social shyness and feelings of social insufficiency; fears of certain places *(agoraphobia)*, fears of being shut in *(claustrophobia)*, fears of the existence in them of symptoms of incurable disease or of insanity *(nosophobia)*, fears of contamination with unclean or infectious objects *(mysophobia)*, or fears of contaminating anything that they themselves may touch *(délire de toucher)*.

In such states, some patients suffer from imperative impulses to speak obscenely *(coprolalia)*, to echo what they hear *(echolalia)*, or to ask themselves and their physicians foolish questions continually regarding ordinary things in the environment *(interrogative mania)*. Many of the patients are greatly pestered by imperative ideas *(obsessions, scruples)* and by overconscientiousness.

Feelings of guilt often arise because of sexual urges

and actions; a monk may suffer much because he has occasionally given way to the impulse to masturbate, since he regards this as a violation of his vow to chastity, the act thus being regarded as contrary to his self-imposed moral code. The symptoms of a psychasthenic appear against the will of the patient, who often recognizes them as abnormal and as something foreign to him, though he tries in vain to resist them. Severer and milder forms of obsessive-compulsive neuroses occur. In severer cases, the patients may be actually incapacitated. Cases that are mild at first may, if inadequately treated, go over into severer forms later.

The diagnosis is easy, as a rule, the only exceptions being the obsessions and compulsions that are sometimes met with in manic-depressive and in schizophrenic psychoses; if these psychoses can be ruled out by the diagnostic study, a primary psychasthenic state may be assumed to exist.

In my opinion, the majority of psychasthenic states, contrary to Freud's ideas of an infantile sexual origin, arise mainly because of the constitutional nature of the patients, though contributing causal factors in the environment should not be overlooked.

In the treatment of a psychasthenic state, the physician should first acquaint himself with the main features of the patient's personality, though so-called "deep psychoanalysis" along Freudian lines, with the idea of discovering anal-erotic and sadistic factors dating from early childhood, ought not to be strongly advocated. Freudians, as I have said, seem to believe

that psychasthenic compulsions represent a defense to, and a gratification of, anal-sadistic strivings, the patients gaining a distorted satisfaction, or a feeling of merited punishment and atonement by means of their symptoms.

When psychasthenic symptoms are so severe as to make the continuance of living in the ordinary environment impracticable, the patient should be temporarily isolated in a hospital or nursing home where, with the aid of a special nurse, the physician may make his general diagnostic study, including personality analysis; improve the physical status; give repeated reassurance; make use of occupational therapy; and gradually re-educate the patient to a more normal life and to capacity for self-discipline. Such patients are often helped by being told authoritatively (1) that "the thing they fear will not happen," (2) that they can really do the things they fear they can not do, (3) that it is often better to make a decision (even a wrong one) than to remain continuously in a state of indecision, and (4) that tendencies to overconscientiousness and to perfectionism should not be permitted to interfere too much with the affairs of everyday life, since every one should be content with what he can accomplish by "means of reasonable effort and within a reasonable time."

Some patients, finding a "refuge" in a hospital, are loath to leave it. The physician will, however, decide how long the hospital treatment should be continued and will keep ever in mind the necessity of making life outside the hospital not only possible but attrac-

tive. Interests that exist in the patient should be discovered and utilized to his advantage, and group activities should be encouraged. The heroic treatment (surgical removal or section of parts of the frontal lobes of the brain) recommended by Freeman and Watts for severe psychasthenic states seems to me to be scarcely justifiable; if such "psychosurgery" be used at all, it should only be as a last resort.

Patients with milder psychasthenic states are well known to general practitioners and can often be wisely handled by them in a series of office consultations. The better the psychological insight and the more thorough the psychiatric training of the physician, the greater will be his success in the management of psychasthenic patients. His aim, always, should be to re-educate them and gradually to modify and reform their faulty mental habits.

An interesting example of a peculiar psychasthenic state demanding reassurance in a special way may here be recorded:

An elderly spinster, who was engaged successfully in philanthropic work and was doing a vast deal of good in a poorer section of the city, has during the past seven years visited me repeatedly because she required reassurance of an especial kind. Aside from chronic arthritis and a moderate degree of obesity, she had no physical ailments.

At her first visit she told me that she was mortified to have to confess that she was troubled because of certain "vagaries in her mind" and, as she had heard that I had been helpful to an acquaintance of hers who had suf-

fered from similar vagaries, she was turning to me for aid.

She had just read a magazine article entitled "What If Man's Idea of Time Changed?" and had been very much perturbed by it. She brought me two papers and asked me to write at the bottom of each paper the words "This is all true and correct" and to sign my name to both. Paper Number One read as follows: "One amount of time for one person couldn't be another amount of time for another person in the world or universe including the farthest planet." Paper No. 2 read: "What appears to be five minutes is five minutes, of course, and what speed we perceive with our senses we can be sure that is the speed. This is the same for anybody in the universe."

I asked her if she had been troubled earlier in life with any similar vagary. She told me that, at the age of thirteen, after a febrile attack of some sort, she had been obsessed with the idea that she had a hump-back. She said she knew that she did not have it, but the idea continued in her subconsciousness and was the cause of much strain. She told no one but her mother about it because she was so terribly ashamed of it.

I told her that I was glad that she recognized the absurdity of being troubled by such ideas, but she replied that this did not help her. She had to have assurance from some one in whom she had confidence.

I next asked her why she should be bothered about ideas of time and speed and urged her to try living her own life, in which she was doing so much good, without ruminating over things and becoming so upset by what she called her "vagaries." I also told her that, from the common-sense point of view, the statements made in the two papers about time and speed were true and that even if philosophers, metaphysicians, and some scientists

were discussing certain questions relating to time and speed, there was no need for her to worry about the matter. I pointed out to her that much had been written about "vulgar time" and "true time," "sidereal time," "apparent solar time," and "mean solar time." She was insistent, however, that I should sign the two papers as they stood, if she was to have any rest, and, in the circumstances, I felt justified in doing so, since, in the ordinary sense of the word "time," her statements would be regarded as true.

A little later on, she returned with two other papers for me to sign, indicating that I believed that the statements they contained were "all true and correct," and these I also signed. I urged her, however, to avoid dwelling upon such obsessive ideas in the future; when any such idea came into her mind, she should try to displace it at once by thoughts connected with the good work she was doing. She was much reassured, her symptoms became less disturbing, and for quite a long period she did not return with any more difficulties.

After some time, however, she began to be troubled once more. She said, "When I have something that seems entirely unreasonable to me, I just want to feel that there are some things that we can be sure of and certain of, fundamental things—seeing and feeling, what our senses tell us—and that without being able to prove it we can be sure of it, and that I can rest my mind in peace and security and certainty upon this and be sure that this is reason. And what I want from you is certainty and assurance. I want you to sign the paper which says that when I am seeing and feeling a thing in a certain place, I can be perfectly sure it is in that place."

I told her that her statement was true for people who

were in health, though some sick people might have hallucinations of seeing or feeling things when they were not there. Having made this explanation to her, I then signed the paper with the words "I am sure this is all true and correct."

She afterward wrote me that I could not imagine how much my signing of this paper had helped her. The matter had been on her mind for a long time and had made her very nervous. She said that one of the most painful parts of her condition was her consciousness and appreciation of it and the difficulty of telling anybody about it, even me, since it was a blow to her pride. But, on the other hand, she felt that the only possible means of relief for her was through her expression of the vagary and the reassurance received from another in whom she had confidence. She declared that it was a cruel trouble to have. I had told her that I try never to deceive my patients. She said that her belief and confidence as a result of that statement had been a great help and comfort to her, for she felt that I was conscientious in every detail.

From time to time, especially when she had been under strain, she re-appeared with still other papers to sign. Then another doubt came into her mind. She wrote to me as follows: "I have begun to think that perhaps you were a little anxious regarding my condition and that you have thought it might be better to deviate from your usual methods of being strictly truthful to patients and to have given me answers to my questions such as I so much desired."

She then asked me if I would be offended with her if she requested me to write down the following words, if I could do so truthfully: "I have always told you the

truth, I always shall, and what I told you when you first came to me is still true now." I signed this paper for her and she told me that she hoped she would "never feel like that again," both for her sake and for mine.

After about three years of recurring visits and requests for signing of papers, I began to wonder if it would not be better to attempt a change in the method of giving her reassurance, so when she came with other papers to sign, I said to her, "It seems to me that it would be better if I gave you reassurance by word of mouth, rather than by the signing of papers all the time; you seem to me to be too dependent upon them."

I told her that if she would write out things that troubled her, I would answer her to her face. The patient's reaction to this suggestion was interesting. She became very much upset, began to weep, and said she did not know how she could possibly get along if I insisted upon the change. She went home and wrote me a letter saying that, through several years, I had shown very great sympathy with her and had understood her difficulties and had told her repeatedly not to hesitate to come to me when she needed help. She said also that she had appreciated this immensely and that everything I had said and done for her had satisfied her. And it was because of the help and comfort that I had been to her that she had been able to talk so freely, not only of any happiness that came to her, but also of any sorrows and any mental difficulties. She was not prepared, she said, all of a sudden to have such a drastic change in method of treatment, and she begged me to continue to be kind to her and not to be severe. The thought of the change had upset her so much that she was suffering from headache, burning in the stomach, and inability to sleep. . . . She

felt very unhappy. She wanted to assure me of her attitude of respect and deference and her confidence in my knowledge and experience. Now, however, she felt that "the bottom had fallen out of everything." She had feared for a long time that she might get "stuck" in one of her mental vagaries and not be able to come out of it, but every time when I signed a paper as requested, she was, for the time being, entirely relieved. She begged me to continue to permit her to express her troubles in writing and to give her reassurance in the way that had hitherto been so helpful to her. She promised to bother me as rarely as possible and closed her letter with the words "Please continue to help me, for I am ill and you are my doctor."

When I had thought the matter over, had remembered that the patient was approaching her seventieth year of life, that she really did receive great comfort and at least temporary benefit from the signing of the papers she brought to me, and that it was improbable that any other method of handling her would yield any better results, I decided to accede to her wishes and to give her the reassurance she required in the form that she desired it.

I must give her credit for making a strong effort to solve as many of her difficulties by herself as she could. Every now and again she would bring me written statements which, for her peace of mind, she desired me to sign with the statement that they were "all true and correct." Here are a few of them:

1. "If we, according to our weight-table, name a certain amount of weight an ounce, then we can be sure an ounce is that much weight, and if we name a certain amount of weight a pound we can be sure a pound is

that much weight. We can be sure a pound is sixteen ounces. And we can be sure of the correct measurements of weight and of the weight our scales tell us, provided, of course, that the scales are accurate and we can be sure that they can be made accurate. This is all simple common sense."

2. "When we put something on the outside under our nose, not in the mouth, we always get pure odor only and no combination of taste and odor and no taste at all. You say that there are four qualities of taste: sweet, sour, salt, and bitter, and that when we speak of flavor in foods we have to think not only of these taste qualities but also of temperature sense, touch sense on the tongue, and the possibility of odors of the food reaching the nose. It seems to me that the sense of taste alone is what tells us is really a 'flavor.' The sense of smell is a different sensation from the sense of taste, and they can be distinguished from one another in this combination of taste and odor."

3. "When I am standing out in the open field or anywhere I can be sure that I am not seeing everything that falls on the eye upside down for I can tell by feeling that I am seeing everything as it is and not upside down. We know and can be sure by our senses of seeing and feeling whether we are standing up, lying down or sitting down, or wherever we are, and without being able to prove it, we can be sure of it."

4. "If there were no animal life of any kind (even the most infinitesimal) in the world and universe, and everything in the world and universe was moving at the same speed and time it would be for the speed of our sense perception, then if a person came into the world or uni-

verse under such conditions he would have to have the same speed of sense perception as we have."

Many other examples could be given. It was certainly extraordinary that this woman, who was of higher than average intelligence and who did such excellent work for the poor in the community, should have been so mentally tormented from time to time with ideas that never bother the majority of persons. She had insight into her condition in as far as she recognized the fact that she had "mental vagaries" that would seem foolish and trivial to most people, though they were very upsetting to her until she could get relief by writing them down on papers and having me sign statements that they "were all true and correct."

If this woman had appealed to me for help in earlier life, I would have thought it desirable to make a thorough study of her personality and to try, through deeper psychological analysis, to find the roots of her malady, in the hope of giving her permanent relief rather than merely temporary aid by the signing of her papers. Whether I could have succeeded or not, I do not know. But as she was already senescent when she first came to me, I am inclined to think that the procedure I adopted was perhaps best for her.

Affective Disorders (Elative and Depressive Disturbances; Thymergasias).—Under this heading are included various disturbances of the affective life (feelings, emotions, moods). Among these may be mentioned: (1) *pathological increase of emotional excitability,* seen, for example, in certain hysterical reactions, in the irritability of neurasthenics, in the violent outbreaks of certain demented patients (senile

or paretic); (2) *apathy* (abnormal depression of emotional excitability), such as is seen in various forms of stupor, in some schizophrenics, and in imbeciles; (3) *elation* (exaltation or hyperthymia) in which positive feeling-tones (joy, excitement) accompany almost all activities, as we observe in mania, in certain stages of intoxication by alcohol or drugs, and in the euphoria of the general paretic; and (4) *depression* (dysthymia) in which ordinary intellectual activities are accompanied by intense negative feeling-tones (discomfort, sadness, "torture"), leading to inhibition of activity or to abnormal states of tension, as seen especially in melancholia.

The most characteristic affective disorders are those met with in the *manic-depressive psychoses.* These psychoses develop in patients mainly because of their constitutional make-up (hence are called endogenous psychoses), though environmental influences may act as precipitating factors. The form of hereditary transmission is dominant rather than recessive; Kleist thought that there must be separate genes for mania and melancholia.

Some patients suffer from only one attack, either of mania or of melancholia; some have several attacks with preservation of normal mental functions between attacks. Often there is a regular recurrence (cycle) of the two opposite states of elation and depression, the single cycles repeating themselves, after shorter or longer free intervals, throughout the whole of life (circular psychoses, cyclothymia). In addition to liability to recurrence, subsequent attacks tend to

come closer together and to last longer than the earlier attacks. Many patients, however, who have recurrent depressions, never exhibit elative phases.

Why an attack of manic-depressive psychosis occurs in a given patient at a particular time is not yet understood; we need further studies of the precipitating factors. Freud assumed that the loss of the "love object" may be the precipitating cause of an attack of melancholia. Withdrawal of love into the patient's self followed and was, he thought, evidence of "narcissistic regression."

In the *elative* (manic) phases of the manic-depressive psychosis, the mood of the patient is exalted. Sudden changes in humor, flight of ideas, easy distractibility of attention, and pressure of activity in occupation are observed. Everything is easy for the patient; the world is seen in a rosy light. Often there is marked talkativeness and many unnecessary letters may be written or telegrams sent; extravagant purchases may be made, and a tendency to excessive traveling and visiting may be exhibited. Alcoholic bouts and sexual misdemeanors may be indulged in. The "drives" of the elated individual are strikingly excessive.

Milder forms of pathological elation (hypomanic states) may easily be overlooked by the uninitiated, since persons manifesting them may seem to be unusually healthy (blooming appearance, bright eyes, rapid conversation, non-fatigability, hail-fellow-well-met); but the physician who has had psychiatric training will recognize the patient's real state by the

poverty of the underlying thought; the tendency of the mental associations to be influenced by sound, similarity, and contiguity; the resemblance to mild intoxication with alcohol, and the entire absence in the patient of any disease-insight. There is often a loss of body-weight because of insomnia, lack of food, and the excessive activity.

In severer forms of pathological elation (hypermanic states) there are often delusions of grandeur, extravagant self-appreciation, and sudden outbreaks of anger or violence with attacks upon the surroundings. Some patients, during maniacal attacks, may gesticulate, dance, yell, tear up their clothes, or pull out their hair. Criminal sexual assaults may be made by hypermanic persons. In such severe states of manic excitement, the community must take measures to defend itself (commitment to a psychiatric institution).

In the *depressive* (melancholic) phase of the manic-depressive psychosis, there is pathological sadness and slowing of thought and movement, usually accompanied by weeping spells, loss of interests, ideas of self-depreciation and unworthiness, ideas of poverty, and ideas of sin (micromanic delusions). The patients blame themselves for their condition (though in reality it is entirely independent of their will-power or their morality); think that they are, because of their own fault, a burden upon their families; are convinced that they can never be well again, and often harbor ideas of self-destruction. *In such patients there is always danger of suicide.*

The symptoms of the depression are often most marked at certain times of the day (especially in the forenoon), less marked at other times (so-called "diurnal variation of symptoms"). Wendell Muncie (1934) has described depressions in which "tension" was the dominant feature; Hohman earlier pictured certain types of "hypochondriacal" depressions. In some cases, depression is accompanied by marked anxiety—so-called "anxious depressions"; in others the depression is accompanied not by psychomotor retardation but by pathological over-motility (restlessness, jerking of the extremities, pacing about, picking at the bedclothes, etc.)—the so-called "agitated depressions."

In the treatment of all severer forms of manic-depressive psychosis, hospitalization is necessary (for the protection of the environment and for allaying agitation in manias and for prevention of suicide in melancholias). Patients with suicidal ideas must never be left alone at any time of the day or night (so-called "suicidal observation").

Barring the development of intercurrent diseases, patients suffering from typical manic-depressive psychoses and exhibiting an attack either of mania or of melancholia will get over the attack in time.* The patients should be told so, though many of them will not believe it when told. The physician should, however, never make prophecies regarding

* Depression occurring for the first time during the climacteric period or later (fortieth to sixtieth year) may differ from the depressive phase of ordinary manic-depressive psychosis, in that it is likely to be very protracted and may not end in recovery. In such an "involutional melancholia" the physician should make a very guarded prognosis.

the *duration* of an agitation or of a depression, since this varies in different cases (months to one and a half or two years, or even longer), as well as in different attacks in the same patient. He should be satisfied with strongly assuring the patient of ultimate recovery from the attack, and of his determination that he will leave nothing undone that he believes will be helpful while the attack is running its course. He will try to make the patient accept the situation as stoically as possible, while at the same time applying measures that will ameliorate symptoms like insomnia and constipation.

Rest in bed, at first, with special nursing, isolation from family and friends, general massage at regular intervals, and mild hydrotherapeutic measures will go far to permit the institution of regularity of régime. Phenobarbital, three or four times a day, or divided doses of barbital, may be helpful during the early stages of the treatment. If insomnia be marked, paraldehyde may be helpful. No alcohol should be given. As soon as feasible, systematic occupational therapy (sewing, crocheting, solving picture-puzzles, leather-tooling, or the like) should be begun, and the patient should be encouraged to read, to play card-games with the nurse, or to keep occupied in other activities that may be of interest and help to prevent the tendency to incessant rumination and self-observation. Here both the physician and the nurses must exercise ingenuity in the discovery of possible interests and capacities in the patient that can advantageously be made use of.

When the attack has shown definite signs of subsidence, the physician must use his best judgment as to times when activities should be increased, when isolation may be less rigorously enforced, and when familial or social relations of one sort or another dare be permitted. Relapses sometimes occur, and the physician must be on the lookout for them and, when necessary, increase restrictions temporarily.

A good example of a recurrent depression of the agitated type may be cited:

A woman of fifty-five consulted us because of the appearance of severe nervous symptoms, following an attack of influenza. During convalescence she had gone to a southern climate in the hope of more rapid recuperation. While in the South she began to dread seeing people and developed a fear of losing her mind. She accused herself of being a coward and of allowing herself to get, as she called it, "soft." She made a lot of good resolutions but found it difficult to follow them.

On returning to the North she found a relative desperately ill and, later on, after this relative's death, she suffered from deep grief and self-accusatory thoughts because she remembered that there had been times when she had not been as kind to this relative as she should have been. She began to have weeping spells and consulted a physician who reassured her, telling her that she was nervous and needed mild sedatives and "some medicine for her endocrine glands."

She had a friend who was a Christian Scientist, who came to see her, induced her to read Mrs. Eddy's book, and arranged for "absent-treatment" by a Christian Sci-

ence practitioner. Her physician had told her husband that she was not to be sympathized with, that she should not take medicine and that she should be made to fight out her troubles by herself, as there was nothing the matter with her but "nerves." Her husband, naturally a kind and tender man, deeply devoted to her, found it extremely difficult not to be sympathetic but he did his best to be stern with her and she did her best to get well by herself. Instead, she grew steadily worse and she reported to us later that she had finally turned on her husband and said hideous things to him, hurting his feelings terribly, though at the time she could not help but be glad of it. It was this situation which brought her to Baltimore for study and treatment.

She had an agonizing sense of guilt regarding her behavior but was determined at first not to make a full avowal of the situation because she did not want the physicians to know about her "black heart." On inquiry, it was found that the patient had passed through a depression, lasting several months, some fourteen years earlier. It was found also that at different times in her life she had had feelings of uncertainty, rather marked indecision, feelings of unreality, bewilderment, and she thought that people were talking about her, whispering unkind things. She had worried about finances, though there was no reason for this, since both she and her husband had very good incomes. Her own married life had been happy, though her parents had been divorced when she was sixteen years of age.

It seemed clear that we had to deal with an agitated depression in a patient of elative-depressive trend, associated with many psychasthenic symptoms. The danger of suicide was kept in mind, but it was felt that the patient,

under suitable care, would in time emerge from her depression and be happy again.

Aside from her affective disorder (depression), she had some spasticity of the colon, with mucous colitis, and a myomatous uterus, but the latter was not causing any symptoms.

The patient was placed in a good nursing home, in the care of special nurses, with orders that she was not to be left alone either by night or by day (suicidal observation), and one of my associates, Dr. Thomas P. Sprunt, kept a close eye upon her. The patient was isolated for a time, receiving neither visitors nor letters from family or friends. General massage three times a week was ordered. Her diet was regulated and she was given small doses of barbital at two, five, and nine P.M. For the spastic colon, a novatropine tablet was given after each meal. The patient was told that the depression would pass off in time, though it might last for a considerable period and no definite prophecy as to its duration could be made.

The patient afterward told us that one of the attending nurses had been especially helpful to her. She said that she had recognized her good qualities at once, for she saw that she was kind, unselfish, gentle, and unfailing in sympathy and that she felt as though she were being mothered as tenderly as her own mother would have cared for her if she had been ill in her youth.

The patient's suicidal ideas continued for a time. Though she would have been sorry, by resort to a desperate act, to hurt the nurse she liked so much and her attending physician, in whom she came to have increasing confidence, she begged to be permitted to go home, secretly intending to put an end to her life, with the idea

in her mind that this would give her husband a chance to marry again and be as happy as he deserved to be. She was told, however, that it was not wise for her to go home until the depression had passed and that unless she were willing to stay on in the nursing home she would have to be transferred to a psychiatric hospital. She did stay and gradually the depression died down.

As she became quieter, occupational therapy was begun, and she became interested in doing various things with her hands. She soon decided that her favorite nurse "had mastered the fine art of human relationships better than any one else she had ever known intimately." She also developed increasing admiration for my associate, who supervised her, and later told him how much his unfailing courtesy, kindness, sensitiveness to her moods, and efforts to find things that would be of interest to her, had done to help her. This affective *rapport,* established between the patient and her nurse and her physician, was undoubtedly helpful in the further management of the case.

Little by little the cloud lifted. As the patient improved, she was allowed to take walks with the nurse and later to go to places of entertainment. One night, at a moving-picture show, she found herself laughing and having a good time. After five months of treatment in the nursing home it was thought safe to send the patient away with her nurse to a cool place in the country. She still had periods when she was somewhat more depressed, but it became easier for her to talk and she was ever more responsive to encouragement.

After another two months, she began to feel that she would be able to take up her work again and that her confidence in herself would be restored. She enjoyed

automobiling and participated in games, and it was possible gradually to reduce the amount of barbital she had been taking. In less than a year the depression had fully passed, and the patient had become active again.

It was then pointed out to her that after a depression patients often go too far in the other direction and feel that they can accomplish almost anything they set out to do. She was warned to take things easily for a while and to maintain regular periods of rest and recreation. A little later she reported by letter that she had never been as well in her life before as she was when she wrote, and that she was enjoying life as she had not done for years. Emphasis was again laid on the fact that after a depression the mood often becomes one of over-elation and that this, in turn, should be guarded against. When she later still reported to us that she had taken up her work again and "found it sheer joy instead of the usual hard grind," the danger of pressure of activity was again pointed out to her and, as she had profited so much by following advice earlier, she has thus far seemed inclined to be cautious about overdoing. Though she has made a good recovery, one can not be sure that she will not, later on in life, have another depression.

No two manic-depressive patients are exactly alike. The old idea that we can do nothing for a melancholic except to prevent him from committing suicide and to "let Nature take her course" was fallacious. Individualization of the treatment is of real importance; through a variety of psychotherapeutic and other measures, the modern physician can do much more than his predecessors for the welfare of his manic-depressive patients. Recently, "shock-therapy"

by insulin has been recommended as a method of shortening manic-depressive attacks, but we have not yet had sufficient experience with it to make definite pronouncements regarding its value in these affective disorders. In one of my manic-depressive patients who was suffering from a marked depression, shock-treatment was given by Dr. Marion Booth; after several weeks, she emerged from the depression. Whether it would have ended as quickly without shock-therapy, we could not, of course, be sure.

Schizophrenia (Parergasia).—Formerly, all patients falling in this group were described as suffering from what Morel (1857) spoke of as "*démence précoce*," or "dementia praecox" (the term adopted by Kraepelin), since it was thought that sooner or later "dementia" was inevitable. Bleuler's term (1911), "schizophrenia" (cleavage of the psychic functions), is now preferred, since it does not lay emphasis upon a terminal dementia, which many of the patients escape. Later, Adolf Meyer made use of the term "parergasia," stressing (1) the importance of the constitutional make-up that predisposes, and (2) the precipitating life-experiences.

Schizophrenic reactions, often exhibited by adolescents, and hence sometimes referred to as the "adolescent psychoses," may appear in any one of several different forms: (1) *hebephrenia* (Hecker, 1871), in which dementia develops in young people, (2) *catatonia* (Kahlbaum, 1874), in which symptoms of negativism, command-automatism, grimacing, etc., are followed by a dementing process, (3) *dementia paranoides* (hallucinations or delusions prominent), and

(4) *simple schizophrenia,* in which only functional symptoms, without accessory symptoms (see below), appear throughout the whole course.

Bleuler divided the symptoms of schizophrenic reactions into (1) *fundamental symptoms* and (2) *accessory symptoms.* Among the "fundamental symptoms," he placed (1) alterations from reality, which he spoke of as "autismus," the patients tending to be "shut in," to live in a world by themselves, (2) enfeeblement of the active attention, (3) disturbances of the will (either abulia or hyperbulia), (4) disturbances of the person (tendency to cleavage of the ego), (5) disturbances of intelligence (faulty thought-processes) and (6) disturbances of behavior (maladaptations, eccentricities, bizarre actions).

Among the "accessory symptoms," Bleuler placed (1) hallucinations, (2) delusions, (3) disturbances of memory, (4) alterations of personality, (5) alterations of speech and writing, (6) certain bodily symptoms, (7) catatonic symptoms (catalepsy, stupor, stereotyped movements, mannerisms, negativism, command-automatism, impulsive acts), and (8) various acute syndromes (manic or melancholic states, twilight states, incoherence, etc.).

In the mildest cases, the schizophrenia may be so latent that even the physician may not suspect its existence; such "latent" cases are far more numerous than the "manifest" cases. It is in this latent stage that psychotherapy may be expected to be of the greatest help. An attempt should be made to gain as full an understanding of the patient's personality

make-up as possible. If a tendency to autistic withdrawal is in evidence, efforts are made to counteract it; behavior disorders are as far as possible corrected; interests are appealed to and capacities utilized. The patient should be kept at useful occupation and opportunities for helpful social contacts should be arranged. Through such psychotherapy and gradual reeducation, many milder schizophrenics may make a fairly satisfactory life-adjustment.

Unfortunately, in the majority of patients exhibiting marked schizophrenic reactions and evidences of dementia, it is not possible through psychotherapy or through any other method of treatment to bring about satisfactory readjustments, even at low levels of attainment. These patients, for the sake of their families and for their own welfare, are best kept permanently under institutional care. Recently, through the "shock-therapy" of Sakel (insulin-coma or metrazol convulsions), some rather severe schizophrenic states have been markedly ameliorated. Insulin treatment is preferable to metrazol treatment, since, during the convulsions produced by metrazol, fractures of the spine frequently occur. The real value of "shock-therapy" for schizophrenia remains for the future to appraise.

Physicians should see to it that families of patients are discouraged from arranging for expensive Freudian psychoanalytic treatment over months and years for actually demented schizophrenic relatives; in my opinion, money should not be wasted in this way, even by wealthy people. Though psychoanalysis may

have a place in the treatment of latent and mild schizophrenic reactions, the prospects for any marked benefit from it in outspoken and prolonged schizophrenic states are illusory. Physicians must, in such cases, be content with being as helpful as possible by means of symptomatic treatment; correction of any bodily disorders; attempts at re-education of the schizophrenic thinking disorder; occupation at simple tasks planned according to original interests and well within the powers of the patients; and reorganization, as far as possible, of the patient's habits.

In how far inherited constitutional factors are concerned in the origin of schizophrenic states, we do not yet know. The earlier studies of the relation of heredity to dementia praecox were made by Rüdin (1916); they were followed by the investigations of Kahn (1923), who postulated two factors of inheritance—one dominant (for psychopathy), the other recessive (for deterioration). Mott (1921-22) suggested an endocrine rôle in etiology (gonadal atrophy; changes in the interstitial cells of Leydig); Lewis (1923) put forward the theory of a primary cardiovascular aplasia as a cause. More recently, the theory has been advanced that disturbances of intermediary metabolism may be responsible—an abnormal course of the disintegration of nitrogenous compounds in the organism, with production of substances that are toxic for the brain. If the latter view should prove to be well founded, we should, in schizophrenia, have to deal with a secondary, rather than with a primary cerebral involvement!

Schizophrenic reactions are very common in all countries. In Germany, Gaupp reports that of 270,000 patients in asylums, 190,000 are cases of schizophrenia. The cost to families and to governments is prodigious. Every effort must be made to further the progress of investigation of causes and prevention, both for humanitarian and for economic reasons.

Paranoia.—Aside from the paranoid symptoms manifested in some schizophrenic reactions, the "acute paranoia" that may develop suddenly in chronic alcoholics (often assuming the form of an "acute jealousy-insanity"), or occasionally in women after childbirth, should be kept in mind, as well as the "chronic paranoia" that develops slowly and becomes "systematized."

In the latter condition, the early symptoms may be hypochondriacal in type, or the patient may become retiring and suspicious and develop "ideas of reference," referring to himself words heard, or the behavior of others, when there is no justification for such reference. Such a patient often thinks that others are making fun of him, scorning him, or defaming him. Ideas of persecution (others treat him badly; he does not get his deserts; conspiracies are being formed against him) develop. Ideas of grandeur (of unusual personalities and powers, of direct revelations from God, of royal descent, etc.) are common.

In addition to these delusions of persecution and of grandeur, many paranoiacs have hallucinations (they may hear "voices" or see "visions"). According to the nature of their delusions, the clinical picture may be

that of erotic mania, of religious mania, of political mania, or of jealousy mania. Such paranoiacs are often dangerous to other people or even to a whole nation.

Outspoken paranoid states demand hospitalization at once. An acute paranoia may disappear under simple custodial care when the circumstances in which it developed are changed (alcohol, puerperium, lactation). Chronic paranoia is a different matter. Once fully developed, with systematization of the delusions, I am very sceptical of any marked benefits derivable from either psychotherapy or any other form of treatment. Permanent custodial care in a psychiatric institution is necessary for the patient and desirable for the safety and comfort of others.

Chronic paranoia is prone to develop in persons of a certain constitution in which there is a rigid organization of the personality. As Diethelm describes it, the set personality "does not allow bending to insurmountable obstacles and handicaps"; there is a sensitiveness about the attitude and behavior of others, concern about the impression made upon others, a tendency to brooding and ruminations along the line of set suspicions and fancies (with inability to make concessions), and constant anticipation of possible future developments. Upon the basis of this constitution, the characteristic symptoms of chronic paranoia often gradually develop.

It is in persons of this paranoid type of constitution (when discovered early) that much can, I believe, be done to prevent, or at least to delay, the systematic

development of chronic paranoia. If the physician, after painstaking physical and mental study of the patient, and after carefully listening to the patient's ideas and complaints without disagreeing with him or antagonizing him, can establish a sympathetic *rapport* between the patient and himself, he may hope to be of help.

The nature of the patient's constitutional tendencies may next be cautiously explained to him and their inherent dangers pointed out. The patient may have high aspirations but be without adequate capacity for realizing success in them. If so, the physician should endeavor to convince the patient that he should be content with the kinds of success that are possible for him; he should be taught to adjust himself to reality. It should be explained to the patient that he needs to understand others—their motives, personalities, and reactions—better than he does; if he can be taught to study these, he may become more tolerant and be led to see that the ideas he has harbored have been misinterpretations. Habits of concreteness in thinking should, as Adolf Meyer has emphasized, be cultivated and a more healthy type of inquiring mind should be developed. Training to willingness to recognize one's own shortcomings and failures, especially with regard to suspicion and to over-assertion can be helpful. Occasionally, through this process of mental hygiene, a constructive solution of the patient's problems may be reached.

Freud looked upon the paranoid reaction as a "defense against homosexuality," a view that has been

widely accepted by other psychoanalysts. Whether or not there is any real basis for this view I do not know, but I can not help but share the natural scepticism entertained by most "common-sense physicians" regarding many of the Freudian theories of sexual causality. The Freudians would say that this attitude must be due to the fact that I have never yet submitted myself to a thorough-going orthodox Freudian psychoanalysis! I can, at any rate, agree with the more moderate psychoanalyst, L. S. Kubie, when he intimates that in differences of opinion among investigators "it is only an unresolved emotional bias which makes either party belittle the efforts of the other or contend that all variables will be found by his own particular approach."

Psychiatrists in general formerly took a fatalistic attitude toward chronic paranoia, regarding it as progressive and incurable. Some of the modern psychiatrists are a little more hopeful, believing that, at least in some cases, a practical adjustment to life can be attained. But, despite the optimistic reports of certain successes that have been achieved, the pessimism of Bleuler regarding the results of treatment of chronic paranoia seems to be justified by clinical experience thus far.

Psychopathic Personalities.—Under this term a variety of pathological conditions have been included. "Constitutional psychopathic inferiority" is a diagnosis frequently made, though hitherto it has been hard to reach any unanimous agreement regarding a definition of this state. A group of psychiatrists, at a

recent meeting of the Medical Council of the United States Veterans' Bureau, defined it as follows: "A congenital or hereditary defect in the personality make-up, which manifests itself, not in the intellectual field, but in the inability of the individual to adapt himself to the varied demands of domestic, social, and economic life. His inadaptability may become aggravated through special and unfavorable experiences. Such an individual may develop a well defined psychosis or neurosis."

In some cases there is a "disturbance in the synthesis of the personality," in others, there is a paranoid trend "characterized by lack of plasticity and rigidity"; in still others, we probably have to deal with a larval cyclothymia or a latent schizophrenia.

In each case, a comprehensive physical, mental, and social study should be made with full consideration of all possible hereditary and environmental factors, with a view to appropriate modification of abnormal bodily states, personality difficulties, and environmental strains and stresses. Any of the psychotherapeutic methods described in Chapter V that promise help may be applied, though we have to depend chiefly upon re-education, guidance, and the solution, whenever possible, of definite personality difficulties. The constitutional psychopath is definitely handicapped by his make-up, but the psychotherapist must do the best he can for him by utilizing the assets he finds available and by minimizing as much as possible the baneful effects of his liabilities.

CHAPTER VIII

Psychotherapy at Different Ages of Life

The problems for the solution of which psychotherapy may be of help differ markedly at different stages of life. The problems of childhood differ from those of adolescence; those of maturity differ from those of the senescent period. The general practitioner treats patients of all ages; the pediatrician confines his attention to childhood disorders; the educator encounters the problems of students in school and college; the obstetrician's work is limited to adult patients; the gerontologist pays especial attention to the disorders of old age.

Childhood.—First the period between birth and puberty may be referred to. During this time of bodily and mental growth and development, the child must be studied for itself, for it has features that are peculiarly its own; "the child is not just a miniature adult."

In childhood there are greater opportunities for preventive medicine, for the preservation of health of body and mind, than in any other period of life. The rate of infant and child mortality has been greatly reduced in our time, and the application of prophylactic methods has contributed much to the safety of the child in its early life, as well as to its future as

an adult. Increasing interest has been shown, too, by parents, physicians, social workers, educators, and workers in the juvenile courts, in the personality disturbances and behavior problems of childhood and their relations to inheritance and to environment. The importance of the mental hygiene of childhood has attained to general recognition, and, in connection with it, the psychobiological pluralistic method of approach to the problems of early behavior, the consideration of the "child as a whole," the study of "the mentally integrated individual" during early development, as advocated by Adolf Meyer and his students, has made many important practical contributions.

Fortunately, parents are becoming ever better orientated as to the needs of their children, and many of them study carefully little books of instruction as to how to keep a child normal in mind and in morals. Intelligent parents who have taken the trouble to inform themselves regarding the best methods of understanding and managing childhood difficulties are today to be classed among our more important psychotherapists. When problems arise that they find themselves incapable of dealing with satisfactorily, many of them are sensible enough to call the family physician, a pediatrician, or, in graver cases, a psychiatrist to their aid.

When medical aid is necessary, a comprehensive diagnostic study should be made, including (1) a record of the complaints made by the child, or reported by its parents or its teachers, (2) a full account of the

personal history of the child from birth to the time of examination, with notes upon its development, illnesses, habits, personality traits observed, school record, environmental situations, etc., (3) the results of physical examinations and of laboratory tests, (4) the results of a mental examination (behavior on examination; intelligence tests; attitudes toward parents and other members of the family, playmates, and teachers; special interests and aversions; recreational opportunities; expressed wishes, fears, frustrations, or obsessions). The physician pays close attention to all the important findings, gives deep consideration to the assets and liabilities of the child's personality, and synthesizes his diagnostic impressions. When the child is more than two years of age, it and its parents should be interviewed separately rather than together.

In deciding upon treatment, the physician will think (1) of the various possibilities of improving the physical and mental condition of the patient by modifying the child itself, (2) of possible modifications of the parents and their attitudes for the child's benefit, and (3) of possible changes in the total situation that can advantageously be made. The methods to be applied, the possible obstacles to the use of these methods, the constructive use of the child's assets, and the best ways of inspiring confidence and securing cooperation in the treatment, will all be given due consideration. The whole plan of treatment may include not only work with the child but also work with the child's family and with the community (school, welfare agencies, etc.).

Parents should remember that the training of children should begin while they are in the cradle and should be steadily continued throughout the period of growth and development. The mother should establish her authority over her children while they are still babies and later on must demand respect and obedience at all times. Children who are allowed to be disobedient, self-indulgent, and disrespectful are sure to be a source of trouble and sorrow to their parents in later years.

If the study reveals outspoken *idiocy* or *imbecility* (due either to congenital or acquired disease of the brain), the psychotherapist should advise permanent custodial care away from home in an institution for the feeble-minded; this is important for the best welfare of the afflicted child, but it is even more important for the other members of the family. When it is evident from the nature of the disease found in the child that other children born from the same parents are likely to be feeble-minded, the mother should avoid having more children, either through contraceptive devices or through surgical sterilization of the parent who has transmitted the faulty genes (see Dickinson and Bryant, 1934).

Many infants, during the first year of life, have the habit of *thumb-sucking*, or *finger-sucking*. In some, the sucking occurs almost all the time; in others it is most often observed just before the child goes to sleep. Of course, the Freudians regard this habit as an expression of infantile sexuality, the child "gaining pleasure from stimulation of the oral erotogenic

zone." If this sucking does not persist too long it need not be taken very seriously.

The much-vaunted methods of breaking the habit by mechanical restraint (metal or cardboard splint), by wearing a protective mitten, or by placing bitter substances (quinine, aloes) on the thumb, rarely do much good, for they tend to keep the child's attention fixed on the habit and sometimes arouse its hostility to its parents. The child should not be punished for indulgence in the habit, nor nagged about it, though the mother's disapproval of it may be expressed. If the mother will interest the child in toys or in play with other children, and will give some kind of reward for abstention from the habit, gradual relinquishment of this kind of "oral satisfaction" may be expected.

A very common habit in children (sometimes met with also in adults) is *nail-biting* (onychophagy). It is indulged in most often in states of tenseness, occurring rarely when the child is pleasantly occupied and fully at ease. Not infrequently the mother of a nail-biting child is a nail-biter herself. It is usually the finger-nails that are bitten, though some children also bite their toe-nails. The treatment should be directed toward removal of the causes of the tension; mechanical restraint and applications of quinine or iodine are best avoided. The methods suggested above for the overcoming of thumb-sucking may also be used with advantage in the treatment of nail-biting.

If *stuttering* or other forms of speech disturbance be found, the treatment should, as a rule, be directed

toward the child as a whole rather than to an immediate attack upon the speech disorder itself. The child should be kept in the best possible condition of physical health. No expressions of pity for him should be made in his presence, and teasing him, ridiculing him, or scolding him should be forbidden. The child's self-confidence should be built up in every way possible. Personality difficulties should be looked for and, when found, an effort should be made to correct them. Special speech training for the stutterer is usually best avoided; only too often it aggravates the stuttering, rather than ameliorating it.

Recently, I studied a patient with a speech disturbance—not stuttering but a difficulty in vocalization. She had seen several laryngologists and had even been subjected to bronchoscopy. No local disease could be made out. The condition, psychobiological in origin, was what J. S. Greene has called *psychophonasthenia;* he regards it as a conversion neurosis calling for skilful psychotherapy.

When the child exhibits *tics* or *habit-spasms,* making sudden non-purposeful movements over and over again, a study of the personality frequently reveals other disorders, such as general restlessness, excessive self-consciousness and sensitiveness, over-concientiousness, or the so-called "spoiled-child reaction."

Tics may develop in either boys or girls; they are uncommon before the sixth year of life. A child exhibiting a tic has the feeling that the movement is irresistible and uncontrollable; he does not feel in any way responsible for it. The psychotherapeutic

treatment should be directed to the personality disorders found, rather than to the tic itself.

When the mother of a child reports that it has *nightmare* (incubus) or that it suffers from *night terror* (pavor nocturnus), such fright reactions during sleep should be considered as evidence of need for personality-study and readjustment. The child wakes up during a nightmare but does not do so when it has a night terror. The child having a nightmare can, on awaking, give a full account of the experience, whereas a child that, by its shouting and screaming in sleep, has shown that it has had night terror has no memory afterward of the reasons for the fright.

In treatment, adenoids, if present, should be removed and hypoglycemic states, if found, should be corrected. Otherwise, treatment should be directed to personality disturbances or to modification of harmful environmental influences. Neither nightmare nor night terror has any relation to epilepsy, but night terror may possibly be related to hysteria.

If a child walks in its sleep *(somnambulism)*, there is rarely any danger, though occasionally there may be an accident from a fall on the stairs. The treatment is the same as that applied for nightmare and night terror.

Most children, by the time they are three years old, have learned to avoid wetting the bed or their clothing by the passage of urine; some have learned to do so much earlier. But not a few children, after their third year, wet the bed one or more times during the night *(nocturnal enuresis)*; a few wet their clothing

during the day-time *(diurnal enuresis)*. Some of these children continue bed-wetting until the age of puberty. Of course, for some Freudians, enuresis is evidence of "a wish-fulfilling regression to the early stages of infancy"; for other Freudians, it is regarded as "a substitute for masturbation"!

A careful general study should be made of every enuretic child and any physical abnormalities, whether directly related to the enuresis or not, should as far as possible be corrected. Among such physical conditions may be mentioned phimosis, infected tonsils, carious teeth, refraction errors, and intestinal parasitism.

In studying enuretic children, one often finds that over-indulgent parents have been negligent in training their children and have shown indifference, not only about urinary habits but also about habit formation in general. Another contributory factor to bed-wetting in some older children is inaccessibility of toilet facilities to their bedrooms.

In the treatment of enuresis, the physician must consider not merely the troublesome symptom, but the whole child and the parental and environmental influences under which he lives. Many children are very much ashamed of the habit but feel that they are powerless to break it. The understanding doctor will at once see to it that such children are not teased, scolded, or punished for bed-wetting. Instead, the self-confidence of the child should be gradually built up and his attitude of hopelessness overcome. Emotional and situational difficulties are looked into and suit-

able help given in arriving at better states of adjustment.

The use of drugs (for example, belladonna) is to be avoided. For a time, the intake of fluids may be restricted after 4 P.M. If the child wets the bed at a regular hour of the night, it is often helpful to awaken an older child a half-hour earlier by means of an alarm clock or a younger child by the call of a parent, in order that he may establish a habit of rising to void urine at this time. Promises of special favors (gifts, holidays, etc.) for success in avoiding bed-wetting may make the effort to overcome his difficulty attractive to the child. Social workers may be called upon with advantage, in some cases, to help in the re-education of the child's parents and siblings.

A condition for which physicians are often called upon for help is that of recurring *temper tantrums* in a child. Boys (and, somewhat less often, girls) between the ages of two and ten years may exhibit emotional outbursts of anger or resentment far beyond the bounds of any justifiable indignation which they might show at treatment that they considered unfair.

The attacks sometimes follow a simple request to wash the face, to go to bed, or to eat more properly. In such outbursts the children fly into a rage; they may yell, kick, bite, pull their hair, or bang their heads against the wall and not infrequently make attacks upon others. Such children seem determined to have their own way about things and when they are balked by a member of the family or by a playmate

they resort to explosions of temper as a means to gain their ends.

Parents who yield to their children too easily when they rebel at authority are likely soon to find that "temper tantrums" will be used by the children to get what they want. The danger of such a development exists especially when parents are too sympathetic with a child who has been ill, or who has a "nervous disposition," since fear of doing the child physical or mental harm may in such cases deter the parents from proper discipline and control of its behavior. Sometimes outbursts of temper in a child simulate similar outbursts which the child has observed in one of its parents, or in one of its older brothers or sisters, for temper tantrums are notoriously "contagious."

In the management of an actual attack, it is best to ignore it, to be indifferent to it, and to leave the child alone or to place him in a room in which he can do no harm until the anger dies down. Scolding the child, punishing it, or attempting to "appeal to his better nature" is useless while the attack is on. The parents should see to it that the child does not gain the end it strives for by means of the tantrum; failure to secure the gratification of wishes by explosions of temper does much to deter the child from the repetition of the outbursts, whereas yielding to the child will have the effect of encouraging the bad habit.

Between attacks, besides the correction of any physical disorders (such as irritating skin troubles, or undernutrition) found to exist, the physician will

warn the family of the bad influence of emotional outbursts by a parent or sibling in the child's presence, will teach the parents how to maintain a sensible discipline, and will have talks with the child quietly (if he is old enough to profit by such conversations) about his problems, teaching him how they are to be solved without resort to the harmful exhibitions of rage.

Another emotional disturbance common in childhood is seen in *jealousy reactions* (cf. S. Foster, 1927). A child that has its "nose put out of joint" by the arrival of a new baby which monopolizes the attention of the parents, or one who feels that favoritism is shown to one of its brothers or sisters, is likely to become jealous and to show its resentment.

To prevent this, parents should prepare the child when a new baby is expected and give it some responsibility in the care of the infant after its arrival, trying, if possible, to make the child feel that this responsibility is a privilege rather than a disagreeable burden. And when there are several children in the family, the parents should make every effort to show no favoritism to any one child and to allow no member of the family to feel that he is placed at a disadvantage.

In the management of *anti-social trends* (disrespect for authority, lying, stealing, cruelty, truancy from school, wandering away from home), the reader is referred to the advice contained in the writings of L. Kanner and W. Healy (see bibliography at the end of this book).

The psychotherapeutic treatment of the psychoneuroses and of the psychoses that are met with in children is conducted along similar lines to those followed in the treatment of adults (see Chapter VII).

The establishment of psychiatric units in pediatric hospitals is a recent development that is full of promise. But the psychiatrist should be a psychobiologist rather than a Freudian psychoanalyst who insists on solving all problems on the basis of the theory of infantile sexuality. Only lack of common sense could account for a pediatrician who would arrange to have a child psychoanalyzed for two years "because he will not eat his carrots, tells fibs, blinks his eyes, bites his fingernails, or does not get along at school" (L. Kanner).

Adolescence.—During this period that extends from the age of puberty to that of arrival at manhood or womanhood, the psychotherapist finds many special opportunities for usefulness.

The Boy Scout movement and the Girl Scout movement deserve high praise for the wholesome effects they are producing upon our young people. During the past few years, the Civilian Conservation Corps has also undoubtedly done much among older boys to counteract tendencies to juvenile delinquency; the work done in the C.C.C. camps and the wholesome atmosphere that prevails in them has had a most salutary influence upon young men.

Adolescence, ordinarily considered as extending from fourteen to twenty-five in males and from twelve to twenty-one in females, represents the time during

which the child becomes gradually emancipated from home and parents and prepares itself through further education for the interests and the work of maturity.

The emancipation from the home is more easily achieved by some young people than by others. Thus, some adolescents suffer from a *fixation of love impulses upon a parent* (usually upon the parent of the opposite sex), remaining in an abnormal degree of dependence upon this parent, being abnormally content with continuance of life in the parent's home, and exhibiting a relative want of interest in persons and things outside it, as well as suffering from preternatural feelings of sorrow and loneliness when compelled for any reason to be away from home or parent. Such a parent-fixation may make the adolescent feel unable to direct love freely and fully toward any other person of the same sex as the over-loved parent, so that the "falling in love" normal in adolescence or in early maturity may fail to occur. Should such a person later on marry from motives other than those of genuine affection, sexual frigidity is likely to be reported.

Psychoanalysts regard this situation as evidence of the repression of primitive incestuous trends and maintain that active dislike of other persons of the same sex as the loved parent may develop with displacement of sexual desire so as to center it upon some one of the same sex as that of the patient ("homosexuality as a result of incestuous fixation").

Fixation (in the "unconscious") at the stage of parent-love is believed by psychoanalysts to be such

that the parent thus over-loved is the one known in early childhood when to the father, for example, was attributed infinite strength, wisdom, knowledge, and authority, or when to the mother was attributed exquisite beauty, tenderness, mercy, and protective powers.

The maintenance of such over-idealization of one parent is said to be more likely to continue when that parent dies young, before the child's powers of observation, criticism, and comparison have developed, making it easily understandable why the relatively imperfect human beings that become available as love-objects for the adolescent stand but little chance of selection because of the exaggerated estimate of the beloved parent cherished in memory and imagination. Hence the fruitless search for the "ideal" man or woman, who can never be found because of the distorted images in the mind of the seeker.

Attempts to find a "suitable" partner seem doomed to disappointment; one after another may be tried, but each falls short of hopes and expectations (so-called "Don Juanism"). The fickleness shown to successive love-objects is said, in such cases, to be due to the extreme steadfastness of the original love for the parent. One wonders if the repeated visits of certain persons to Reno may not be accounted for by the considerations just mentioned!

The family physician should, perhaps, assume, as a part of his functions, the duty of instructing parents with regard to the importance of gradually weaning their children from the parent-child relationships

both of love and of dependence. The adolescent, while retaining normal love and esteem for parents, should not be encouraged in the exaggeration of these qualities but should remain free from parent-fixation and be able to fall in love at the right time with some admired member of the opposite sex. The parents can be, of course, very helpful to their offspring in the inculcation of ideals of what a marital partner should be, may give early warnings when obviously unsuitable persons become the objects of adolescent affection, and may instruct as to the inadvisability of long engagements. Too early marriages are to be discouraged, for statistics indicate that most marriages contracted before the age of twenty turn out to be failures; as that wise columnist counselor, Dorothy Dix, has said, "Callow boys and girls simply court disaster who undertake to cut their wisdom teeth on a wedding ring." The optimal age for marriage is about twenty-four for women and twenty-eight for men. After thirty, marriage again becomes a more hazardous venture and the divorce rate becomes higher.

Again, during adolescence, dependence upon the family should undergo gradual diminution so that when adulthood is reached the world may be faced in an independent manner. The family should see to it that during adolescence their sons and their daughters receive as good an education (suited to their capacities) as can be afforded and of a kind likely to make them economically independent. Experience in the use of money can be gained by young people if

their parents will give them small monthly allowances of cash and permit them to make purchases for their own needs, the monthly sums being gradually increased as they grow older.

Adequate provision for social contacts among equals should be made, in order that desirable acquaintances and friendships may be formed that will be helpful in later life. But social intercourse should not be limited to family friends; some choice of their associates should be permitted to the adolescents themselves.

Parental authority should be gradually relaxed as maturity is approached. Some parents find it difficult to "loosen the reins," especially when they are of strong personality and have a love of power. But the aim of parents should be steadily to develop the powers of self-regulation and of self-direction in their children. Parental authority too greatly insisted upon and unduly prolonged may easily inhibit the development of desirable initiative in a son or daughter. Especially is this true of children who lack self-confidence and tend to lean too much upon others for the making of decisions; for such children, harshness on the part of a parent can only be harmful, for what they need is encouragement, reassurance, and opportunities for developing the power of self-determination.

Some young people, it is true, may be too self-confident, too much inclined to have their own way, even when it is obviously injurious to them; for these, parental authority may have to be more rigidly im-

posed and continued until their shortcomings are sufficiently realized by the young people and they learn not to be too highly pleased with themselves. In all cases, there should be a steady and consistent attitude on the part of the parents, for oscillation between over-indulgence and over-strictness has a detrimental effect.

It is important, too, as J. C. Flügel, in his volume on the study of the family (1931), has strongly emphasized, that parent-substitutes (guardians, nurses, teachers, institutions, etc.) should similarly recognize the importance of gradual emancipation of the young people under their charge; too often such parent-substitutes do not understand or apply the principles above enunciated and fail to grant sufficient autonomy and to cultivate responsibility and self-control, so that personal development is hampered or delayed.

An interesting discussion of some of the agonizing incompatibilities that may exist between the points of view of parents and those of their children will be found in George Bernard Shaw's essay entitled, "Parents and Children." It contains much material that can be helpful to the psychotherapist who is called upon to give advice with regard to family life. A good account of many difficulties of adolescents will be found in the volume by Schwab and Veeder (1929).

The education to be given to an adolescent should be decided by his abilities. Many parents insist upon their children going to college when they are not "college material." A young woman was recently brought to me because of nervous symptoms and because of

difficulties in college work. The diagnostic study showed that she was mentally somewhat retarded, apparently because of an obscure infection (encephalitis?) from which she had suffered some years earlier. This was explained to the parents, and the girl, on learning that she did not have to return to college but might take up a business course, quickly made a satisfactory adjustment.

The treatment of psychoneurotic and psychotic manifestations has been dealt with in Chapter VII and is applicable to such disorders when they occur during adolescence. The physician should keep strongly in mind the fact that the first signs of schizophrenia make their appearance during the adolescent years.

Adulthood.—The psychotherapy to be applied to adults suffering from either organic or functional disease has been sufficiently discussed in earlier chapters of this volume. Certain situations in which adults find themselves are, however, deserving of special mention.

Marriage, in order to be successful, demands adaptations on the part of both husband and wife. Marital maladjustments and marital conflicts make great demands upon the knowledge and skill of psychotherapists who try to compose them.

The dangers that attend upon very early marriages have already been referred to. Thrown together through gusts of sex attraction, youths under twenty enter upon marriage at a time when they are too young to know really what they are doing. The too

youthful husband is unwilling to spend his evenings at home and tends to seek his fun outside, whereas the girlish wife, in turn, does not want to be "tagged down" by babies. As a result, the partners begin to quarrel and to make reciprocal accusations. Each becomes "disillusioned" of the other, and sooner or later a third party comes into the picture, with the result that the marriage terminates in the divorce court.

There is far less danger when marriages at optimal ages (around twenty-eight for men and around twenty-four for women) are arranged, for, habits and tastes having been formed, congeniality of the marital partners will be more probable. Because of maturity, also, their attractiveness for one another is more likely to persist. Home then will be of greater interest than a night-club, for it has become a refuge rather than a prison, and children are regarded as "gifts from heaven" rather than as unwanted burdens. Moreover, by the age of twenty-eight the man has usually become financially able to support a family, no longer fearing that rent can not be paid or that necessities can not be supplied.

Marriage late in life may turn out happily, but special difficulties may arise because powers of adaptation lessen as the years advance; the marital partners are less plastic than they were in earlier life, and irritations are prone to ensue upon interference with tastes and habits that have become fixed. On the other hand, the marriage of an elderly widower to an elderly widow will often promote the happiness of

both, and all the more if their former marriages have been satisfactory experiences.

In all marriages there must be a great deal of "give and take." Terman and his associates (1938) have given us a good account of the many possible sources of marital unhappiness. The first year of marriage is proverbially the hardest, for it is then that the bride and groom are likely to find out that mutual adjustment is more difficult than they had supposed it would be. Previously unsuspected traits of character and disposition are discovered to which adaptations may not be easy. To avoid hurting one another's feelings, to make sacrifices gracefully, to be unselfish, and to be just, are not the easiest of tasks for marital partners. Moreover, the emotional heights of the days of courtship can not be lived upon after marriage has been consummated, for such romance is incompatible with the wear and tear of everyday living. Instead, true friendship and loyal comradeship must take the place of the picturesqueness of romance, and, when firmly established, these are more satisfying than the illusions that they displace. Little faults are more than compensated for by the discovery of greater virtues. The beauty of youth may pass but affectionate ministrations should increase with the years. Weaknesses are forgiven when they are manifested by a person for whom one really cares.

A man should not forget to praise his wife occasionally rather than taking everything for granted if he expects his home to be a happy place. He should keep a diary that will give him timely notice of the

date of his wife's birthday and of their wedding anniversary and should please her by celebrating them in one way or another. He should refrain from anything like philandering or spending too much of his time with, or money on, other women.

A wife, in turn, should remember that, for her, marriage must be a full-time job and that it is her duty to do all in her power to make her husband and her children comfortable and happy. If, however, she has had a gainful occupation before marriage and her husband's earnings are small, she is justified in continuing to earn some money by working outside the home early in her married life, in order to increase the family income. No wife should ever "nag" her husband about trivial faults. She will insist upon her husband spending an evening at his club or elsewhere occasionally and will encourage his participation in a hunting or a fishing party now and then. A married woman should join a club and take part in its activities; a game of bridge with other women once a week will afford further recreation.

Experience has shown that it is good for both man and wife to have occasional short vacations from one another. After a temporary change of scene and companionship, well-mated partners in marriage are glad to return to their own homes. The problems of the married woman have been well discussed in a recent volume by Groves (1939).

The psychotherapist should be equipped to give advice regarding all the problems of marriage and of having children. Children, if healthy, may be a source

of great joy to their parents, but if the heredity indicates that there is great danger of the children being feeble-minded or psychotic, advice regarding birth control may be asked for. If the hereditary taint is pronounced, it would have been better not to have married. But after such a marriage has taken place, contraceptive devices or sterilization of the man or woman of bad heredity will have to be considered. Here great caution should be observed by the physician, the genealogical trees being first studied assiduously with a view to determination of the necessity of birth control. (See the volume on control of conception by Dickinson and Bryant, 1934; also E. Novak's *The Woman Asks the Doctor.*) Furthermore, birth control is contrary to the tenets of some religious organizations and the physician will not want to coerce his patient to act contrary to the dictates of conscience. A woman is most apt to conceive about midway between two menstrual periods (fourteen or fifteen days after the first day of the preceding period). Abstinence from intercourse during the middle week of the intermenstrual period greatly reduces the probability of impregnation, and this method of contraception is not frowned upon by any church.

When people dare not have children of their own because of transmissible hereditary disease, or when they can not have them because of sterility of either the man or the wife, the physician may sometimes find it advantageous to advise the adoption of two or more children, especially when the heart's desire of the childless is to have children. But a child should

never be adopted "sight unseen," no matter how generous the minds of the adopters. The physician may know of babies available for adoption, or he may find them through some orphanage or some Child Welfare Association.

Before adoption, the heredity should be inquired into and a physical examination and laboratory tests should be made to rule out disease processes; only after these precautions have been observed may the physician conscientiously advise adoption. When parents have a single child and for any reason can not have another, it is often well for them to adopt a second child, for an "only child" is liable to be spoiled because of "emotional overloading of the filio-parental tie." Moreover, the emancipation of an only child from the family influences, the importance of which has been pointed out in the discussion of adolescence, may be more difficult than when there are two or more children in the family.

A "spinster," a woman who has remained single after the ordinary age of marriage, may present problems that complicate the life of a family. The failure to marry is sometimes due to the death of the girl's mother; an extravagant feeling of duty to the father who needs some one to take care of the home may have kept a girl single, a fate for which a selfish father is sometimes responsible.

In other instances, a girl becomes an "old maid" because she has thrown overboard chances of marrying fine men since she remained too long enamored of men (especially married men) who could not marry

her. Some girls make the mistake of becoming engaged to young men who are financially unable to marry and have no near prospects of becoming so; they may be youths who are entering college or who accept business positions in some distant town or city where, through time, new associations, and the formation of new habits, their interests change and the girls who patiently and expectantly await their return cease to be attractive to them. Again, some girls, without being "engaged," permit young men to monopolize their time and attention, "keeping steady company" with them, and preventing the development of love affairs with other men until youth is gone, the marriage offers have failed to come, and the girls are left lamenting. If such girls had realized that failure of marriage offers to come after three months of "steady company" meant that they probably would never come and had given notice of their decisions to seek interest and affection elsewhere, they might have escaped spinsterhood.

A girl must use her brains and plan well if she wishes to make a good marriage at the optimal age. Most men think that they select their marital companions, but, as a matter of fact, men are more often selected (and without their knowledge!) by women who have seen that they would make suitable husbands.

What is the elderly spinster to do? Should she live with, or apart from, her family? Now that more economic opportunities are open than formerly to women, many spinsters achieve financial success in

business or in teaching, and are able to maintain a separate ménage. Sometimes, through inheritance of money, or through gifts from relatives or friends, a spinster can do the same thing. A dwelling separate from the family is desirable whenever possible, since it permits of far greater independence in the conduct of life in accordance with personal aims and interests. Moreover, there is an old rhyme about "two women in one house, two cats and one mouse" that doubtless, like most proverbs, had its origin in generations of shrewd human observers! For further light upon some of the problems that the unmarried woman may have to face, the reader is referred to the volume by R. L. Dickinson (1934) and that by E. Hutton (1935).

The problems of the "old bachelor" differ somewhat from those of the elderly spinster. Most bachelors have remained unmarried from choice. Owing to difficulty in attaining financial independence early, some of them were unwilling to permit themselves to think of marriage until middle life had been reached, and by that time the urge for marital comradeship has often died down. Others who have remained single have lacked, even in early life, the strong instinctive drives that lead most men, sooner or later, to the marriage altar. Still others abnegate marriage from pure selfishness; though financially able to marry, or even rich, they prefer to live in a club, or well-attended in an elaborate home, sometimes gratifying their sex needs through mistresses or even in brothels. A few have remained single because they had contracted syphilis in youth and feared that they might transmit

the disease. More have been advised by their physician not to marry because of bad heredity, or because of advanced tuberculous or other serious organic disease.

Now and then a man fails to marry because he has not the courage to ask a woman to share life with him. Again, through some psychasthenic quirk of over-conscientiousness, a man may break off an engagement after his offer of marriage has been accepted. (I succeeded some years ago in inducing one such man, after many years of indecision and after breaking off several times his engagement to the woman of his choice, finally to marry her, and they lived most happily together afterward.) Finally, homosexuality may account for permanent bachelordom of some men, for the homosexual male has, as a rule, a fear of women that he can not conquer.

The sex life of adults often presents important problems that the psychotherapist may be called upon to solve. The appeal for help is usually first made to the family doctor, to a gynecologist, or to a genito-urinary specialist. If these physicians have had some training in psychiatry and are well-versed in the factors that play a part in normal sex life and its development, they may be able to give the psychotherapy that is necessary and satisfactorily to overcome minor ailments; but, if they have not had this training, and especially if major sexual difficulties are encountered, the aid of a psychiatrist who is expert in this special field may well be invoked. A wealth of information concerning the psychology of sex is to be

found in the three thousand pages of Havelock Ellis' four-volume treatise (1936).

Desire for the gratification of the sexual instincts is a normal phenomenon in both men and women, though there is a tendency on the part of many physicians and laymen to place too much stress upon it, with neglect of other important features of the whole personality. In a general personality study, inquiry into the sexual functions is always made. The history of their development in the individual is recorded and any personal peculiarities noted. In women, sex desire may be accentuated just before, or just after, the menstrual periods and usually is markedly diminished after the menopause; in men it is more marked at certain seasons of the year (spring months) and after eating certain foods (raw oysters). After taking alcohol, sexual desire may be increased in both men and women, but potency in the man is diminished. Imagination, dwelling upon lascivious ideas, reading certain books, and exposure to special situations may be factors in the excitation of sexual passion.

Capacity for adequate sex control can be formed in normal persons by early education in sex ethics, by the cultivation of desirable thoughts and associations, and by the sedulous avoidance by the individual of the factors that excite passion when it should be suppressed. Much help in gaining sex control can be derived from developing physical and mental powers other than those of sex. Daily exercise in some form of outdoor sport is desirable, and a well-planned regular life in which hard work at one's vocation is prop-

erly balanced by recreation can also be contributory.

Lack of power of the adult male to complete the sexual act, known as "impotence" (impotentia coeundi) may be due to organic disease (as in tabes dorsalis), to certain intoxications (alcohol, tobacco, drugs) or to purely mental causes (psychic impotency). In the latter case, careful studies of the personality and of maladjustments that need correction should be made. Sometimes a study of the sexual conditions in the wife of a physically impotent man may throw light upon the disturbance and furnish the clues for successful treatment.

Frigidity in the female is the correlate of psychic impotence in the male but, since it may interfere but little with sexual intercourse, it is often supposed to indicate a lack of normal endowment with sex instincts. Sometimes it develops in a woman who has previously experienced normal sex-enjoyment but, through the abnormal demands of an over-sexed husband, has developed a disgust for sexual intercourse. Treatment by psychotherapeutic guidance may be helpful; in some cases hypnosis with suggestion has been beneficial. An excellent discussion of the sex-life of women will be found in the volume by K. B. Davis (1929).

Practically all adolescents and adults have some bisexual tendencies—they are to some degree both heterosexual and homosexual. In outspoken *homosexuality*, a thorough study of the whole personality should be made. In treatment, avoidance of homosexual companions as well as sexual continence should

be advised. Total abstinence from sex relations with a person of the same sex may here be as important as total abstinence from drinking, in an alcoholic addict. In some patients, a more normal heterosexual interest may be gradually developed.

The actively homosexual person is liable to get into legal entanglements or may be subject to blackmail. In such cases the psychotherapist should advise the immediate employment of an able lawyer.

Homosexual groups are not uncommon in our larger cities. Many of the members of these groups are alcoholic addicts as well as homosexuals.

There has been much discussion as to the origin of homosexuality in a given person, some maintaining that it is the result of environmental influences, especially upon seduction by another homosexual, others believing that it is based in the constitution of the person concerned. It is now thought that there are several kinds of homosexuality (both constitutional and accidental, as well as transition forms).

Transitory homosexual attitudes have been observed in schools and other institutions, in the navy, and in barracks; they were especially common during the Great War. Alcohol or cocaine may, it is said, occasionally evoke homosexuality, especially in those constitutionally predisposed to it. Homosexuality seems to be less common in persons of pyknic habitus and syntone temperament than in persons of asthenic autistic constitutional type.

The attempt has been made to differentiate between (1) the "true homosexual" who, besides overt

sexual behavior with persons of the same sex, has sex feelings aroused by such persons, and (2) the "accidental homosexual" who becomes such because of special situations ("homosexuality of necessity and opportunity"). The "true homosexual" is convinced that he is not a "sexual pervert" and is sure that in being a homosexual he is living in accord with his own individual nature. Some poets and artists have been homosexuals. (For a full discussion of homosexuality, the reader is referred to E. Kahn's *Psychopathic Personalities,* 1931.)

Later Life and Old Age.—In later life the parents of children often become grandparents and, as their own powers gradually subside, they find an ever greater interest in the activities of their children and their grandchildren. No longer being responsible for these, a great deal of pleasure may thus be gained by elderly persons. Such pleasure serves to compensate to a certain extent for the decline of their other interests and of their capacities.

It is fortunate when older persons remain healthy and financially independent. Sometimes, however, through economic reverses, they become impoverished or, through illness, they become infirm. In primitive human communities, needy and sick old people were in a very bad "fix," for the young did not feel responsible for the welfare of the old any more than animals did. As civilization developed, however, children came to feel that they owed a duty to aged parents who had become lonely, poverty-stricken, or infirm. Though the performance of this duty may

have no direct value in the biological struggle for the existence of the race, it is of great value from the standpoint of human morality and is an excellent example of the difference between man and brute. However, the care of the aged may place some families in a desperate economic plight, as illustrated by the fact that in Chicago at Christmas time, in 1939, a woman of sixty-six killed her blind mother of ninety by strangulation and then attempted to kill herself, in order to lessen the financial burden upon the younger members of the family. The double burden of paying for the maintenance of both old and young may certainly be beyond the powers of many families, in which case the State may be forced to provide aid.

In physiological old age there is a slow decline of the functions of the body as a whole. Every one, as Cato urged, should prepare himself for old age and learn how to mitigate its natural infirmities. Though many of the activities and pleasures of earlier life cease to be available to the old, many things can still be enjoyed, including the giving of wise counsel to the young, companionship with persons of different ages, and enjoying the charms of country life.

The family practitioner should see to it that the demands made upon the bodies and minds of his elderly patients after they have passed through their golden age (fifty to sixty) are gradually diminished. Hours of work should be lessened after the age of sixty or sixty-five, whereas time devoted to rest and recreation should be correspondingly increased. Worries should be avoided, exercise should be more gen-

tle, and moderation in the use of food and drink should be observed. Business men should early learn gradually to delegate certain responsibilities to others, saving their own powers for the more important duties and decisions. Professional men, as they grow older, should develop associates who will become able later on to carry an increasing proportion of their burdens.

To reach normal old age a person must be more or less fortunate in both his heredity and his environment. Longevity is exquisitely hereditary, but environmental influences, such as accidents and organic diseases, may be responsible for the shortening of life in those of good heredity. If, however, one has had long-lived parents and grandparents, has not suffered too severely from infections, intoxications, or physical traumata in early life, has taken care to adjust his diet to his nutritional needs, and has been wise enough to go to his physician and dentist once or twice a year for a "check-up" (periodic health examination), he will be likely to live long and to enjoy a relatively healthy old age. Men and women whose careers have been active in adolescence and during adulthood tend to live longer than those who have led lives of idleness.

Physicians are often called upon to give advice about the time for retirement, or about sudden and marked reduction of activities. It is not safe to lay down any hard-and-fast rules regarding these points, since these matters are individual and personal; but, in general, physicians believe that every one should

continue his activities as long as he can do so without undue fatigue and without injury to his constitution. If the active older man will learn "to take in sail" to some extent when he begins to notice over-fatigue, if he will properly time the delegation of some of his duties and responsibilities (as above referred to), and if he will avoid any tendency to narrow the horizon of his interests to his immediate environment, he will be doing what is best for the prolongation of his life into a healthy and useful old age. Mental hygiene at senescence has recently been discussed by G. Lawton (1939).

When the time comes for older people to relinquish their business or professional activities, the psychotherapist may advise them to turn to various altruistic, social, or literary interests as substitutes. The writing of his own biography often appeals to an elderly man, even if it is not to be published. Travel is a resource for the elderly, since it has been made relatively safe and comfortable, not only by land and sea but also in the air. A trip around the world may be found enjoyable by some persons over seventy.

Normal old people desire to live on and on, as long as they can be of any real service to the world. The wise old man will, however, know that death can not be very far away and will accept this fact philosophically, without fear and without refusing to think of it.

Physicians who have reached a ripe old age will be inclined to welcome sudden surcease, since they know how much better this would be for themselves and

for their families than to linger on a long time in a state of physical and intellectual decay. But if the Great Silencer should not appear thus suddenly, and should they be doomed to helpless infirmity, they should try to accept their fate with equanimity and should never yield to the temptation to end life by suicide, for they should set an example of fortitude to their juniors. As Carlyle has said, "The duty of being brave is an everlasting duty, even though it may lead to the last great mystery."

Pathological old age is, of course, to be dreaded. Physicians who have studied senile dementia, or who have watched old people live on during years of incapacitation after a severe hemorrhage into the brain, or who have observed persons doomed to complete and permanent disability after an attack of "sleeping sickness," can not help but feel great sympathy for such unfortunates. The picture of King Lear (a senile dement) as described by Shakespeare, is a strikingly sad example of pathological old age. Though Lear knew that he had become a "foolish, fond old man, fourscore and upward," he did not know where he was, where he had slept the night before, or whence his clothes had come any more than did a babe. Such a senile dement must be considered to be lucky if he be suddenly attacked with lobar pneumonia and is not cured by the administration of sulfapyridine! It is far better for him thus to enter upon permanent sleep and forgetfulness than to continue to be a grievous burden to himself and to others.

The psychotherapeutic problems connected with

old age are on the increase in the United States because of the ever greater life-expectancy of our people. Between 1910 and 1930, average life-expectancy was increased by about thirteen and one-half years (for both men and women) and by 1935 the life-expectancy had risen to over sixty-one years! Moreover, the ratio of young to old has been undergoing rapid change, a fact that is accounted for by (1) restriction of immigration, (2) rapid decline in the birth-rate, and (3) advances in curative and preventive medicine leading to increase of life-expectancy.

Ten years ago there were in this country about 12 million children below 5 years of age, and about 6½ million persons over 65 years of age. It has been estimated that by 1975 there will be 6½ million or less of children under 5, 30 million over 60, and perhaps 22 million over 65!

The idea that people after sixty or sixty-five must cease to be useful and should be "laid on the shelf" is still far too prevalent. Though some of them may show infirmities that are incapacitating and irremediable, this is not true of the majority. Compulsory retirement from governmental or civil services at any given chronological age is, I believe, a mistake, and our social, professional, and industrial organization as well as government officials should become better instructed concerning this error.

If for any reason, retirement of a person from his position should be deemed necessary, care should be taken to see to it that, unless he is fully incapacitated, his knowledge and the skill that he still pos-

sesses may find opportunity for use in the service of society. Nothing can be more depressing to an older man or woman than to be made to feel that usefulness has ceased and that independence is gone; nothing will make a man or woman grow old more quickly and more dangerously than that. Interest in personal appearance and even in cleanliness may quickly diminish when pride is gone and morale has become impaired. Life will seem to be useless to those who are told that they can no longer be useful.

Wonderful contributions to art, literature, and science have been made by many persons over seventy; as illustrations, I need mention the names of only a few men who were exceedingly serviceable to the world at advanced ages—Sophocles at 90, Titian at 99, Benjamin Franklin at 80, Oliver Wendell Holmes at 80, Thomas A. Edison at 80, Elihu Root at 90, William H. Welch at 80, and Charles Evans Hughes at over 75. It is a pity for the world to lose the useful services of any one—either young or old.

Attempts are, of course, being made to prevent hardship in old age by our Social Security laws which arrange to supply money to those who are not gainfully employed. But the old have needs that are fully as important as the need of money, if not more so. They need to feel that they are still of social value, that the capacities and skills they still possess may be usefully employed, and that their happiness and independence are not things of the past.

How to work out the problem of meeting these needs of the old must, at the present time, be re-

garded as a matter of prime importance in the United States. We have seen already signs of great unrest among our older people. Recent attempts to secure ill-advised legislation in California and in Ohio are evidences of this unrest and dissatisfaction and though, fortunately, the attempts were unsuccessful (they would have bankrupted those States), we shall have further disquiet until the problems I have referred to are solved in better ways.

The matter is urgent, for, if by 1975 we find that we have twenty-two million people over sixty-five years of age, the pressure that can be brought by such a large proportion of the electorate upon Congress and upon state legislatures will be enormous. It is to be hoped that our people will have foresight enough to attack the old-age problem scientifically and to devise and institute rational measures for meeting it before it is too late. Obviously, the problems of the psychotherapist with regard to old age are likely to increase rather than soon to diminish.

The activities of the Child Welfare League of America have greatly improved the condition of the children of this country. I have suggested in Cowdry's book on the *Problems of Ageing* the possible advisability of forming an American League for the Promotion of the Health and Welfare of Elderly People as a national organization with local branches in the different states. I have already had favorable responses from several quarters and I have the hope that this suggestion may, sooner or later, be acted upon.

CHAPTER IX

The Future of Psychotherapy

In this small volume, the attempt has been made to show how valuable psychotherapy can be at the present time and in the existing state of knowledge. The methods that are in use have been discussed, as well as their application to the management of patients suffering from either "organic" or "functional" disorders. In Chapter VIII, the usefulness of psychotherapy in connection with certain special situations in childhood, adolescence, maturity, and senescence has been emphasized.

But what lies in store for psychotherapy in the future? Prophecy is always difficult, but it seems to me probable that, as time goes on and our knowledge increases, psychotherapy will be found to be of ever increasing importance.

Medical science is growing steadily, and the too long neglected branches of medical psychology and psychiatry have recently made great progress and are full of promise of further rapid growth. The outlook for an expansion and a deepening of studies of the human personality would seem to be particularly bright, since psychobiologists have emphasized the inseparable unity of structure and function, of the physical and the psychical, and have taught us to con-

sider always the individual personality as a whole as well as its part-components.

Every personality, as we have seen, has certain assets and certain liabilities; these depend partly upon inborn tendencies, partly upon experiential influences. The inheritance of the personality under study can not be changed, but environmental influences may further modify it in desirable directions. Psychotherapy is one of the environmental influences to be used to advantage whenever possible.

Studies of the heredity of a given patient will throw much light upon the nature of his inborn tendencies, and an increase of our knowledge of genetics will doubtless enlarge our powers of recognizing these tendencies. Studies of the environment from earliest infancy on, and a history of all that the patient has passed through will give us clues to the various formative influences that have been of importance, and those clues will become ever more reliable as our knowledge concerning familial, social, educational, occupational, economic, and recreational influences gradually grows. Our inquiries into intellectual resources, temperament, emotional states, personal ideals and ambitions, attitudes, resistances, group adjustments, habits, and handicaps will become more acute as we learn gradually more about such things, and the replies we receive to our questions will be ever better interpreted as our general psychiatric insight becomes keener.

Undoubtedly, too, psychological methods of analysis will become continually more fruitful when we

have gone further in the process of weeding out the false hypotheses, the gratuitous assumptions, the capricious interpretations, and the more absurd conceptions of symbols that have hitherto led many into false paths.

In the future, therefore, better than ever before, the psychotherapist should be able to pass judgment upon his patient's capacities, upon the nature of his deficiencies, and upon the possibilities of modifying the latter to advantage. He will thus learn of how much help he can hope to be to his patient and will gain all that he can for him; but he will be satisfied with this, rather than attempting to achieve results that his studies show can not reasonably be expected.

We shall learn, too, how better to avoid the *dangers* that attend upon some forms of psychotherapy. Thus, though hypnotism, when carefully used, is a valuable psychotherapeutic method in the treatment of certain selected cases, it may be very injurious when applied to the wrong kind of cases by unskilled hypnotizers, for it has resulted occasionally in the suicide of the patient or in the outbreak of a manifest psychosis in a latently psychotic person. Deeper psychoanalytic procedures are doubtless helpful and advisable in the treatment of some neurotics, though they may be harmful to others.

The use of psychotherapy, like that of other healing methods by the unskilled is a very real danger, particularly when persons without medical and psychiatric training try to earn money by it. Some lay practitioners of psychotherapy are unhealed psycho-

paths who have read books and have developed an irresistible drive to heal others by psychological methods, projecting their own suffering into a third person (G. R. Heyer). Lay persons often underestimate the complexity of the "psyche," thinking that the "mind" is something simple, easy to understand, and easily influenced by persons of good-will and kindness of heart. They are wrong, and, if they try to use psychotherapy at all, they should do so only under, or in association with, a physician who has determined which disturbances in the patients are organic and which are functional.

Psychotherapy may exert powerful influences, even in serious organic diseases. Thus, vomiting due to brain tumor has been temporarily relieved by hypnosis; patients with abdominal pains have been markedly relieved by psychotherapy, even when duodenal ulcers or gallstones were present. I have read also a report of a woman who feared cancer, was operated upon by a surgeon who found an irremovable cancer of the stomach and told her he had found a tumor and had removed it! Whereupon she improved rapidly, began to eat well, and gained forty pounds in weight though she died two years later from hemorrhage due to the tumor.

Thus mental influences can be more powerful than many are inclined to think. I do not, however, believe in lying to patients in order to try to help them; in the long run we do more good by telling them, or at any rate, their families, the truth and helping them to face facts as they are. When an inoperable

malignant tumor is discovered, however, it is sometimes wise to withold the fact from the patient as long as possible, though it is usually desirable to inform some member of the family regarding the situation, particularly if a will has not been made or if financial affairs require attention.

Though further applications of psychotherapy are sure to be devised, it seems to me to be quite possible that in the future we may be able to replace some of the psychotherapy now in use by chemical or physical methods of therapy. Any one who has read the reports of Beringer and his co-workers (1932) upon the effects of mescaline and of hashish can not have failed to be impressed by them. These psychiatric investigators intoxicated themselves with these substances and made precise reports of their observations upon themselves during the intoxications, as well as of the observations of those who watched them.

The experiences of these auto-experimenters were very remarkable indeed. They have described the abnormal sense-impressions (especially visual), the alterations in consciousness, and the pathological emotional states that were produced. Surprising psychopathic syndromes developed, which, in many ways, resembled those of early schizophrenic reactions.

Among the symptoms were illusions and hallucinations, modifications of thought, anomalies of mood (passing from exalted and uncontrollable gaiety to deep and unmotivated anguish), ideas of interpretation and of influence, various psychomotor disturbances (even catalepsy), and abnormal bizarre impres-

sions against which they were defenceless—all strongly suggestive of the accounts schizophrenic patients give of themselves.

Such experimental toxic psychoses may, in time, throw a flood of light upon the origin of abnormal mental symptoms; in how far the symptoms that were experimentally produced were due to direct toxic effect upon nerve cells in the brain, and in how far they were due to disturbances of intermediary metabolism, we can not yet be sure, though it is interesting that in mescaline drunkenness there was a definite increase of calcium and phosphorus in the blood.

Moreover, if abnormal mental symptoms so like those of schizophrenia can be chemically produced, may it not be possible that in the future we may also find ways by which they can be chemically suppressed? In other words, may not a part of psychotherapy in the future be compelled to give way to new forms of chemotherapy? The medical profession would not be surprised at such a development; after the marvelous effects of sulfanilamide and of sulfapyridine that they have recently witnessed, medical men are now prepared for almost anything from treatment by new chemical substances. Meanwhile, it is our duty to apply to our patients all forms of treatment that we think will be helpful, and, in the treatment of the neuroses and psychoses especially, psychotherapy is likely for a long time to continue to occupy a dominant place.

Glossary

Abreaction. Emotional discharge that occurs when a repressed memory is recalled; in a traumatic neurosis if such a memory can be recalled under hypnosis it may be beneficial to the patient.

Abulia. Abnormal weakness of will.

Acroparesthesia. Pains, tingling, or other abnormal sensations in the hands and fingers, especially at the tips.

Actual neuroses. A term used by Freud to include anxiety neurosis, neurasthenia, and hypochondriasis.

Affect. The conscious aspect of emotion or feeling.

Affective disorder. States of pathological increase or decrease of emotional excitability; in apathy and depression there is pathological decrease; in exaltation there is pathological increase, as in mania, in certain intoxications, and in the extreme feeling of well-being of general paretics.

Affective life. The life of feeling and emotion, as contrasted with that of intellect or of will.

Ageusia. Loss of sense of taste.

Agnosia. Inability to appreciate and to interpret the meaning of sensory stimuli, even when the peripheral sense organs are unimpaired, owing to disease of the cortex of the brain. Auditory agnosia is known as "mind deafness"; optic agnosia as "mind blindness." Similarly, there can be a tactile agnosia.

Agoraphobia. Fear of places.

Agraphia. Inability to express thoughts by writing because of disease in a certain portion of the brain.

Alexia. Inability to read, even though the patient can see.

AMAUROSIS. Blindness.

AMBIVALENCE. Bipolarity of instincts, or tendency to satisfy both of two antagonistic functions, like love and hate, or masculinity and femininity.

AMBLYOPIA. Defective visual acuity not due to refraction error.

AMENTIA. Acute confusional insanity usually accompanied by hallucinations. Loss of memory; this may be general, taking the form of exaggeration of normal forgetfulness, or partial, in which there are isolated or elective defects involving only certain groups of the general store of memories.

AMUSIA. State of one who has lost the power to understand music, though he may still be able to sing.

ANAL-EROTICISM. A term used by psychoanalysts to designate conscious or unconscious wishes associated with sensory stimulation of the anus.

ANALGESIA. Loss of pain sense.

ANESTHESIA. Loss of sensibility to stimulation.

ANOREXIA NERVOSA. Want of appetite as a prominent symptom in a functional neurosis.

ANOSMIA. Loss of sense of smell.

ANXIETY. Uneasiness or trouble of mind.

ANXIETY NEUROSIS. A condition of agitation and depression often associated with sensation of tightness and distress in the region of the heart, with fear that something serious is impending.

APATHY. Indifference to what ordinarily moves the feelings or excites interest or action.

APHASIA. Loss of the faculty of speech as the result of brain disease. In motor aphasia the patient can not speak; in sensory aphasia he can not understand what others say.

APRAXIA. Inability to make use of the extremities for certain definite combinations of movements necessary for the performance of certain acts, though there is no paralysis of the muscles.

ARTERIOSCLEROSIS. Hardening and thickening of the arteries.

ASTHENIA. Lack of strength; weakness, debility.

ATAXIA. Inability to coördinate voluntary movements.

AURA. An abnormal sensation occurring as a premonitory symptom of an epileptic attack.

AUTO-EROTICISM. Pleasure derived from self-stimulation of sex organs, as in masturbation.

BISEXUALITY. Presence of the instinctive sexual aims of both sexes in the same individual.

CASTRATION COMPLEX. The idea that the penis will be damaged or destroyed if sex activity is detected by adults; an infantile punishment phantasy.

CATATONIA (OR KATATONIA). A form of dementia præcox or schizophrenia characterized by negativism, grimacing, and episodes of stupor or of excitation.

CENSOR. The theoretical mental power postulated by Freud which excludes unconscious wishes during the daytime and even during sleep, in which it disguises unconscious wishes of the latent content of dreams.

CHOREA. Combinations of involuntary and somewhat disarranged contractions of muscles leading to unpurposeful movements; often seen in young persons who have had rheumatism, or sometimes in later life in a hereditary disease known as "Huntington's chorea."

CIRCULAR INSANITY. A mental disease in which periods of exaltation or mania alternate with periods of depression or melancholia; manic-depressive psychosis.

CLAUSTROPHOBIA. Fear of being shut in; fear of closed places.

CLAVUS. Feeling as though a nail were being driven into the forehead, met with in hysteria.

COITUS. Sexual intercourse.

COITUS INTERRUPTUS. Voluntary withdrawal of the male sex organ during sexual intercourse before the occurrence of orgasm.

COMA. State of unconsciousness without voluntary movements, met with in many severe disease states; for example, uremic poisoning, apoplexy, encephalitis, etc.

COMMAND AUTOMATISM. A disturbance of the will in which a patient will repeat movements, such as the clapping of the hands, made before him, or will repeat words heard.

COMPLEX. The term used by psychoanalysts to denote a group of associated ideas that is emotionally charged.

COMPULSION. Nervous symptom in which the patient feels compelled to repeat purposeless acts, even though their futility is recognized.

CONATION. The power of will; volition.

CONDENSATION. A term used by psychoanalysts to define the representation of several unconscious wishes or objects in one conscious dream-image, thought, act, or symptom.

CONFABULATION. Falsifications of memory in which the patient describes as experiences things that are wholly imaginary.

CONFLICT. Antagonism of impulses.

CONFUSION. Mental state in which the ideas are incoherent and in which the patient may fail to recognize the relation of his own person to the surrounding world, to space, and to time.

CONSCIOUSNESS. Mental awareness; capacity for rational perception or apprehension.

CONSTITUTION. The part of the organism inherited from the parents.

CONVERSION. The transformation of an emotional impulse into an abnormal physiological function simulating organic disease (seen in hysteria).

COPROLALIA. An imperative impulse to speak obscenely.

CYCLOTHYMIA. Circular insanity; alternation of mania with melancholia.

DEATH INSTINCTS. A term used by psychoanalysts to designate a hypothetical group of instincts whose ultimate aim is death, and whose psychological manifestations are impulses to destroy or injure.

DELIRIUM. A disturbance of consciousness in which there may be loss of knowledge of the surroundings, along with symptoms of motor and sensory irritation.

DELIRIUM TREMENS. Form of delirium seen in chronic alcoholics who suddenly are deprived of alcohol and begin to see large numbers of small, black, moving objects.

DELUSIONS. False ideas believed to be true by patients suffering from mental disease.

DEMENTIA. Extensive failure or loss of mental powers earlier possessed; seen in general paresis of the insane, in severe schizophrenia, and in other serious mental diseases.

DEPRESSION. A mental state in which there is slowing of thought and action, tendency to self-blame, and incapacity for pleasurable experience; melancholy or "the blues."

DIPLOPIA. Seeing double, owing to disturbance of nerve-supply of eye muscles.

DIPSOMANIA. A state in which persons usually abstinent are suddenly seized with a pathological and irresistible desire to drink alcohol to excess.

DISORIENTATION. Loss of power to distinguish one's relations to other people, to time, and to place; often accompanied by very disagreeable feelings of perplexity.

DISPLACEMENT. A psychoanalytic term for the substitution of the original and unconscious object of an instinctual impulse by a surrogate in act or conscious fantasy.

EGO. The self; the part of the personality concerned in conscious perception, thought, feeling, and action. According to Freud, the Ego is that organized portion of the personality which enforces repression and the Reality Principle, controlling voluntary thought and the external discharge of emotional tensions.

EGO INSTINCT. The instinct that serves the self-preservative function.

EJACULATIO PRAECOX. Premature discharge of semen during sexual intercourse.

ENURESIS. Involuntary discharge of urine, as in the bed-wetting of children, or during an epileptic convulsion.

EPILEPSY. "Falling sickness"; a condition in which there are sudden peculiar disturbances of consciousness, often accompanied by a convulsion, and sometimes preceded by an aura.

EPILEPTIC CHARACTER. Progressive change in the personality occurring in epileptics, characterized by irritability, ethical defects, violent egoism, lying, forgetfulness, and feeble judgment.

EROS. A psychoanalytic term for the group of instincts whose aims are sexual pleasure and self-preservation; the "life instincts" as opposed to the "death instincts."

EROTOGENIC ZONES. Areas of the skin or mucous membrane that yield sensory pleasure on friction (external genitals, lips, anus, urethra).

ETIOLOGY. An account of the causes of symptoms or diseases.

EXALTATION. An abnormal emotional state in which the positive feeling-tones of joy and excitement are exaggerated; hyperthymia.

EXTROVERT. One who tends to turn his thoughts outward; opposite of introvert.

EUPHORIA. A feeling of well-being, of perfect ease and comfort, often out of proportion to the actual condition; met with in certain disease states like general paresis of the insane.

EXHIBITIONISM. A sexual perversion in which unseemly exposure of the sex organs is used to increase sex feelings.

FIXATION. A term used by psychoanalysts to designate a persistent and excessive unconscious wish for a specific form of pre-genital sexual pleasure or infantile object.

FOLIE DU DOUTE. A high grade of indecision or doubt met with in psychasthenic states.

FREE ASSOCIATION. A method of psychoanalytic technic introduced by Freud, in which all thoughts occurring to the patient are reported to the examiner as they become spontaneously conscious.

FRIGIDITY. Incapacity for pleasure from sexual intercourse by a female.

FRUSTRATION. Condition in which an act that would gratify an instinct is prevented by some cause either in the environment or in the mind of the patient.

FUGUE. A journey undertaken by a patient during a "twilight state," as in epilepsy.

FUNCTIONAL DISORDER. Manifestations of disease in a patient without changes in the tissues demonstrable by present methods.

FUSION. According to psychoanalysts, an impulse the aim of which is to gratify both Eros (or "life instincts") and "death instincts" at the same time; believed to occur in masochism and sadism.

GONADS. The sex glands.

GRANDIOSE IDEAS. Ideas of grandeur or abnormal overvaluation of the self.

GRATIFICATION. Wish-fulfilment; reduction of emotional tension through an act.

GRAVES' DISEASE. Exophthalmic goiter.

HALLUCINATION. A perception that appears in consciousness without excitation of a sense organ; seeing visions; hearing voices; feeling contacts that seem real, though they are purely subjective in origin.

HEBEPHRENIA. A form of dementia praecox or schizophrenia in which there is either a simple progressive dementia or a dementia complicated by states of depression, excitation, or delusion.

HEMERALOPIA. Inability to see in dim light or, perhaps, only after long adaptation; "night-blindness."

HEMIANOPIA. Inability to see to one side (with one or both eyes).

HEMICRANIA. Unilateral headache (as seen in migraine or "sick headache").

HEMIPLEGIA. Paralysis of the muscles of one half of the body.

HEREDITY. Inheritance; the part of the organism that is derived from the germ plasm.

HOMOSEXUALITY. Abnormal erotic relationship with a person of one's own sex; possession of psychological traits characteristic of one of opposite sex.

HORMONE. Chemical substance produced by one of the glands of internal secretion and acting upon distant organs; "chemical messenger."

HYPERALGESIA. Exaggerated response to a painful stimulus.

HYPERTHYMIA. Exaggerated joyousness; exaltation.

HYPNOSIS. A condition similar to that of normal sleep occurring in persons who are preternaturally suggestible and usually psychologically induced for therapeutic purposes; mesmerism.

HYPOCHONDRIASIS. Condition in which the patient's attention is continuously occupied with the state of his own body or mind, with complaints of abnormal sensations referable to internal organs that are not diseased.

HYSTERIA. A functional neurosis in which there is a marked disproportion between emotional reactions and the stimuli that arouse them, with exhibition of various symptoms simulating organic disease of the nervous system in the absence of demonstrable pathological changes; the suggestibility of the patients is greatly heightened.

ID. Freud's term for that portion of the personality which is the source of primitive instinctual impulses to think or to act.

IDENTIFICATION. Recognition of sameness. The term is also used in a different sense by psychoanalysts to mean the unconscious mechanism by which the characteristics (real or imagined) of one person are reproduced in the personality of another.

IDIOCY. Extreme mental deficiency.

ILLUSIONS. Distorted perceptions resulting from sensory stimulation; external objects are wrongly interpreted.

IMBECILITY. Feeble-mindedness, less marked than in idiocy.

IMPERATIVE ACTS. Acts performed by patients because of an irresistible tendency (for example, nail-biting).

IMPOTENCE. Want of strength or power to perform an act; impairment in the male of capacity for sexual intercourse.

IMPULSE. Incitement or stimulus to action arising from some state of mind or feeling.

INCOHERENCE. Serious alteration of the connections among ideas.

INFANCY. The first five or six years of life; the pre-school period.

INFANTILE SEXUALITY. A term much used by Freudians to designate what they believe to be the normal sexuality of infancy and its unconscious and conscious derivatives in the adult.

INHIBITION. A restraint (or a paralysis) of function, due to mental causes in either a normal or a diseased person.

INSTINCT. An innate propensity to act.

INTROJECTION. The psychic experience of incorporating the love-object within one's self; for example, a child loving its mother may feel that he "swallows her."

INTROVERSION. Term used by psychoanalysts to designate instinctual processes that do not require an external object for gratification.

INTROVERT. One who turns his thoughts inward upon himself, rather than to the outside.

LIBIDO. Impulse to gain pleasure, especially sexual gratification.

MALINGERING. A pretence of illness to escape duty or for other personal gain.

MANIA. Mental derangement characterized by exaltation, excitement, pressure of activity, and preternatural feeling of well-being.

MANIC-DEPRESSIVE PSYCHOSIS. Circular insanity; alternation of melancholia with mania, with intervals of health.

MASCULINE PROTEST. In women, the refusal to accept the female rôle; this is common in female homosexuality.

MASOCHISM. A sexual perversion in which the patient feels the need of being injured or of experiencing physical pain in order to obtain maximal erotic satisfaction.

MEGALOMANIA. The mental state of one who suffers from delusions of grandeur.

MELANCHOLIA. Severe mental depression characterized by pathological sadness, slowing of thought, self-depreciation, self-blame, and often by suicidal tendencies.

NARCISSISM. Condition in which the dominant sex interest is auto-eroticism, with limitation of capacity for love of a person of opposite sex.

NEGATIVISM. Resistance to change (active or passive), often seen in schizophrenic states.

NEURASTHENIA. A functional neurosis characterized by irritable weakness, fatigability, and various mental and physical incapacities.

NEUROSIS. A functional nervous disorder.

NIGHT-BLINDNESS. Inability to see well in dim light.

NIGHTMARE. A feeling of suffocation or other great distress felt during sleep.

NOSOPHOBIA. An ungrounded fear of incurable disease or insanity.

NYMPHOMANIA. A disease in women characterized by morbid and uncontrollable sexual desire.

NYSTAGMUS. Recurring involuntary movements of the eyes (horizontal, vertical, or rotary).

OBSESSION. An imperative idea arising in the patient's consciousness and often recognized by him as an unjustifiable, nonsensical intruder.

OEDIPUS COMPLEX. Abnormal love of a son for his mother, with jealousy for the father; "mother fixation."

Sometimes used also to mean the abnormal love of a daughter for her father with jealousy of the mother, or "father fixation," though a better name for this is the "Electra complex."

ONTOGENESIS. The phases of the development of an individual.

ONYCHOPHAGY. Nail-biting.

OPHTHALMOPLEGIA. Eye-muscle paralysis.

ORAL EROTICISM. A psychoanalytic term for conscious or unconscious wishes connected with sensory stimulation of lips and mouth.

PARANOIA. A mental disease characterized by systematized delusions of persecution.

PARKINSON'S DISEASE. Paralysis agitans or shaking palsy, characterized by rigidity of the muscles, tremor, and mask-like face.

PERSONALITY. The assemblage of qualities that makes a person what he is, as distinct from other persons; the totality of the mental and social reactions of an individual.

PHOBIA. Abnormal fear.

PLEASURE PRINCIPLE. According to Freud, the principle that pleasure results from lessening instinctual tension and that all psychological processes are determined by a desire for maximal pleasure and minimal pain.

PROJECTION. Psychoanalytic term for an unconscious wish, character trait, or ideal that is ascribed to another person; for example, a man who is, or wishes to be, unfaithful to his wife, accuses her of infidelity to him.

PSEUDOREMINISCENCE. Something described by a patient as a memory of an actual event, though it has, in reality, no counterpart in his past.

PSYCHASTHENIA. A neurosis characterized by phobias and obsessions.

PSYCHIATRY. The part of medicine that has to deal with diseases of the mind.

PSYCHOANALYSIS. The method introduced by Freud for the study and treatment of abnormal mental states.

PSYCHONEUROSIS. A functional nervous disorder (like neurasthenia, hysteria, anxiety neurosis, or psychasthenia).

PSYCHOSIS. Insanity (not due to organic lesion) in which the symptoms are more severe than the mental changes in a neurosis.

PSYCHOTHERAPY. Treatment of patients by psychological methods.

PTOSIS. Falling of the upper eyelid, with inability to raise it; paralysis of the muscle that lifts the upper lid.

PUBERTY. The age of fourteen in boys and of twelve in girls.

RATIONALIZATION. A psychoanalytic term for an attempt to explain plausibly an event often unconsciously motivated, but without loyalty to all of the facts, as, for example, a woman saying that she loves music, when in reality she loves the conductor of an orchestra.

REALITY PRINCIPLE. A Freudian term for that function of the ego which governs the temporary denial of immediate pleasure in order to avoid painful consequences.

REFLEXES. Muscular or glandular responses to stimuli before they are perceived mentally.

REGRESSION. Reversion to earlier infantile modes of obtaining satisfaction.

REPRESSION. Renunciation of the gratification of wishes, accomplished unconsciously.

RESISTANCE. A term used by psychoanalysts to designate opposition to the methods of relieving the suffering of which the patient complains because of some unconscious craving.

SADISM. A sexual perversion marked by love of cruelty and by a need to inflict physical pain in order to attain to greatest sexual satisfaction.

SATYRIASIS. Excessively great venereal desire in the male.

SCHIZOID PERSONALITY. A type characterized by queerness or eccentricity, seclusiveness, and lack of sociability, depending upon a split in the internal harmony of the personality.

SCHIZOPHRENIA. Another name for the different forms of dementia praecox.

SOMNAMBULISM. Walking about or performing other actions while asleep.

SUBLIMATION. Term used by psychoanalysts to indicate the deflection of an unconscious sexual wish into some productive channel (work, play, art) that is socially useful and yields gratification.

SUGGESTION. A method of treating patients by authoritative statements that symptoms will disappear.

SUPER-EGO. Freud's term for the part of the personality that is concerned in self-observation and the development of conscience and ideals; according to Freud, feelings of moral guilt are expressive of a conflict between the "ego" and the "super-ego."

SYMBOL. Something used to represent something else; psychoanalysts regard the manifest elements of dreams as symbols of unconscious dream-thoughts (latent content of the dream).

SYNCOPE. A fainting spell, or brief unconscious state.

TRANCE. An intermediate state between sleeping and waking, met with in hysterical patients.

TRANSFERENCE. A psychoanalytic term for the emotional attitude developed by the patient toward his physician during treatment; this may be an attitude of affection and dependence (positive transference) or, in some cases, a hostile attitude (negative transference).

VERBIGERATION. A condition met with in mental diseases in which patients repeat nonsensical words over and over again.

VOLITION. Act of willing; conation.

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